

**Investigation into the circumstances
surrounding the death of a young woman
at HMP Durham in August 2005**

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

February 2007

This is the report of an investigation into the circumstances of the death of a young woman on 21 August 2005. At the time of her death, the young woman was a life sentence prisoner at HMP Durham. She was one of just six women held there in high security conditions. She was only 20 years old.

I would like to extend my condolences her family and friends for their very sad loss. I must also apologise for the delay in preparing this report and the further distress this will have caused them.

In June 2005 Her Majesty's Chief Inspector of Prisons had inspected the women's unit at Durham prison. In her report, published a fortnight after the young woman died, she wrote:

“Three months before this inspection, representatives of the women's team at [Prison Service] headquarters had noted that distress levels were very high among the women and there was a real risk of suicide unless significant changes were made quickly. Urgent action is needed to ensure that women prisoners are no longer held in such isolated and alienating conditions.”

Sadly action came too late for the young woman. On 20 August, following many episodes of self harm over the previous year, she tied a ligature round her neck with fatal consequences. Despite efforts to revive her, she was certified dead by just after midnight on 21 August.

This investigation was initiated by two of my colleagues. In June 2006, the investigation was passed to another investigator, a registered nurse who works in my office. In addition, a clinical review into the young woman's care and treatment was commissioned from the local Primary Care Trust. They appointed the Prisons Lead, for another Care Trust, to undertake the review.

I am grateful to all who have assisted, and to the Governors (past and present) and staff of HMP Durham for their co-operation with this investigation. I am particularly indebted to the Safer Custody Co-ordinator, who acted as liaison officer for my investigators throughout the investigation.

I have made seven recommendations arising from this investigation, three for the Governor of Durham, one for consideration by the Director of Prison Health and the Prison Service's women's team, one for the Medical Director at Durham together with the Durham and Chester le Street PCT, one for the Prison Service Press Office, and one for the Director General. The Prison Service has accepted and is acting, or has already acted, on five of my recommendations. It has rejected my recommendation for a change in procedure in its Press Office. The recommendation to the Director General, which has been partially accepted, was added following my personal consideration of the draft.

In addition to the usual recipients of my investigation reports, I am sending a copy of this report to the Governor of HMP New Hall for her consideration. The young woman spent some time at New Hall before being transferred to Durham.

One of the major issues arising from my investigation concerns the application of 'restricted status' to the very small number of women prisoners judged to represent a serious danger to the public. Given their small numbers, and the fact that some of these women may be a danger to themselves as well as to others, I believe there should be a more flexible and individualised approach to their treatment. Policies and procedures designed for the much larger number of Category A men do not reflect the special circumstances of women prisoners.

It will be clear to any reader of this report that the young woman was very troubled. She had been the subject of many psychiatric assessments in the community, in hospitals and in prison. Ten days before she died, she was assessed for the second time for her suitability for Rampton high security hospital by a consultant forensic psychiatrist. In his report, which was produced after the young woman had died, he concluded that she was:

“... undoubtedly mentally unwell but not so mentally unwell that she could be seen as suffering from mental disorder of a nature or degree which made it appropriate for her to be detained in hospital for treatment.”

This is a painfully sad report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The young woman was 20 years old when she died from strangulation by ligature on 21 August 2005 at HMP Durham. She had been there since 30 March 2005, having been transferred from HMP & YOI New Hall following her re-categorisation to 'Restricted Status' on 29 March. Restricted Status was introduced as a security category for women in December 2004. Prior to this, women of restricted status would have been categorised as 'category A' prisoners. The young woman had been in New Hall since July 2004, with the exception of seven weeks in a medium secure unit from October to December.

The young woman was first remanded into custody on 9 July 2004, charged with murder. She had an extensive history of offending over the previous year and had been on remand in New Hall before. However, she had never served a custodial sentence, having previously received community punishments for her offences.

Despite difficulties with being bullied and showing aggression at secondary school, the young woman had never been referred to the child and adolescent mental health services. However, she had been in the care of psychiatric services since she started offending. She started to self harm within that same adolescent period. When she came into prison, reports were received from outside agencies that she had a history of taking overdoses of medication and cutting her wrists. She had tried to hang herself less than two weeks prior to being remanded in custody. There were numerous psychiatric assessments in the run up to her trial, but little consensus on her diagnosis.

The young woman self harmed prolifically whilst in New Hall and to a slightly lesser extent at Durham. As well as tying ligatures and cutting herself, she caused herself injury by inserting foreign bodies into her arm and setting fire to her clothes. Until the act which led to her death, none of her actions had been life threatening. She was supervised and monitored within the arrangements set out in PSO 2700, Suicide and Self Harm Prevention, throughout her time in New Hall and Durham. I have raised some criticisms of compliance with PSO 2700 at Durham and made a recommendation accordingly.

Staff found it extremely difficult to motivate the young woman to engage in activities and keep herself and her surroundings clean. Staff at Durham tried to encourage her to change her behaviour, using the incentives and privileges available to them in the differential regime with its basic, standard and enhanced levels. Unfortunately, the wing staff undertook this responsibility in isolation from healthcare staff and the visiting forensic mental health team. The clinical reviewer has commented, and I agree with him, that attempting behavioural modification by withdrawing privileges was unlikely to help her mental state, and clinicians may have counselled against that course of action had they been involved. I have made a recommendation relating to this issue.

The clinical reviewer has also attempted to judge whether the young woman's care was equitable with that she might have received in the community. He says that it is difficult to imagine how latterly she could have been managed in a community setting and so, in this respect, custodial care was superior. He continues by saying that,

although the young woman was a 'very difficult patient', for the most part she received competent and even compassionate care from the healthcare teams supported by mental health in-reach services.

I quote in full another paragraph from the clinical reviewer:

“From start to finish in prison the young woman remained a danger to herself, and to a lesser extent, to others. Any of her suicidal gestures could have resulted in her death either by accident or intent. Although many of her self harming incidents were very minor and attention seeking, any episode which involves hanging or self strangulation is capable of going wrong and resulting in death from strangulation or other complications.”

THE INVESTIGATION PROCESS

1. The investigation was opened on 23 August 2005, by one of my investigators, assisted by an assistant ombudsman. That day, my investigator spoke to the young woman's mother on the telephone and also wrote explaining how liaison with the family would progress.
2. My investigator travelled to Durham on 26 August to visit the prison and familiarise herself with the environment, in particular that of I wing on which women prisoners were held. She also collected many of the records pertaining to the young woman's time in custody, including a large number of psychiatric reports.
3. My investigators returned to the prison on 30 and 31 August and 1 September. They met with the Governor, a representative of the Prison Officers' Association (POA), and with two members of the Independent Monitoring Board including its chair. They also conducted interviews with a number of staff and prisoners.
4. One of my Family Liaison Officers (FLOs), wrote to the young woman's mother on 14 September to introduce herself and the service that the FLO provides. She also confirmed a meeting with herself, my investigator, the young woman's mother and her solicitor, to be held on 3 October. Unfortunately, this meeting had to be postponed and it eventually took place on 2 November.
5. On 14 September, my investigators consulted with staff in the High Security Directorate (HSD) at Prison Service Headquarters (PSHQ) in order to learn more about the security classification and allocation of women prisoners. On 15 September, the assistant ombudsman contacted the security department at New Hall prison where the young woman had been held prior to her transfer to Durham. The purpose of the call was to ascertain the circumstances surrounding that transfer and the change in the young woman's security status. On 20 September, the investigators returned to Durham to conduct further interviews with staff.
6. On 28 September, my investigators met with the Women's Policy Group at PSHQ to find out more about the management of women prisoners and, in particular, the women at Durham. On 23 November, they met staff from the High Security Directorate to learn more about security categories and allocation of prisoners, in particular the application of category A.
7. On 25 November, the Primary Care Trust confirmed that they would be commissioning a clinical review into the circumstances of the young woman's death. A clinical reviewer was appointed and was provided with all the relevant medical documentation, including the psychiatric reports. The post mortem report was not available at that time.
8. Due to the complexity of the circumstances surrounding the final closure of the female wing at Durham in September 2005, the investigators met with the Head of the Women's Team at PSHQ and the healthcare advisor to that team, on 8

December. The purpose was to learn more about the management of women with 'Restricted' status under the security categorisation used in the Prison Service.

9. Subsequently, due to the illness of the principal investigator, the investigation fell into abeyance, and on 10 April 2006, the family liaison officer left my team. However, before she left she wrote to introduce her successor and to apologise for the delay in the investigation.
10. In early June 2006, I passed the investigation to a registered nurse who is also an investigator contracted by my office. Although it was unfortunate to change investigators during an enquiry, the replacement was able to immerse herself in the case fairly quickly, commencing on 22 June. She familiarised herself with the material amassed by my investigator and the assistant ombudsman.
11. The family liaison officer contacted the young woman's mother to explain the new arrangements and offer a meeting with the new investigator. The young woman's mother and sister preferred to hold any meeting once a draft report had been completed. This took place on 24 October 2006.
12. The particular issues identified by the family at their meeting with my office on 2 November 2005 were:
 - a) Why was the young woman a Restricted status prisoner?
 - b) Why was she not held at a local prison?
 - c) Why was there not more effective psychiatric assessment and intervention?
 - d) Was the young woman's self harming appropriately monitored and managed?
 - e) In addition the family felt that contact with the family had not been handled well by Durham. At the meeting on 24 October, they enlarged on this issue. They cited the following examples:

Initially, they were offered only transport costs for the young woman's body to be returned to Sheffield. It took a week for the prison to decide what contribution they would make to the funeral expenses. They said they had to call the prison many times and were not provided with consistent information.

The prison suggested that they would bring the young woman's property to the funeral. Understandably, the family felt that was inappropriate. Following the funeral, some property was returned by courier without the required itemised list.

The prison was represented at the funeral but sent no flowers. The letter they sent to the young woman's mother offered no condolences

but simply stated that they were enclosing a cheque for her outstanding personal money.

- f) The family were upset by how quickly the news of the young woman's death was on Ceefax.

13. Subsequently, the family and their solicitor raised further issues of concern. These were:

- g) Why was the young woman held in a men's high security prison (Wakefield) during her trial?
- h) Why were Women's Policy Group at Prison Service Headquarters not consulted about the decision to hold her in Wakefield?
- i) When the young woman was held at Wakefield, her family were not allowed to know her movements and were consequently unable to visit her or provide property or money.
- j) The young woman's family described the regime on I Wing at Durham as lacking systems and procedures, leading to a poor visiting environment. (Visits for the few women prisoners took place on the wing.) They found it difficult to send the young woman new clothes which would fit her, and believed that some money and property they sent in did not reach her.

14. On 17 July 2006, my investigator arranged to visit Durham to conduct a second interview with one member of staff. The interview was undertaken on 3 August. She also met with a community psychiatric nurse (CPN) who had worked with the young woman, and with the clinical reviewer to discuss the clinical review. In addition she met the Coroner's Officer who provided her with a copy of the post mortem report. It had not been forwarded to my office within the usual timescale of two or three months due to an administrative oversight.

All transcripts of taped interviews were forwarded to the prison for the interviewees to read, amend where necessary, sign and return. All interview transcripts were duly signed and filed.

HMP DURHAM

15. Following a full unannounced inspection of Durham from 18 - 22 August 2003, Her Majesty's Chief Inspector of Prisons described Durham as a very complex prison holding Category A men and women as well as operating as a local prison, and running a closed supervision centre for some of the most dangerous male prisoners in the prison system. The inspectorate returned unannounced on 5–9 January 2004, to make the first separate inspection of the women's prison. At that time, the female centre was a high security facility in one wing that held up to 124 women, mainly those serving long sentences including a small number of Category A prisoners.
16. The unannounced inspection took place at the end of an 18-month period in which there had been five self-inflicted deaths, four of them women serving life sentences. That was a very high proportion of a small and relatively stable population who were not subject to the risks inherent in the early days of custody. Two general points emerged from the inspection. First, in spite of attempts to brighten the interior, the female centre was a constricted physical environment with little space for association or activity and a particularly dispiriting and bleak exercise yard. This was described as:

“scarcely likely to enhance the mental state of women who were feeling depressed and anxious.”
17. Second, the Chief Inspector concluded that the women's prison was, to a considerable extent, “out of the line of sight” of the overall management of the prison. The men's prison was referred to as the ‘main’ prison; and across important areas – such as suicide management, drugs and resettlement –there were no separate policies for women. Furthermore, the Chief Inspector described the women's prison as being on the periphery of the women's estate, being managed as part of the high security estate, overwhelmingly consisting of serious, and often dangerous, male offenders.
18. In the Chief Inspector's view, these factors had contributed to the levels of distress and mental disorder that were evident during the inspection. She concluded her report by recommending that the women's prison should be closed, and the women accommodated in other women's prisons with better facilities and appropriate security restrictions for those few women who needed them.
19. The Chief Inspector returned to Durham on 7 – 8 June 2005. By that time, the vast majority of the women previously held in the women's prison had been relocated to other establishments. The women's unit was now located on I wing (which formerly housed the close supervision centre (CSC) for men) and comprised eight cells. The inspection report said that the Chief Inspector had been advised by the Prison Service that no accommodation in the rest of the women's estate was considered sufficiently secure for the six women who remained. There were plans to transfer some of them to Low Newton when security improvements allowed (and the remainder elsewhere), but there was no clarity among staff or prisoners about the progress of these plans. This was

still the prevailing view during my initial investigation, although it was clear that women would not remain at Durham indefinitely.

20. Accountability for decisions about the women in Durham was complex. The Governor and the North East Area Manager had operational responsibility for the running of the unit, while the women's team at Prison Service headquarters (PSHQ) had the task of managing the women's relocation. The Director of the High Secure Estate alone could decide on the women's security status and the suitability of any proposed future accommodation.
21. I would not normally quote from an Inspection Report at such length but I feel that it is significant to this investigation that in July 2005, only a month before the young woman's death, the Chief Inspector wrote:

"The Prison Service itself was well aware that the situation was having a seriously damaging effect on the few remaining prisoners. Three months before this inspection, representatives of the women's team at headquarters had noted that distress levels were very high among the women and there was a real risk of suicide unless significant changes were made quickly. In the three months before the inspection, four women accounted for nearly a third of all self harm incidents among the prison's total population of over 700; and seven of the fifteen most serious suicide attempts in the prison as a whole had been carried out by women."

"Previously, we described the 100 or so women at Durham as being out of the line of sight of the overall management of the prison. This remained the case for the six who remained; and the conditions in which they were held had deteriorated. Urgent action is needed to ensure that women prisoners are no longer held in such isolated and alienating conditions."

KEY FINDINGS

At New Hall 9 July 2004 – 30 March 2005

22. The young woman was received into New Hall on 9 July 2004. She had been remanded in custody, charged with the murder of a stranger in a public place. She was 19 years old. She gave an address in Yorkshire and her occupation as receptionist. The young woman had been at New Hall before (from 15 December 2003 until she was discharged to the psychiatric unit in Liverpool on a hospital order under Section 38 of the Mental Health Act 1983 (MHA 1983) on 2 March 2004). Her offending history since 2003 was substantial, including violence and carrying a weapon, but she had not served a custodial sentence.
23. The young woman was initially received into the Healthcare Centre (HCC) because of reports received from outside agencies which indicated that the young woman had a history of taking overdoses of medication and self harming by cutting her wrists. She had tried to hang herself less than two weeks previously. A suicide and self harm monitoring form (F2052SH) was opened. (This document was not among the papers provided to my investigator, but it evidently remained open until she was transferred to an outside hospital on 25 October.)
24. A Cell Sharing Risk Assessment (CSRA) was completed on 10 July which concluded that the young woman was a high risk for sharing due to the nature of her charge. On 11 July, she was seen by the Lifer Liaison Officer (LLO) who completed Form LSP0 – identification of potential life sentence prisoner. The question whether the young woman's case was to be submitted as a potential category A prisoner was answered in the negative on the form. An information pack for potential lifers was logged as being given to the young woman on 16 August.
25. On 14 July 2004, the young woman was discharged from the HCC to F wing. On 18 July, she wrote a letter to the Governor telling her that the wing was too big, there were too many people and the other young women knew about her offence. She wanted to be moved to the segregation unit. She wanted her concerns to be taken seriously and said: "I just want to die."
26. It was difficult to establish whether the young woman actually moved from F wing. However, there were strong indications that she spent the core day on the HCC from this time until her transfer to a Secure Unit on 25 October. In particular, her Incentives and Earned Privileges (IEP) record was maintained in the HCC. As was usual practice, the young woman was initially placed on the standard level of IEP scheme. On 14 August, she was warned about her swearing and reminded that she could be put down to basic as a penalty for continued breaches of behaviour. On 4 September, the young woman was recommended to be upgraded from standard to enhanced level at her next review. The upgrading was confirmed on 12 September.
27. Despite one or two warnings for misuse of her cell bell, the young woman remained on the enhanced level until she was transferred under the MHA 1983

an independent medium secure psychiatric unit for women in Nottinghamshire on 25 October. She remained there until 13 December when she returned to New Hall. In a letter to the Mental Health unit (MHU) at the Home Office, written on 10 December, the consultant psychiatrist wrote that he had diagnosed “emotionally unstable personality disorder of the borderline type”. He said they had stabilised the young woman and there was no further treatment they could offer at that time. However, he believed that the young woman might require further periods in a secure hospital in the future.

28. The evidence about how the young woman felt about being in hospital rather than prison or vice versa is equivocal. Staff at the psychiatric hospital thought she was happy to be going back to New Hall, whereas a note in her lifer file made on 15 December contradicted that view. In a letter from New Hall, read by staff and made the subject of a security information report (SIR), the young woman wrote to a friend:

“I made the decision to come back here as I have more chance of harming myself.”

29. The young woman was identified in reception as a suicide risk when she returned to New Hall on 13 December. A F2052SH form was opened and she went to the HCC for observation for the night. Before she was moved to F wing at 2.45pm on 14 December, her CSRA was reviewed and she was found to be still a high risk due to the murder charge. She was found with a ligature at 3.15pm. She tied another ligature at 8.25pm. Staff provided her with the Samaritans telephone.¹ Later that evening she complained to staff that she was hearing voices being transmitted over the radio. At 1.45am, she told staff she was feeling suicidal. She accepted the Samaritans telephone and settled down. She was disturbed by the ‘voices’ again at 3.10am.
30. On 15 December, a lifer officer completed a further LSP0 form identifying the young woman as a potential life sentence prisoner. Potential Category A status was again rejected. The young woman told him that she had not known her victim. The young woman was described as a prolific self harmer with mental health problems. Later she told staff she could not cope on F wing. She was very tearful and handed over a piece of metal. A F2052SH review was held which the young woman attended and at which she agreed to the support plan. She was found with a ligature at 9pm and later used the Samaritans telephone.
31. On 16 December, she was found with a ligature round her neck at 8.05am. She gave staff no explanation of her actions, but again telephoned the Samaritans. She later went to the chapel with the chaplain who made an entry in the F2052SH at 11.55am. The chaplain reported that the young woman had been emotional but was now in good spirits. At 9.35pm, the young woman was found under her bed with a ligature around her neck.

¹ The Samaritans and the Prison Service have collaborated to provide mobile or cordless telephones which prisoners can only use to telephone the Samaritans.

32. On 17 December at 6.20pm, the young woman tied a ligature and barricaded her cell but staff were able to gain access and remove the ligature. On 18 December, at lunchtime, she told staff she wanted to kill herself. She said she was being threatened by the other women and wanted to be moved to the segregation unit for her own protection. Staff helped her to write a statement to the Governor regarding this request. At 3.35pm, the young woman was found with yet another ligature.
33. A F2052SH review was held on 19 December. It was noted that the young woman found the wing too big and was nervous about associating with the other women. She said she wanted to die. The staff decided to keep her on frequent observations four times an hour. The young woman had a visit from which she returned very unhappy, saying she felt like hanging herself. Later she talked to staff about how unhappy she was about leaving her family at the end of the visit. Ten minutes later she was found with a plastic bag in her mouth. That evening the young woman was persuaded by another trainee to participate in association. At 9.15pm, she was again expressing suicidal thoughts to staff and she handed over a length of material which she had intended to make into a ligature. The young woman was again found with ligatures at 5.45pm and 6.15pm on 20 December.
34. On 21 December, the young woman attended an adjudication on a charge related to the barricade on 17 December. The adjudication was not proceeded with, but no reason was recorded. A governor grade chaired a F2052SH review on 21 December and drew up a plan to help staff manage the young woman over the Christmas and New Year period, including defining 'triggers for management action'. The young woman had agreed to the plan which involved increasing her participation in activities and association with others, and promising not to tie ligatures. It detailed the purposeful activity to be undertaken whilst in the HCC. It is evident that the young woman was located on F wing, but spending the core day in the HCC. The objective of the plan was to equip her with the necessary knowledge and skills to work as a cleaner on the care and support unit (CSU) by being a cleaner in the HCC initially. Staff were reminded that she would want to move to the HCC, but they were to avoid that if at all possible. The young woman helped with Christmas decorations, but was tearful in the evening and used the Samaritans telephone again.
35. The young woman was next found with a ligature on 22 December at 9.30pm. She tied another ligature on 23 December at 8.30pm. On 24 December, the deputy governor told wing staff that the young woman had written to her solicitor saying she wanted to die. The young woman's suicide risk was again reviewed as she had tied two ligatures in the previous 24 hours. She refused to attend the review. She was reported to be isolating herself from the other prisoners and failing to comply with her compact. She tied another ligature at 6.20pm. There was a note on the file dated 24 December about a visit arranged by the young woman's mother for 2 January 2005. A further note indicated that the young woman's great grandfather had died that day, but she was not told immediately at her mother's request.

36. The young woman did not participate in any Christmas Day activities and refused her dinner. She tied another ligature at 5.25pm and another at 10.00pm. She was found with another at 11.00am on Boxing Day and again at 9.10pm on 27 December. At her mother's request, the young woman was informed of her great grandfather's death by the chaplain on 28 December at 4pm. She also spoke to her mother on the telephone. The chaplain prepared the young woman for the likely decision that she was ineligible to attend the funeral (a governor's discretion is limited to only very close relatives). At 4.15pm, a F2052SH review was held. It was arranged that she would receive daily visits with the chaplaincy staff for three days. It was noted that her mother was visiting on 2 January 2005. She remained on four observations per hour and had ready access to the Samaritans telephone. The young woman tied a ligature at 5.45pm.
37. The next ligature was at the same time on 29 December. Later that evening, she spoke with the senior officer about her bereavement. She said she would write a poem for her great grandfather and take it to the chapel the next day. On 30 December, the young woman was seen by a lifer officer who noted in the file that she said she was unfit to plead and would not stand trial. She tied a ligature at 4.25pm using torn bedding. The staff member warned her that if she continued to tear the sheets, they might have to give her the indestructible (strip) bedding. She did not tie another ligature until 4.30pm on 1 January. The young woman's mother visited on the afternoon of 2 January and, although initially thought to have no problems on her return to the wing at 4.15pm, the young woman made a ligature at 5pm.
38. On 3 January in the evening, the young woman asked for a Listener² who came to see her about 6.30pm. On 4 January, her self-harming was reviewed at 11.00am and considered to have reduced. Her observations were consequently reduced to twice an hour. She made a ligature at 2.55pm, but then went to see the chaplain and felt better on her return. Early on 5 January, The young woman first expressed an interest in earning enhanced status in the IEP scheme. She later attended a service in the chapel timed to coincide with her great grandfather's funeral. The chaplain noted that it had made her think of the girl whom she was charged with killing and expressed concern about her vulnerability at this time. She tied a ligature at 12.50pm. At 9.00pm she told an officer she felt like self-harming. However, her next attempt was at 5.30pm on 6 January when she tied another ligature. She talked to a Listener that evening.
39. At 5.15pm on 7 January, the young woman was found with another ligature. A note on the same date in her history sheet indicated that she had been told that the state of her room was not good enough for someone seeking enhanced status. The following day she tied a ligature at 4.45pm and saw a Listener later in the evening. On 9 January, she tied a ligature at 3.00pm and again received support from a Listener. On 10 January, she tied a ligature at 3.15pm but later came out for association. On 11 January, the young woman was interacting

² Listeners are prisoners who volunteer to act in support of other prisoners at risk of suicide or self harm. They are trained by the Samaritans.

well with staff. She had the Samaritans telephone overnight. On 12 January, she spent half an hour of the evening with a Listener. On 13 January, a F2052SH review was held. Support was to continue from the healthcare centre and the young woman was hoping to be employed there as a cleaner. She had not self-harmed for three days so observations were reduced to hourly, but irregular.

40. On 16 January, the young woman had visitors. She told staff later that she felt very low and might hang herself. She was offered a Listener and the Samaritans telephone, both of which she accepted. The senior officer increased the frequency of observations to half hourly, for further review in the morning. A risk assessment for sharing a cell (CSRA) was repeated on 19 January and she continued to be considered as high risk. Observations were continued virtually half hourly until the next review on 20 January, when they were reduced to two hourly as the young woman had not self harmed since 10 January and was appearing to benefit from medication.
41. On 23 January at 9.30pm, she called the staff to tell them she had inserted a staple in an old cut on her arm. However, after being seen by a nurse she settled for the night. On 25 January at 1.10pm, the young woman told staff she had inserted a pen into her left arm and the nurse attended. At 9.00pm on 26 January, she called staff and told them she had swallowed a quantity of tablets. At 9.40pm, she was admitted to the HCC. Nothing untoward occurred overnight and a F2052SH review was held at 11am on 27 January before the young woman was discharged back to F wing. She told the review that she had taken the tablets to get some sleep and the pen injury was simply opportunistic. Those present acknowledged how much improvement she woman had made. The chaplain saw the young woman for an hour and attended her review.
42. On 27 January, as part of her F2052SH support plan and after numerous appeals from the young woman recorded in her history sheet, her personal officer made a referral for her IEP status to be upgraded. She was further reviewed on 29 January and found to be settling well on F wing. The support plan included a proposal for the young woman to undertake a computer course in education.
43. On 1 February, the young woman went by taxi to the Accident and Emergency Department (A&E) at hospital, regarding the injury to her arm. A foreign body was removed and she returned to the prison at 5.00pm. Later that evening, she asked for the Samaritans telephone saying she felt very 'down'. At 9.15, she put a pen into her left forearm. After assessment by a nurse, she was booked in to see the doctor next morning. The following evening she had the Samaritans telephone again. On 3 February, the young woman had the telephone again in the day time. She also had a positive session with a member of the chaplaincy. From the review report it is clear the young woman was very distressed that there had been a death in custody at New Hall. At 9.50pm, she called staff to tell them she had put a pencil in her arm. She was seen by a nurse and settled down for the night.

44. There were pages missing from the suicide and self harm record from 10.00pm on 3 February to 3.00am on 8 February. However, in her history sheet her personal officer noted on 7 February that healthcare staff had reported that the young woman had been self harming. They emphasised that refraining from self harming was a condition of the job they had given her in the HCC. The personal officer recorded that healthcare staff thought she was self harming to avoid work, and s/he commented that the young woman must work if she was to achieve enhanced status.
45. At 11.05pm on 8 February, the young woman put a ligature round her neck and tied it to the window. Staff entered the cell and at the same time the ligature snapped. A note in the F2052SH on 9 February said that a Principal Officer reported that the ligature attempt had involved the young woman attaching the ligature to a pipe and attempting to jump. The nurse was called to attend. At 11.45, the young woman was described as having set fire to her arm. The fire was put out and the nurse called again. She admitted the young woman to the HCC for observation.
46. The young woman had a review on 9 February, at which she reported that she was being bullied on the wing. It was felt that this might account for the recent increase in the young woman's self harming and an investigation was ordered. Staff were asked to reinforce to her how well she was doing on the wing. Observations were set at four times an hour, although at 6.35pm the term constant supervision was written in the supervision and support record and she was then observed quarter hourly.
47. On 10 February, the young woman had a very positive day, attending education where she made a Valentine card for her mother. However, at 5.10pm she set a fire in her cell as she did again at 6.20pm. She was recorded as uninjured (although an entry on 12 February referred to her hand being re-dressed). The young woman was moved to a cell where she could be observed on camera. A note on her security file dated that day recorded that the young woman had set fire to her clothes and herself. The note continued that she had been placed on a disciplinary report. The young woman was charged with having an unauthorised article (a cigarette lighter). At the adjudication on 12 February she pleaded guilty and was given a suspended punishment
48. On 12 February, the young woman attended a concert which she said she enjoyed. Quarter hourly observations were recorded without any event until 1.10pm on 14 February when the young woman said she had put a pencil in her arm. A nurse attended and confirmed it could be felt in her left arm. Later, she played board games with other prisoners.
49. The young woman's self harming was reviewed at 3.45pm on 15 February (the review report is dated 14 February, but this was clearly an error). The young woman attended the review and said she had been stupid. She asked to have her access to pens and pencils restricted. She said she did not want to die. Her observation regime was agreed at four times an hour and she was to move back to F wing in the afternoon. The HCC discharge report said she was 'well

behaved, pleasant mood' and repeated the decisions from the review. The report also advised she should not have access to lighting materials because of her history of fire starting. All her medication was to be taken under supervision by the nursing staff.

50. At 8.40pm on 16 February, the young woman called the night staff and told them she felt suicidal. They raised their level of vigilance accordingly. The young woman went out to hospital on 17 February to have the foreign body removed from her arm. She was seen by a lifer officer on 18 February who found her 'in a good mood'.
51. On 19 February, the young woman's self harm risk was reviewed at 10.45am. She was seen to be in a bright mood, reported being settled on F wing and wanted her observations reduced to hourly. The reviewers decided to reduce the observations to half hourly during periods of lock down with 'qualitative' entries at other times. She was being supported by a named nurse and a member of the chaplaincy team.
52. At 5.35pm, she told staff she was upset about not seeing her parents on a visit. Later she was reassured by a message about her mother ringing in. At 7.25pm, the young woman went to see a nurse who then informed staff that the young woman had taken a quantity of tablets but there was no reason for concern. The young woman told staff that she could not cope on the wing. An entry in her history sheet notes that the young woman was being bullied, but no consequent action was recorded. The young woman spoke to staff of her continuing distress over her mother being unable to visit the next day.
53. After a call from the young woman about feeling suicidal at 12.25 am on 20 February, staff increased the level of observations again. The young woman later inserted a pen in her arm. A nurse attended and treated her. At 8.45pm on 21 February, the young woman was seen by a Senior Officer with regard to a move to another location the next day. At 8.55pm, an officer recorded that the young woman had named the prisoner who was bullying her. There was no record of any direct action following this disclosure. At 9.45pm, the young woman claimed she had swallowed the batteries from the Samaritans telephone that afternoon. Nursing staff said they did not believe her claim and a member of wing staff said the young woman had been using the telephone at 8pm. The young woman spoke again of her wish to move off the wing.
54. At 3pm on 22 February, a chaplain who had been seeing the young woman quite regularly, wrote a detailed entry in the F2052SH detailing her concerns. She had found the woman tearful, not coping and was disappointed with what she saw as a lack of action following her naming of the bully. Again there was nothing on the file to show that anti-bullying measures had been implemented. The young woman mentioned to the chaplain that she missed her family and was concerned about her impending court appearance. At 8.35pm, the young woman claimed she had taken 23 ibuprofen tablets. Healthcare were informed and the poisons bureau contacted for advice. No action was taken, although staff spent time trying to talk and listen to her anxieties. At 11.20, the young woman claimed she had taken 10 epilim tablets, saying she was upset about

her court appearance. A nurse was contacted, but advised that it was unlikely she had taken anything.

55. The night and following day passed uneventfully until 4.00pm when staff rang the young woman's mother as she was concerned she had not had a letter for two weeks. The young woman was reassured by the message that a letter and cheque had been posted and her mother would be visiting on Sunday. At 8.40pm, she was found with a ligature. She repeated to the officer who found her the concerns she had about being bullied for tobacco. Again no consequent action was recorded in her file. At a late stage in the investigation my investigators sought to find out if the bullying allegation had been investigated and logged in the alleged bully's file, but to no avail.
56. The young woman attended hospital on 24 February for an x-ray. The x-ray showed two batteries in her body. She also still had a pen in her arm. The wound had healed and the hospital had not had any plan to remove it. At 12.30pm, the young woman was found on the floor of her cell with a ligature around her neck. It was removed and the wing nurse attended. At 2.15pm, she had a self harm review where they noted her repeated attempts of late. Her previous support plan was reiterated. At 4.30pm, the probation department organised a call to her mother for her and she was seen to be happy after it. However, she tied another ligature later that evening.
57. The young woman went to Crown Court on 25 February. In reception she told staff that she did not want to go to court and that she wanted to kill herself. At court she made a self harm attempt at 10.15am. Court staff reported that she had opened up the old wound on her arm and taken a pen out. She was subsequently strip searched to exclude any other objects and received treatment to her arm from the court custody staff who put her under constant watch.³ At 12.55pm, the young woman said she did not like New Hall and wanted to go on the 'hospital wing'. At 1.10pm, she told other court custody staff that she was 'fucked in the head' and said that she was schizophrenic. She also told them she feared being sent to a psychiatric hospital, a long way from her family. She said ill people made her worse and she did not want to go on the hospital wing.
58. The young woman later returned to New Hall, unhappy that she had not been able to make her plea in court. She was found with a ligature at 8.10pm, but would not talk to staff. Ten minutes later she made another ligature. She said that voices were telling her to do it and asked to see the nurse. The nurse was contacted, but said there was no need for her to see the young woman. However, she did come to see her at 10.05pm. She told the wing staff there were no concerns.
59. At 10.15am on 26 February, the young woman told staff that voices were telling her to kill herself. She said she had been hearing them all night and was trying to ignore them. At 7.20pm, she told staff she wanted to kill herself because of

³ The Prison Service wish to point out that it 'is trying very hard to ensure that everyone uses the term constant observations/supervision' instead of constant watch. Constant watch has been used in this report because it was the term used in the documentary evidence and/or by staff at interview.

her worries about her family and going to court. She was complaining of stomach pains which she thought were due to the batteries. Healthcare staff were informed and a nurse came and reassured her the batteries would pass naturally. The young woman reiterated her suicidal thoughts at 8.20pm but staff reassured her, reminding her that her family were visiting next day. At 8.50pm, the young woman used bedding to tie a ligature. The nurse attended and no treatment was necessary.

60. On 27 February, wing staff noted in the history sheet that the young woman was not caring for herself. They had talked to her about it and encouraged her to be more active. At 7.30pm, she told staff she 'felt like doing something' after an emotional visit. The staff raised their level of vigilance. On 28 February, The young woman attended a further adjudication in respect of the previous fire setting. She pleaded guilty and received a further suspended punishment. The chaplaincy reported that she later made a real effort to participate in their art class. At 10.00pm, she made a ligature and said she was hearing voices.
61. On 1 March, the woman told staff she was worried about which hospital she would go to and felt like 'tying up'. At 5.15pm, she tied a ligature and healthcare staff attended. The young woman initially refused a transfer to the HCC, but then agreed and was relocated there at 6.45pm. On 2 March, her self harm was reviewed. The reviewers noted that she was being assessed with a view to transferring her to psychiatric hospital under the Mental Health Act. She would be staying in the HCC until discharged by the psychiatrists. She was to be observed half hourly.
62. Over the next few days, the young woman attended education classes in the HCC. On 4 March, she told the chaplain she would hang herself and had the means to do it. She often had use of the Samaritans telephone. On 8 March, she was upset and told staff she wanted to go home to her parents. The young woman saw a psychiatrist for 15 minutes at 4.00pm. She tied a ligature at 6.35pm. On 9 March, the young woman's self harm behaviour was again reviewed. She told the reviewers she was unhappy in the HCC. They decided to set her observations twice hourly.
63. An event occurred on 11 March which came to be referred to as 'the hostage incident', although the security file entry uses the term 'potential hostage incident'. The young woman was attending education classes in the HCC, although during the morning she had also seen the chaplain and been to the probation department. At 11.33am, she grabbed a teacher and held a metal cup hook to her throat. Staff intervened without using physical restraint. The young woman stopped her action with little persuasion being necessary and there was no injury to the teacher. The incident was reported locally and statements are on file from officers.
64. At 12.00 noon, her observations were increased to four per hour. At 12.15pm, she was found tying a ligature. At 2.45pm, she was described as crawling round her bed crying and screaming, but by 3.00pm she was reading a book. The same day (11 March), the young woman wrote to the healthcare manager, and a senior healthcare worker. In the letter she apologised for what she had

done that morning. She wrote that she did not know why she had taken the cup hook, but did know exactly what she would do with it. She spoke of letting down herself and the staff. She mentioned that she might need some counselling or something to come to terms with her situation which she was finding very difficult to cope with. She asked for help and emphasised that she would ring for someone to come when she was not feeling good as she had been told frequently to do. However, she said she did not like doing that because she would rather cope on her own. She added that she was expecting too much of herself. She finished: "As much as I hate to say it, I need help. I don't know how much longer I'm going to be able to cope".

65. The young woman was placed on a disciplinary report for the 'attack' on the teacher and the charge of assault was referred to an independent adjudicator (a District Judge). However, the adjudication was not proceeded with because it became 'out of time' after her move to Durham. This was due to no response being received from the department responsible for allocating cases to independent adjudicators. The department claimed later that it had no record of the request.
66. The wing observation book shows that on 12 March the young woman was on a 'restricted unlock' and standard level of IEP. She was found with another ligature round her neck at 12.30pm on 14 March. On 15 March, she had a case review attended by eight staff from a wide cross section of disciplines. The support plan identified action for the doctor and staff in the chaplaincy, probation and education departments. The nursing staff were to implement a care plan. The report was written by the healthcare manager. It states:

"Long debate took place about her location and her safety and the safety of others in view of the incident on Friday. It was eventually agreed that she would remain located on HCC until Monday and reviewed by the Public Protection meeting with a hope of a long term plan. To have continuous observation between the hours of 8am – 8pm on HCC because of trying to reduce the risk of others approaching her and passing implements to her. 4 obs an hour during the night. To remain 3 officer unlock until Monday then for review."
67. An entry in the F2052SH at 4.10pm referred to the case review. She added, "after discussion with staff agreed to give her a telly tomorrow if her behaviour remains stable." (It is not clear when the young woman's television had been removed.) The young woman's CSRA was reviewed on 15 March and she was still considered a high risk for sharing. She saw a visiting psychiatrist for almost two hours on 16 March. The following days were uneventful for the young woman in the HCC. She had her television back and occasionally used the Samaritans telephone.
68. A Public Protection meeting was held on 21 March attended by 12 people including the governor responsible for young offenders, the head of psychology, two probation staff, the head of healthcare, a senior nurse and a community psychiatric nurse as well as a member of the security department. The meeting noted the prolific self harming. A senior nurse commented that it

would 'be a miracle if she stayed alive in prison'. The meeting also noted that, although she had made several assaults on staff during previous periods in custody at New Hall, she had been 'quite well behaved' this time. The meeting was told that the incident with the teacher had been 'quite gentle'. Although the young woman had said she could 'rip the teacher's throat out', she had let go of her immediately when other staff arrived and left the room without resistance. The meeting recognised the young woman's ability to change behaviour radically at a moment's notice.

69. The meeting continued with a discussion on the woman's mental health. She was reported to be on 'lots of' psychotropic medication. It was recognised that there was little or no consensus between the six psychiatrists who had examined her. Some of those present thought she was aware that a defence of insanity might result in dismissal of her murder charge. The young woman was thought to require a lot of stimulation. She often referred to being 'fed up' or bored. It was agreed the best way forward was some form of motivational reward, and an individual care plan was drawn up for her by the cross section of disciplines represented at the meeting. It covered the period 21 – 29 March initially and included 'constant officer presence' and purposeful activity in her cell. There was no mention of a referral to the High Security Directorate as a potential category A (or restricted status) prisoner.
70. The present deputy governor of New Hall was the head of operations at the time of the potential hostage incident. He told my investigators on 30 November 2006 that the young woman's security category was reconsidered following the hostage situation. He completed the necessary documentation and, on 22 March 2005, instructed the security administration clerk at New Hall, to send a fax to the Directorate of High Security at Prison Service headquarters (PSHQ) reporting the young woman as a potential category A prisoner. In her contemporaneous security file, a note confirmed that she had been submitted as potential Category A and was to be treated as such until a decision was made at headquarters. A lifer officer noted at 10.35am on 22 March that the young woman had been seen, but no mention was made of the category A issue. In another file the security manager at New Hall, noted on 23 March that the young woman's case had been submitted due to the nature of her charge and the recent incident. The Principal Officer noted that the healthcare manager, had confirmed that the young woman was unfit for segregation due to medical concerns.
71. The young woman attended a further review of her suicide and self harm risk on 23 March. She was told during the review that she was now a potential category A prisoner. The young woman interacted well with the team and said she was looking forward to the hour out of her cell on Friday (27 March) which was part of her care plan.
72. On 24 March, the young woman told a community psychiatric nurse (CPN) that she was hearing voices telling her to kill herself, but she could distract herself with puzzle books. On 25 March, she was described as very upset in the afternoon and spent some time on the telephone to the Samaritans. During the next few days, she participated in chapel activities, took her meals, watched

television, slept and occasionally used the Samaritans telephone. On 29 March, she had a routine meeting with the probation department at 11.15am. On her return she was tearful, grumbling to staff about the restrictions still in place from her last case review. The staff drew up a further detailed care plan for her covering the next week.

73. An Executive Officer in the category A review team at PSHQ signed the decision to categorise the young woman as 'restricted status' on 29 March. (This category had come into use in addition to category A or potential category A, in relation to women prisoners in December 2004.) The rationale for the decision was that the (alleged) crime was 'horrific', the victim was unknown to her and she had 'specifically taken a knife out with her, to use on another person'. The Executive Officer also noted that the young woman had attempted to take a teacher hostage at New Hall.
74. On 29 March, faxed confirmation of provisional restricted status was sent to New Hall. A letter ordering the transfer of the young woman to the women's wing at HMP Durham was also sent. The transfer took place on 30 March at 12.45pm. One of the Durham officers who collected her wrote in her history sheet that she was initially shocked by the distance, but excited about the facilities which she had been told about. She was also described as apprehensive, concerned about her visitors and whether she would have to move to another prison. Later on during the journey she became tearful. They arrived at Durham at about 4.40pm that afternoon.

Durham 30 March – 21 August 2005

75. A comprehensive report, together with the minutes of the public protection meeting on 21 March and the most recent care plan, were sent to Durham, along with the contact details of the four staff who had drawn up the plan. The report was in the young woman's documentation, but it is not clear whether it accompanied her or was sent in advance. The report made it clear that she had been considered too high a risk to others to put on a normal residential wing. However, it also stressed that she was too much of a risk to herself to be held in segregation. The young woman's current regime at New Hall was described in some detail. The public protection issues she presented were emphasised as was the fact that she had not yet been made the subject of a formal Multi Agency Public Protection (MAPPA) assessment.
76. From interviews with staff at Durham, it is evident that they had not been given a lot of information about the young woman prior to going to collect her from New Hall. A Senior Officer on I wing commented that she thought the young woman's category A status (as she called it) had come through very quickly. There had been insufficient notice for them to go to New Hall to interview her, which they might have done if time had allowed. The young woman's personal officers, said they knew about the hostage incident, but the third personal officer did not. A Principal Officer, responsible for I wing, told my investigator he had no clear briefing about her. He thought she was 'super cat A', but had no intelligence as to why.

77. A cell sharing risk assessment was completed on arrival at Durham in which it was noted the young woman was reluctant to share accommodation. This was irrelevant since the women on I wing were in single cells. Staff told my investigator they were expecting someone 'extremely dangerous'. The recommended location was in a 'safe cell' with constant watch. According to the I Wing - Staff Observation Book, staff were warned of the 'potential problems'. These were identified as potential hostage situations, self harming and manipulation of staff. It advised 'there should be no physical contact by anyone, no in cell association and she was never to be on her own with probation, chaplain or education.' The young woman's property was to be stored in the cell next door to the safer cell where she was to be located. There were then five other women prisoners on the wing, which had accommodation for eight.
78. At interview, an officer said that when the young woman first arrived she was put in a cell with a perspex covered gate. The cell was normally used for the observation of any prisoner on 'constant watch'. The officer thought she was in that cell for up to two months. From the F2052SH it is evident that the young woman was being watched, because she complained it was preventing her sleeping. However, written observations were intermittent, not four times an hour.
79. On 30 March, a multidisciplinary team which included the young woman reviewed her suicide and self harm risk. She was nervous, but asked questions particularly about visitors. She was apprehensive about meeting the other prisoners. The review did not stipulate the level of observations required and the support plan was in broad terms only.
80. At midnight on 30 March, the young woman was reported in the F2052SH to have told the night officer that she felt suicidal and that she was hearing voices. The wing observation book records that she was awake until 4.55am, pacing the floor, hiding in her toilet area and saying she was too anxious to sleep because it was her first night. At 9.00am, she complained that she was shaking because she needed her medication which she normally got at 8.30am in New Hall.
81. Another F2052SH review was held on 31 March when it was decided to keep the young woman on constant watch until 3 April. The support plan was more specific and included use of the Samaritans phone. A note on the F2052SH dated 30 March, signed by the prison doctor read as follows: "Late entry. I spent some considerable time with the young woman night. I appreciate staff caution but am not convinced that a constant watch is essential."
82. On 31 March, a note in the book from another officer said that the young woman tried to 'cuddle' her. The note continued: "This is typical behaviour for her as warned by New Hall. Not sure whether she understood properly, as she just appears to look straight through you and say nothing just grin. All staff should be aware of her 'need' to touch."

83. Later that morning, the young woman told an officer that she felt like hanging herself. The officer tried to engage her in explaining why she felt like that, but the young woman just 'grinned'. At 1.30 pm, staff were asked to note that the splint on the young woman's wrist had metal in it which she could remove. In the observation book, staff were instructed to watch the young woman regarding her medication because of a risk of hoarding. The doctor had wanted her to have liquid medications, but they were not available.
84. At 7.30pm on 31 March, an officer wrote in the F2052SH that the young woman had played cards with the staff and written to tell her mother 'how wonderful Durham is'. The officer also noted that the young woman 'didn't want to go to Low Newton though'. Five minutes later she added that the young woman had said she would hang herself if she had to go to Low Newton.
85. The young woman was seen by the visiting psychiatrist on 1 April. On 2 April, entries in the F2052SH indicate that a constant watch was in progress, but the observations were not recorded with the expected frequency of four – five times per hour. The young woman told an officer she was feeling a 'bit suicidal'. The officer talked to her for a while and offered the help of a nurse, but the young woman declined. Later, staff were alerted that the young woman might not be swallowing her night medication and were asked to be aware.
86. At 4pm on 3 April, the chaplain held a brief service with the young woman and she 'seemed quite content'. By 4 April, according to the observation book but not corroborated in the F2052SH, the staff were concluding that the young woman required a lot of motivation to perform 'normal everyday tasks'. The writer noted that if staff gave her encouragement and instilled in her some self belief, she would give them fewer problems than indicated by her last establishment. Staff reported encouraging the young woman to do cleaning on the wing so she would be paid earnings. The young woman said she was shaking too much to clean properly, but she hoped to improve with different medication.
87. On 4 April, a further case review was held at 2.15pm. From the report it is evident that the young woman's constant watch was an issue. It was noted that the psychiatrist had advised the need for constant watch on 1 April. However, the registered mental nurse present at the review was asked to contact the psychiatrist 'with a view to reviewing [the constant watch] before the two weeks recommended'. The report concluded: "The review panel felt that an intermittent watch might have otherwise been more suitable."
88. Following a quite sociable interlude, seeing the chaplain, booking a hair appointment and playing cards, the young woman tied a ligature at 8.00pm. Healthcare staff were informed but no treatment was required. At 00.35am on 5 April, an officer noted that she had written a letter for the young woman to her sister. The young woman had told her to say she liked it at Durham apart from the constant watch. The next day, signs of the young woman's lack of motivation began to appear in the F2052SH.

89. At 10.45 on 6 April, the Safer Custody Officer visited the young woman to discuss the reasons for her self harm attempt (ligature). She gave the constant watch as her reason, and he tried to explain the reasons for it which she appeared to him to accept. On 7 April at 1.00am, the young woman told a member of staff that she could not move her arms and she wanted the nurse to send her to hospital. The member of staff told her the nurse would come in the morning. The young woman then said she hated Durham.
90. On 7 April at 9.30am, the young woman had a meeting with a CPN who attended Durham three days per week (for the whole prison population, not solely the women). A case review was recorded as being held at 2.00pm on 7 April, but from the F2052SH it is evident this took place on 8 April. At 10.50pm, staff entered the cell to cut a ligature from the young woman's neck. The orderly officers and a nurse attended. In the wing observation book for that day, staff were reminded that three days before they had been asked to motivate the young woman, yet she was still being allowed to stay in bed all day. The writer of the entry suggested drawing up a timetable for the young woman to achieve some objectives.
91. At 00.20am on 8 April, the young woman was reported by an officer to be laughing about the earlier ligature. At 1.45am, she opened the wound on her left arm with a spoon. At 3.30am, she stuffed a plastic bag in her mouth, but handed it over when asked. She also handed over a pen because she felt like harming herself with it. Staff notes show they were unsure whether the young woman was allowed pens. The case review was held at 2.00pm, but the young woman 'stormed' out in protest about the continued constant watch. The report stated that all who attended agreed that the constant watch was necessary. The support plan was broad and unspecific. It was reported in the observation book that the young woman said she was self harming because she was bored and hated being in her cell all the time. She said she could not do education because she was waiting for glasses. Staff were asked to chase this with the optician. Overnight, the young woman's personal officer wrote an entry about the young woman being in good spirits and having benefited from having had something to do during the day. However, the F2052SH supervision record showed no evidence of productive activity during the day.
92. On 7, 8 and 9 April, the young woman declined breakfast. On 9 April, she also declined lunch, but ate the evening meal and mixed well with staff. A pattern of long periods in bed, even after getting up and dressed, was beginning to emerge. On 11 April, the young woman and the other prisoners had a meeting with a principal officer about the move to Low Newton. The young woman also attended an art class. She had a telephone call with her stepfather and was pleased to know he would be visiting her that Sunday. Later she cried about her mother not being able to visit and was given a telephone call to her. At 9.35pm, the young woman told an officer that she was hoping to go to Rampton Hospital to 'get well again' rather than to Low Newton.
93. The young woman had her hair done at 4.00pm on 12 April. At 8.15pm, she was found beside the toilet having tied a ligature with a 'J' cloth. A nurse attended. The young woman said she would do it again because she missed

her family so much. On 13 April at 00.30am, the constant watch officer removed the young woman's plastic cutlery because she was threatening to cut her arms. The young woman was shaking a lot and agitated as she could not sleep. The officer noted that one reason she could not sleep might be that she had slept all day. The young woman said she liked the television on to get her off to sleep.

94. At 11.30 on 14 April, the Safer Custody Officer visited the young woman. She spoke about being upset about her mother not being able to visit because she suffered from panic attacks. The young woman was also upset because she had no money to telephone her mother. The Safer Custody Officer asked the wing to give her a call at the prison's expense. During the morning, she had a gym assessment and went to the gym again in the afternoon.
95. An entry in her history sheet on 15 April stated that the young woman passed urine on her cell floor, prior to a visit from her solicitor. The writer added that the solicitor had reported that at New Hall the young woman had self harmed or set a fire when he was due to visit. There is no mention of this event in the F2052SH, although the solicitor's visit was corroborated. The young woman told the night officer she felt suicidal and they had a long conversation after which she was calmer.
96. On 16 April at 3.30am, the young woman was recorded to have wet her bed. The night officer supervised her changing her nightie for clean pyjamas, ensured the bed was dry and talked to her for some time. According to the observation book entry for the day, staff asked the young woman to clean her cell because 'she seems to be incontinent which is making the landing smell.' Again there is no mention of this in the F2052SH. During the following night, the young woman insisted on putting her mattress on the floor to sleep.
97. On 17 April, the young woman refused to take a shower even though her family were coming to visit. At 1.50pm, she was seen by a registered mental nurse. She found the young woman difficult to engage, feeling depressed, not settled yet. The young woman was unhappy about the constant watch and wondered when she would next see the psychiatrist to review it. The young woman linked her depression to her admitted loss of interest in self care. She wanted someone to talk to on a regular basis. The nurse said she would come again, possibly the following week.
98. At 3.10pm, the young woman said she wanted to die. She said her solicitor had told her she might be sentenced to 15years. At 5.45pm, the young woman made an attempt to set fire to her 'toilet cell'. No injury was reported. At 7.50pm, she pushed a spoon handle into her left arm and was once again treated by nursing staff. An hour later she did it again. All potentially harmful objects were then removed from the young woman's cell. At 11.10pm, she complained of a numb arm and leg. A nurse attended and gave her some analgesia.
99. On 18 April, staff again reported the young woman had wet herself and there was urine on the floor of her cell. They helped her have a shower. She

appeared to sleep for a large portion of the day and then was very restless during the night. Staff recorded that the state of her cell was unacceptable. Another history sheet entry indicated that the young woman was blaming herself for her mother being ill and unable to visit.

100. At 8.50pm on 19 April, the young woman was observed to have a possible slight fit. Staff entered the cell, called for the nurse and put her in the recovery position. When checked by the nurse nothing untoward was found. At 9.50pm, she wet herself. At 00.30am on 20 April, the night orderly officer recorded that he had opened the young woman's cell for staff to help her clean herself and the cell after wetting herself. He wrote in the record that the state of the cell was 'appalling' and said staff must help her clean thoroughly both it and the cell next door to get rid of the smell of urine. The young woman made a further self harm attempt at 2.50am, going behind her privacy screen and putting a plastic bag in her mouth. The orderly officer and duty nurse attended and the bag was removed with no harm done. However, staff reported that the young woman tried to push her way out of the cell, saying she did not want to be there. Staff prevented her from leaving the cell. The young woman was given a verbal warning for causing disturbance to other prisoners. Her TV was removed briefly, but returned after she had showered, changed her clothes and cleaned her cell.
101. During the day of 20 April, staff reported the young woman being very uncooperative with the wing rules about cleaning and showering. However, she later attended a yoga class which they thought she much enjoyed. She again moved her mattress onto the floor at bedtime. On 21 April, the staff tried to keep the young woman awake in the day and described her as 'getting annoyed' about this. At 6.00pm, the young woman inserted a spoon into her left arm and subsequently received treatment from a nurse. At 10.10pm, she told staff she had put cardboard in the wound. A nurse attended and treated it and gave her night medication. The young woman wet her bed again that night.
102. The young woman had a case review on 22 April (an interval of two weeks despite her continued active self harming). Just three staff attended, two wing staff and the psychiatrist. The psychiatrist had recently changed the young woman's medication and therefore advised that the constant watch be continued. The observation book indicates that the young woman's behaviour was leading to complaints being received from the other prisoners on I Wing.
103. Reports over the next few days refer to the young woman wetting the bed, sleeping throughout the day and being awake for most of the night. On 24 April at 1.05pm, the young woman claimed to have taken an overdose of 30 paracetamol tablets. Healthcare staff organised blood tests for toxicology studies, although the young woman initially refused these. At 3.05pm, she handed a member of staff a note thanking her for her help and saying she took the tablets to sleep not to kill herself. She said that the constant watch made her anxious and upset. She also wrote that it was 10 paracetamol, not 30, plus sodium valproate and haloperidol, and she would have the blood tests. These were all medications prescribed for the young woman. Although the risk of

hoarding had been highlighted previously, there was no evidence of an investigation into this incident or any follow up action to prevent hoarding.

104. The young woman was later described as complaining of stomach pains one minute and laughing and joking the next. At 6.15pm, she was crying because she wanted her mother. An officer distracted her successfully with plans to make a card for her mother next day. The nurses would not give her any medication until they had the blood test results. The results showed no trace of paracetamol or any of the other medication. At 10.30pm, the young woman was seen lying on the floor behind her toilet. Officers entered the cell. The young woman told them she was coughing and vomiting blood. They called the nurses who said the blood was fresh, probably from her mouth or tongue and not from the stomach.
105. On 25 April, the young woman was seen and examined by a doctor who wrote in the F2052SH, but the entry is hardly legible. He prescribed treatment for indigestion and noted her poor sleep pattern which he would further review. At 6.30pm, the young woman was reported to be acting very strangely. At one point she stood on the table and said she was scared of being bitten by the spiders she could see all over the floor. At 8.05pm, she told staff she was hearing voices coming out of the television. She was also tearful. Staff wrote in her observation book that they thought she wanted to go to outside hospital. At 9.30pm, she said she felt suicidal and at 10.40pm handed out of her cell a ligature made from the drawstring of her jogging bottoms. At 10.50pm, she told the night nurse that there was a transmitter talking to her through one of the officers.
106. Night staff found a sharpened pen in her cell on 27 April. They made a note that the young woman must be made to understand that her behaviour and attitude were unacceptable. She was told that the penalty would be the removal of her television and stereo if she continued in the same vein. In the observation book, staff noted that the young woman was hearing voices telling her to assault staff and submitted a security information report (SIR). Security staff noted that it was their impression that she was 'desperate to go to an outside hospital'.
107. At 8.20am on 27 April, the young woman set fire to her pyjama bottoms. According to a member of staff, events unfolded as follows:

“I was on duty that day, I think it was a male member of staff that was watching her basically and she never liked doing her toiletry in her cell, going for a 'number one or two' and she would use this empty cell next door which housed all of her clothes because she only had the basics in there that she couldn't self harm with and she went to use the toilet. It was allowed that she could use the toilet next door and obviously a man would shout, are you alright, are you alright but like female staff, like I would go in, some other staff went in. And you give her the benefit of the doubt that she is on the toilet and when you come out or you look through the obs[ervation] panel, you can see her. And this day this officer just I was sitting on the twos and he just sort of motioned to us like to go and check her which she'd only been in I would say

about five minutes. And of course he was shouting to her, are you alright, yes, yes. And I went in and she was sitting on the floor and I could smell the burning and she was sitting on the floor, we just moved the whatever it was that she'd set fire to but it was on her leg, the material and I had a radio on us and I'd to call for hotel one [duty nurse].”

108. An entry in the F2052SH at 11.20am mentioned that the young woman expressed regret about the fire. At 1.10pm, a member of staff noted that he had discussed with the young woman what might have precipitated her burning her leg. He reported that she was concerned about the continuing constant watch. She said she was hearing voices but did not want to kill herself. 20 minutes later the young woman was told that coming off constant watch was unlikely.
109. It transpired that the young woman had picked up a cigarette lighter from a table used by staff when she was moving from her cell to the toilet cell. She used the lighter to set fire to her clothing. As a result of the fire setting, staff decided that she would not be allowed a lighter in possession at any time. A note to this effect was made in the F2052SH on 27 April (and in the observation book on 28 April). In the afternoon of 27 April, by prior arrangement, the young woman was assessed by staff from Rampton High Security Hospital. The young woman was troubled by hearing 'her' voices that night.
110. The young woman had a much more settled day and night on 28 April. A case review on 29 April showed that those present considered the young woman had shown great signs of improvement. The psychiatrist had seen the young woman prior to the review and again attended herself. She said the improvement warranted a reduction in observations. With everyone's agreement, the self harm monitoring regime was decreased from constant watch to intermittent - five observations per hour, with which she seemed 'very happy.' The officer on duty that night recorded spending 45 minutes sitting with the young woman from midnight because she did not want to be alone. She eventually tried to sleep after one of the other prisoners complained about her talking loudly.
111. On 30 April, staff recorded in the observation book that the young woman had pressed her cell bell every time she wanted to talk rather than waiting to be checked, even though she knew that staff passed her cell every 10 minutes. The writer noted that the young woman had said she felt better knowing staff were 'sat by her cell till she falls asleep.' With the exception of the cell bell reference, the entries in the F2052SH were constructive and staff were given written praise for their work with the young woman by a visiting manager.
112. The young woman then had five fairly positive and uneventful days. However, on the late evening of 5 May, staff noted that she was very restless, hearing the voice of a little girl telling her to harm herself. At 2.25pm, the young woman was reported to have told a member of staff that the voices she was hearing were two men and they were telling her to assault staff. At 4.15pm, she saw the psychiatrist at her cell door to discuss a change in medication. A Senior Officer noted in the F2052SH that the young woman was quite lucid despite her

conversation being about men in her room and a dead girl. In her observation book, staff noted that she was very worried about her court case. She said she had 'a transmitter' in her head and knew that was why everyone thought she was 'mad'.

113. On 6 May, PSHQ issued a movement order authorising the young woman's move to HMP Wakefield (a high security prison for men) where she would stay in the HCC while being tried at Sheffield Crown Court. On 8 May, the young woman asked for plastic bags to pack her belongings, but her request was denied as staff knew of her history of using plastic bags to self harm. The young woman was worried about going to another prison, but relieved that Durham staff were escorting her there. At 7.00am on 9 May, before leaving for court, she had a case review of her self harm risk. She told the reviewers that she was very frightened about what was to happen. She was reassured and her observations were set at intermittent watch, which was implemented in terms of continuing five observations an hour when she was not in court.
114. The escort on 9 May was conducted at the security level required for a Category A prisoner, which was compliant with the instructions for the management of restricted status women when out of the prison. While at court, the young woman was seen three times in the cells by a psychiatrist. She arrived at Wakefield HCC at 6.30pm. The young woman attended court daily and returned to Durham with the same level of security escort at 5.05pm on 13 May. While at Wakefield, a case review was held on 12 May and her support plan and observations remained as before.
115. On 13 May, staff gave the young woman use of a stereo over the weekend. On 14 May, she reported she was hearing voices telling her to harm herself and smash her television. She said she heard voices again the next day. She left Durham at 7.15am on 16 May to return to Wakefield to continue her trial. At 7.20 am on 17 May, the young woman refused to get dressed for court, but she relented and was on the van by 8.10am. She returned to Wakefield at 5.50pm, where she was visited by the chaplain from New Hall. The young woman received a letter from a high security male prisoner which was censored by staff. She said she had written to him because she knew he had been on trial for murder too and might offer her some advice.
116. On 18 May, an officer at Wakefield completed another LSP0 form. It noted that the young woman was accommodated in the Wakefield HCC for the duration of her trial. Inexplicably, the form has been completed to the effect that the young woman was not a potential category A prisoner. On 19 May, Wakefield staff noted in her history sheet that she had been given permission by the judge to 'come and go from the dock as she chose'. She was also reported to be 'demanding' diazepam (a benzodiazepine hypnotic and anxiolytic) three times a day. She was already on a prescription of diazepam twice a day and this was not changed. The young woman was reluctant to go to court on 20 May, but she was persuaded quickly. She returned to Durham at 7.10pm for the weekend. In the observation book, staff noted her cell was 'very smelly' and on 21 May staff wrote that she had to be told constantly to tidy her room, and only complied after staff used a raised voice on three occasions. The young woman

was very tearful at 5.45pm, telling staff she could not cope with her trial and not being able to see her mother. She also claimed she had not been getting her mail. She told staff she felt suicidal.

117. The young woman returned to court on 23 May and then went back to Wakefield that evening. On 24 May, she slept much of the morning in the court cell. On 25 May, she got quite agitated at court and on the van returning to the prison, when she said she could not cope. Staff noted that she was 'clutching her rosary beads'. The night at Wakefield passed uneventfully and 26 May followed a similar pattern to the previous day. A number of times during her court case staff noted that the young woman had asked for photographs of the victim of the crime. She had also previously asked the friend she wrote to in December 2004, to find photographs of her victim for her. She did so again on 27 May when she received a life sentence for murder with a recommended minimum term of 14 years imprisonment. The young woman returned to Durham at 4.10pm. Three of the prisoners who were interviewed remembered that she was shouted at by a member of staff when she asked for a towel for a shower soon after arriving on the unit. My investigators were unable to find any staff who recalled this incident.
118. A Senior Officer held a case review on the same day. In the review summary, the Senior Officer noted that the young woman was feeling sorry for what she had done but gave no indication that she would self harm. The young woman had been able to ring her parents and had already seen the chaplain. The review concluded that constant watch in the safer cell was likely to make her feel worse, so observations remained intermittent. At 5.15pm, the Senior Officer told the young woman her stepfather had booked a visit for 12 June together with her sister. The young woman saw the doctor that evening and he prescribed sleeping medication for two nights.
119. On 1 June, the young woman mentioned the transmitter in her head for the first time for some while. She said the transmitter was telling her the staff were ganging up on her. On 2 June, staff wrote in the observation book that the young woman was experiencing 'drastic mood swings', although this is not fully borne out in the F2052SH. She told staff that her mother had been upset by the news coverage of her trial and their comments about her 'relationship' with a well publicised convicted murderer through an exchange of letters. The young woman was apparently expecting her sister to send her in some new shoes.
120. On 4 June, the young woman was reported to have a shower cap in her possession which she was putting over her face before going to sleep. At a suicide and self harm monitoring review on 5 June, staff decided she should remain on intermittent watch. She was to be allowed her lighter during the day. She had been allocated the task of cleaning the wing's 'beauty salon', and this made her eligible for weekly wages.
121. On 8 June, staff noted in her history sheet that she had been given a verbal warning about the state of her cell. At 8.40pm, the young woman told staff that the voice of the little girl was telling her to cut herself. Later, a different staff

member noted that the young woman had said that staff would not listen to her when she talked about the voices she was hearing. At 10.00pm, she told staff the little girl was trying to get into her body. Staff commented that the young woman was upset one minute and the next was asking for a cigarette or about television programmes.

122. The young woman cleaned the beauty salon on 9 June and was thought to be in good spirits. At 9.40pm, she said she wanted to die because she could not cope with her sentence. She also told staff it was the anniversary of her husband's death and he no longer visited her because of the little girl. At 11.20pm, the young woman told the night officer that no-one came to see her and no-one understood her. The staff member noted that every time the young woman was checked on she wanted to talk. The officer had advised the young woman that at night their voices carried and disturbed the other prisoners. She advised the young woman to try to talk things through in the day time, which might make her more settled at night.
123. There was a further review on 10 June, when the intermittent watch was continued along with multi-disciplinary support as before. The young woman was at this time showing signs of being more talkative and active in the day time. The same day the lifer manager completed the LSP1B form - recommended initial allocation to first stage prison – saying the young woman required separation due to her restricted status, making the Durham (women's unit) the only option. The lifer manager also signed off the LSP1C form – post-conviction induction interview – which an officer had completed on 6 June. The officer had explained the life sentence system to the young woman and told her she would stay at Durham, pending a suitable alternative being found because I Wing was due to close to women. The young woman expressed her guilt, but said she was shocked at the sentence. She expressed her concerns over her mother, who she said was agoraphobic and unable to visit. She also talked about her extended family.
124. In the observation book on 12 June, the young woman was noted to be forming a close friendship with one of the other prisoners on the wing. She had also attended a computer class and helped to put plants in the exercise yard. The young woman was asked about a letter in which she said that, if it was not for her friendship with the other prisoner, she would kill herself. She said she had not meant it, but staff were alerted to be vigilant about the friendship.
125. On 13 June, wing staff noted that the young woman's leg was probably infected (I take this to be a reference to the burn site). A nurse took a swab to identify whether an infection was present. The young woman was noted to be using the exercise treadmill. The next day staff recorded that she and her cell smelled offensively and the young woman was asked to clean it. An officer wrote in detail about the matter in the young woman's history sheet, reporting that her usual response was to accuse staff of picking on her. At 10.20pm, the young woman threatened to self harm when the nurse was giving out the night medicines. In the observation book it was recorded that she got into bed after the officer had told her she would be moved to the safer cell. In the F2052SH, it was noted that the young woman was asking to see the visiting CPN.

126. On 15 June, the young woman was in conflict with the officers over their insistence that she shower herself and clean her cell. Two other prisoners were upset by her behaviour. The young woman asked to see the psychiatrist about her voices. There is an entry in her history sheet on 15 June to the effect that she had been seen by a community psychiatric nurse (CPN), who had said that the young woman's actions were 'normal self harm'. The view expressed was that she was 'manipulating', but to what end was not known.
127. At 7.00pm, the young woman said the voices were telling her to self harm, but after talking to staff she appeared more settled. At 10.20pm, she told the night staff that she was feeling very guilty about her victim. She described the voices that were telling her to self harm as she was born of the devil. She said that talking to her mother made her feel much better. At 10.55pm, the young woman told another officer that she would self harm because it was the anniversary of her boyfriend's suicide and they had had a suicide pact which she did not keep. At 9pm on 16 June, she told the night staff it was the anniversary of her husband's death.
128. At 2.45pm on 17 June, the young woman was seen by an occupational therapist (a member of the visiting psychiatric service) who recorded that, although the young woman was feeling very low, she did not express any intention to harm herself. At 6.10pm, the young woman told an officer she felt like cutting herself. Later, she told staff the voices were telling her to self harm. At 8.00pm, the young woman cut her left wrist with a plastic lid and received treatment from a nurse. It is noteworthy that this was the first episode of actual harm since the fire on 27 April.
129. On 18 June, the young woman was allowed to sleep during the day, only getting up at 4.00pm. Her behaviour was unpredictable, changing from singing loudly to being upset by her voices and saying she wanted to cut herself. At 11.30pm, the young woman opened an old wound with a plastic fork and required medical attention from the night nurse.
130. On 20 June at 9.45pm, the young woman was seen crying on the toilet. She said she was upset over the anniversary of her husband's death. The member of staff recorded that he had tried to console her without success. At 11.05pm, the young woman asked to see a nurse because she had fallen and hurt her neck. A nurse came and gave her some painkillers. The young woman slept throughout the night and much of the following morning. That evening she cut her left arm and was again treated by a nurse.
131. On 21 June, an officer made a long entry about the young woman's bad mood, argumentativeness and generally unacceptable behaviour. He commented that the young woman treated staff with complete disrespect, and then cried to get her own way.
132. On 22 June, the young woman's self harm risk was reviewed. The young woman attended and in the report the reviewers described her as very negative. They offered a variety of support and encouraged the young woman

to open up more to them. Observations were to be 'regular'. The same day an LSP1A form – post conviction immediate needs assessment – was completed, noting the young woman was now on normal location and had been referred to Rampton Hospital. At 10.20pm, the young woman told the night officer she felt the need to cut herself, but he talked to her and the night passed without incident.

133. On 23 June, the lifer manager signed off the LSP1D form – local prison lifer profile – for the young woman. An officer described the young woman as not being a control problem, but noted there was a risk of violence citing the hostage incident at New Hall. She also expressed concern about the young woman's mental health, adding that this might make her 'difficult to manage in normal conditions'. The young woman went to an outside hospital for an x-ray at 1.50pm. Late that night, she cut her left forearm and received treatment from a nurse.
134. On 24 June, the young woman exhibited resistance to the wing routine and instructions from the officers. She did not want to get up, shower or clean her cell. She also refused to attend a session with her personal officers, who wanted to draw up a wing compact with her. The young woman said she was unwell. She said she had been vomiting in the night, but the night staff did not record anything to corroborate this. At 3.30pm, a nurse saw the young woman and issued an instruction for her to 'rest in cell' for three days because of the risk of spreading infection. The young woman used the telephone, returned to her room and slept. She later collected her tea, without reporting any further problem. At 2.25am, the young woman complained about her breathing and a nurse came to see her.
135. The young woman was allowed to sleep all the next morning, although staff recorded that she was unhappy about being woken for a response every 10-15 minutes. The F2052SH entries over the next few days showed that the young woman was doing very little except eat and sleep. She was still officially resting in her cell due to sickness. On 27 June, a nurse saw the young woman to tell her she was no longer under the rest in cell regime. The nurse gave The young woman firm advice about the infection in her leg, warning her she was at risk of septicaemia and putting staff and other prisoners at risk of cross-infection.
136. According to the F2052SH, the young woman was seen by psychologists on 28 June, but nothing was found to corroborate this. In the report of his assessment of the young woman on 10 August, a doctor from Rampton referred to the young woman being assessed by a Consultant Clinical Psychologist and an Assistant Psychologist, on 1 June 2005, but there was no other mention of any contribution from the psychology department at Durham.
137. According to the observation book, staff now decided to try to motivate the young woman with a tailored regime. On 29 June, a new timetable was drawn up for the young woman to start on 3 July. It ran:

1. Shower daily

2. Clean and tidy room daily
3. Make sure you are up and dressed for meals and meds
4. Follow correct procedures for disposal of dressings
5. Follow timetable
6. At all times you must be polite and respectful to staff and fellow prisoners
7. Comply with prison rules
8. Failure to comply will result in downgrading to basic regime

138. The young woman received the behaviour and activity compact from her personal officers and signed it. They reported that they offered to help involve her, but the young woman had little to offer saying she was only interested in horses. She told them they were picking on her. The young woman often had to be cajoled into having a shower and then took one very briefly. On most occasions, she put back on the clothes she had been wearing. The next day staff wrote in the observation book that the young woman had objected to their advice that she must shower before touching food because of the infection in her leg. She was also warned after being heard shouting to male prisoners.
139. An officer spent some time with the young woman on the evening of 1 July, because the young woman was threatening to cut herself again. The officer thought she had made some progress in supporting the young woman and preventing her from self harming at that time. Unfortunately, the young woman presented the oncoming night officer with a further threat to cut herself 20 minutes later. The young woman wrote letters and appeared to staff to be in good spirits on 2 July. She had a family visit with her stepfather and sister on 3 July, which she appeared to enjoy very much. However at 6.20pm, 8.00pm and again at 1.00am she threatened to harm herself.
140. At 5.50pm on 4 July, the young woman told a member of staff that she was very upset about not being able to see her mother and said she wanted to go home. The member of staff tried to help, but the young woman 'stormed off to her room'. That evening, the member of staff spoke at length to the young woman who was threatening to cut herself. Again the young woman rejected the support offered saying: "It's alright for you, you haven't killed anyone."
141. On 5 July at 8.25pm, the young woman cut her left forearm and again received treatment. On 6 July, she attended the women's group in the HCC and reported that she had enjoyed it. At 11.10pm, she made a superficial cut on her right arm. On 7 July, an entry in the observation book recorded that the young woman was not cleaning her room as per the compact and she had also been late for lunch. She was given a verbal warning about her non-compliance with the compact. None of these was noted in the F2052SH.
142. On 8 July, the young woman took part in making cards which she later showed to staff. She also baked a cake and ate most of it. A self harm review was held that day and the young woman was described as 'adhering to her compact'. Her observations were to remain at intermittent. On 10 July, she told staff she was hearing voices and that she wanted to cut herself, but after a long conversation she settled down to watch television.

143. There were many entries in July relating to the progress or otherwise in relation to the compact. On 11 July, wing staff recorded in her history sheet that the young woman had been told she was 'lazy, dirty and idle'. This was also noted in the F2052SH which described a confrontation with the young woman that morning over her poor hygiene and the state of her cell. At 5.59pm on 12 July, the young woman asked a member of staff if she could have a rug hook in her cell overnight. She was not happy about this being refused, even though she was told that the decision would be reviewed when she started to comply with her compact. On 13 July, the young woman mentioned the voices again but said she was able to control them. On 14 July, she was allowed to keep the rug hook until 8.00pm.
144. On 15 July at 3.00pm, she was warned that if she did not get up and clean her room her TV and radio would be removed. The threat was carried out at 3.15pm, whereupon the young woman made toast, and then cleaned (poorly according to the staff, but sufficiently to be given back her TV and radio at 3.55pm).
145. On 16 July, the young woman had an F2052SH review. A note emphasised that she had requested the review as she wanted to come off the intermittent watch. The reviewers all agreed the intermittent watch should be reduced to normal monitoring. The young woman did express concerns about night time, but was reassured of staff support. Entries in her F2052SH demonstrate that there were still strong criticisms from the staff about her cleaning
146. On 17 July, the young woman was assessed by a CARATs⁴ worker. She asked for further CARATs input and for auricular acupuncture.⁵ Staff noted in her history sheet that she had been visited by the chaplain. At 6.00pm, the young woman reported that she had twisted her ankle, but there was no obvious sign of injury. The struggle over compliance with the compact became a running issue over the following days.
147. At 6.00pm on 19 July, the young woman was noted to be on the telephone to her mother. At 1.45am, she told the night staff she had not seen or heard from her mother. According to a security file entry on 22 July, the young woman told staff she was very upset about her mother, but no reason was given. The young woman said the voices were telling her to hurt a prisoner or member of staff. She also claimed to have found a lump under her arm for which she was being referred by the nurse.
148. On 20 July, the young woman had visitors. However, her record also contained a reference to her 'not considering her timetable'. On 21 July, the young

⁴ CARATs is part of the Prison Service's drug strategy. It stands for 'Counselling, Advice, Referral, Assessment and Throughcare'.

⁵ The CPN explained about the provision of auricular acupuncture for the treatment of anxiety and depression. She had conducted one session with The young woman on the HCC. Officers and CARAT workers were also trained to do acupuncture. There had been a risk assessment for conducting acupuncture on the wing.

woman had an auricular acupuncture treatment at 3pm. At 7.50pm, the possibility of the young woman having the rug hook overnight was discussed by staff. They agreed she was doing really well and allowed her to have it. On 22 July, the young woman was given a final warning for not complying with the compact. She was told that the penalty would be to be downgraded to the basic level of IEP. According to a security file entry on 22 July, the young woman told staff she was very upset about her mother, but again no reason was given. On 23 July, one of the young woman's personal officers noted she had made a real effort to shower and interact and described it as a good day.

149. The young woman had a visit with her stepfather and sister on 24 July. On 25 July, according to the observation book, she was up until three in the morning constantly shouting for a named Operational Support Grade (OSG). She was not willing to talk to other staff. There was no mention of this in the F2052SH. The next day, staff noted that she was waiting to see the psychiatrist but she did not arrive. The psychiatrist was the visiting forensic consultant psychiatrist who was responsible for her second referral to Rampton on 1 August.
150. On 27 July, a member of staff made an entry in the young woman's history sheet that she had had a session with her about her non-compliance with the compact. The young woman's lack of interest in complying resulted in a regime assessment panel form being completed, recommending she be downgraded to basic. She wrote that the young woman had had a three week trial period but records showed she had made little effort to comply with her individualised regime. Her other personal officer also recorded a conversation during which she had explained very thoroughly what they were trying to do for her through the compact. She emphasised that 'other prisons would be more strict'. The F2052SH described the young woman trying to justify why she should be allowed to stay in bed all day and not adhere to her timetable.
151. At 11.00am on 27 July, the young woman's Incentives and Earned Privileges status was 'downgraded' to basic. The board was chaired by a governor grade, in the absence of the wing principal officer. The young woman was placed on a specifically tailored regime, referred to by some as 'semi-basic'. The IEP board lasted a long time. When they decided to put the young woman down to basic, she started to cry and had to be calmed down. She was told the board needed to discuss the decision without her and she made 'wailing noises' all the way back to the wing. The board knew the young woman had a history of self-harm and did not want to punish her in case it increased her self-harm. For this reason, they did not reduce any contact with her family or take her television away as they thought this would be too harsh. She had a television and radio in her cell when she was locked in, but it was taken away during association, although this is not totally consistent with what was implemented. When the young woman came back to have the plan explained to her, she was calm and it was thought she appreciated being treated leniently.
152. 'Partial-basic' was an unusual step and had been tailored to suit the woman's circumstances.

153. A member of staff wrote in the F2052SH that it was 'basic with adjustments', to take account of the young woman's circumstances. She also mentioned explaining to the young woman that it was not to 'get at her', but to help her achieve a better standard for herself. The young woman was said to have understood the implications of the compact and signed it. However, the member of staff commented in the history sheet that while they were going through it with her, the young woman was lying on her bed, yawning and grunting her replies. The detail was:

1. No TV or radio during core day
(7.30am – 8pm weekdays, 8.15am – 5pm weekends)
2. No free flow exercise – 1 hour only from 11.00hrs
3. Basic pay £2.50
4. 1hr association weekday evenings (as normal on weekends)
5. To be reviewed on 4 August
6. Failure to comply and show improvement by the date of the review will result in the full basic regime coming into force.

154. Another member of staff commented at interview:

"Well I've never heard of semi basic to be truthful, but she was a poor copper basically, so instead of putting her straight onto basic from standard they sort of put her in the middle which meant she could still have her TV which basics aren't allowed."

155. On 28 July, wing staff discussed with the nurses the possible infection in the young woman's leg. The nurses were waiting for the correct swabs to take a sample for laboratory investigation. An entry in the F2052SH described the young woman being locked in during the evening because she was 'on basic'. On 29 July, it is reported in the history sheet that the young woman had not 'handed out' her TV in the morning, so she had taken it from her at 4.00pm. Staff were reminded that the television had to be removed during the core day. An entry in the F2052SH notes that the young woman was unhappy because, although she was locked in at 6.00pm, she did not get her television back until 8.00pm. At 6.15pm, the young woman had a session of auricular acupuncture which she reported had made her feel much better. The young woman repeatedly asked the night officer for a specific OSG but he was working elsewhere and her request was denied.

156. A suicide and self harm case review was written up as being held on 30 July. However, from the daily support record it seems it was actually held on 31 July. On 30 July, the young woman continued to be at odds with the staff over her TV and the standard of her cleaning and personal hygiene. She attended and enjoyed a birthday party for one of the other women. At 9.15pm, the young woman used her bell to call the night officer to say that watching *Casualty* on TV had reminded her of her crime and upset her. She was told that the bell was for emergencies only. Later, the same officer wrote with more sympathy, recording a chat with the young woman over her continuing sadness over the programme.

157. At the case review on 31 July, the four reviewers concluded that the young woman was much more positive and 'moving forward'. The entries in her history sheet painted a different picture. The young woman asked for a razor 'in possession' which was allowed, as long as she returned it after use. The young woman raised with the panel the possibility of the F2052SH being closed, but the reviewers thought she would need to remain under supervision for another two weeks or so. Her support plan was fairly broad, identifying staff support, chaplaincy visit, medical intervention and women's group with CPN, but without timescales or named individuals. It did not mention the IEP situation or the compact drawn up by the wing staff.
158. On 1 August, the young woman stayed in bed almost all day. At 10.00pm, she rang her bell to tell the night officer she was upset. The young woman said her mother did not want to know her because of what she had done. The rest of the night was uneventful. The young woman was reported to have spent most of the next two days sleeping, despite numerous instructions from staff to get up. On 3 August, a member of staff recommended (in the observation book) that the young woman should stay on 'basic' for a further week. The young woman asked about the F2052SH being closed, saying she felt much more positive now.
159. On 4 August, the young woman's case was discussed at a multi-agency lifer risk assessment panel (MALRAP) and a form LSP1E – MALRAP report – was completed. In the form it was noted that the young woman might need a High Secure (hospital). An action point from the meeting was to check whether Rampton had assessed her. In her lifer file it was noted that an LSP1E form (report of the MALRAP) had been completed and sent to the lifer review section at PSHQ.
160. The young woman fulfilled her compact on 4 August. At her IEP review it was agreed she would stay on the compact regime for a further week to give her a chance to prove herself. On 5 August, a physiotherapist reported to the security department that the young woman had a splint on her arm which contained a metal bar. The physiotherapist said that this would not be allowed in Low Newton. The staff on I wing had known about the metal in the splint since 31 March. The young woman had been wearing the splint before she left New Hall.
161. On 7 August, an entry in the history sheet records that the young woman could not accept that staff were trying to help her (by devising a timetable and compact). An entry in the F2052SH at 6.00pm that a member of staff had spoken to the young woman at length. She was upset about her mother not getting any help for her agoraphobia. It was noted that the young woman made crying noises with no tears and stopped being upset when talking about her dog.
162. From the observation book, it was clear that the young woman's hygiene and compliance with her compact remained poor. On 8 August at 9.45am, a Senior Officer made a long entry in the F2052SH. She had told the young woman that 'if she did not improve her attitude and stop being lazy she would be put on full

basic regime'. The Senior Officer wrote that the young woman did not seem to care.

163. On 9 August at 2.00am, the young woman rang her bell saying that she had taken approximately 15 Paramax tablets. The night orderly officer attended with a nurse. The nurse contacted a doctor who told her that the amount taken was not harmful. The young woman assured staff she did not have any more of the tablets in her possession. She had been prescribed soluble paracetamol on 21 July, but Paramax which contains an anti-emetic, metoclopramide, to prevent sickness was not on her prescription chart.
164. On 9 August, the young woman was given an IEP warning for using her bell on numerous occasions and being late for breakfast. She was also reported to have gone in the shower without turning on the water and stayed in bed until 2.30pm. She was reminded that her IEP review was imminent. A note on her lifer file recorded that an LSP3F form – pre-transfer report – had been sent.
165. On 10 August in the morning, the young woman was assessed by a consultant forensic psychiatrist from Rampton Hospital. It was noted that the young woman had slept all the afternoon and claimed she had taken a shower when she patently had not. The young woman had refused to attend a health education session because 'she couldn't be bothered'.
166. On 11 August at 9.00am, the young woman was told that her standard of cleaning in the beauty room was unacceptable. The young woman replied that she could not understand why people did not clean up after themselves. It was explained that cleaning the beauty room was her job.
167. At 2.00pm, the young woman attended her IEP review. It was found that she had not done what was required of her and she was downgraded to full basic. She was reported to be upset by the decision. The entry in the F2052SH notes that the young woman could not understand they were trying to help her. Later she presented with a cut on her head saying she had fallen in her cell. A nurse attended, dressed the cut and gave the young woman two paracetamol. At 8.00pm, she was noted to be writing a letter and said she was feeling sick. At 8.30pm, the night officer gave reassurance and told the young woman to tell the night nurse about her sickness. At 8.15am next morning, she said she was fine.
168. On 12 August, staff produced with the young woman a detailed cleaning schedule for her cell and the beauty room. She reported spending time ensuring her understanding of it. At 9.30pm, the young woman reported she was hearing voices telling her to cut herself. The young woman was seen doing painting at 10.00pm and said she was trying to distract herself from self harming. At 10.55pm, she called the night officer because she had cut her abdomen with part of a razor blade. The injury was treated by a nurse and the young woman said she felt better after cutting. At 00.53am, the young woman was found on the floor with her wound re-opened. She told staff she had fallen trying to close the window. The nurse attended with the night orderly officer. The young woman slept the rest of the night.

169. The wound reopened the following night, seemingly without trauma, and the nurse redressed it. Forms for an escort for the young woman to attend the local hospital for day surgery on 15 August were completed on 13 August. She was described as having a high motivation to escape, with a history of violence and assaults on staff. She was also described by the writer as obstructive, manipulative and having difficulty following staff instructions.
170. On 14 August, the young woman was visited by her stepfather and sister. The day was uneventful until 7.35pm when she called staff because her wound had opened again. A nurse attended and redressed the wound. The young woman was up at 6.00am on 15 August to go to hospital for her appointment. She had surgery to remove the pen from the old wound in her arm and returned to the wing at 2.00pm. The young woman was given a call to her family to tell them about her operation. At 8.05pm, the young woman asked to talk to a member of staff. In the note of the conversation, the author wrote that the young woman told her she felt like 'putting her hand in her tummy and ripping her intestines out'. The young woman settled and slept through the night.
171. On 16 August, a member of the safer custody team wrote in her history sheet that the young woman had agreed to try and stop self harming. At 11.40pm, the young woman rang her bell to say she had swallowed some bleach. She wrote a note of which there was a copy in her F2052SH, but the note is disjointed as though the original was damaged. There was no report in the supervision plan of the note being received. A nurse attended with the night orderly officer, but no treatment was given except a drink of milk.
172. On 17 August, the young woman was reported to have had a shower and had her leg wound (the burn injury) re-dressed. Notes in the observation book and the history sheet said she had received a warning about cleaning her room and a craft knife had been found in her cell, but these issues did not appear in the F2052SH. In the event, the craft knife had been allowed and was due to be collected by another officer. The young woman wanted to keep it overnight, but that was refused. According to the observation book, the young woman told staff she had the craft knife to attack them, but there was no security report on record about this incident. It was also noted in the observation book that she had requested an inter-prison telephone call with a male prisoner at Long Lartin with whom she was corresponding. This was refused. At 8.30pm, the young woman inserted a plastic knife into the wound on her abdomen. All cutlery was removed from her cell. A nurse attended.
173. On 18 August at 11.00am, the young woman attended her IEP review. The outcome was that she was to remain on basic for a further week. She was apparently happy with that and acknowledged that she had not made the required effort. The history sheet records that the young woman's cell had been searched and found to be in a totally unacceptable state.
174. At 8.00pm, it was noted that the young woman was sitting on her bed writing letters and had told staff she could not stop being sick. An officer noted that she and another officer who had been seated nearby had heard no sound of

vomiting. It was recorded that the young woman said she was okay at 8.10pm, but at 9.10pm she said she had been sick in her towel. On examination, the towel contained only what appeared to be spit and water. At 11.00pm, the young woman said she had forgotten to tell the nurse she had been sick and now her tummy was sore. The nurse was telephoned who said it would be her abdominal wound hurting. The young woman was reassured and she settled for the night. The report in the observation book said the young woman was up half the night sitting on the toilet being sick. The report continued that she had also been scared most of the night and a nurse had been informed, but did not attend.

175. On 19 August, staff reported that the young woman's cell was still in 'a terrible state' and she had made no attempt to clean herself or her clothes. On the morning of 20 August, night staff reported that the young woman had a 'quiet night with no problems'. The day staff recorded that she was in bed all day, again making no attempt to clean herself or her cell. The night officer took over from the day staff at 7.05pm and noted that the young woman had asked her to look for cigarette butts for her, but she had refused. At 8.00pm, the young woman said she felt like self harming. It was recorded that she settled down after a chat with her. At interview the night officer recalled that, as usual, the observation panel on the young woman's door had been open which she preferred. The night officer said that she communicated with the young woman regularly, albeit briefly, through the flap as she passed by the door of her cell.
176. Before the nurse came to do the medicine round that night, the young woman stuck a note on the outside of the door with toothpaste. The night officer could not remember exactly what it said, but a copy was provided to my investigators by the police. The note read as follows:
- "Can I please speak to somebody? I really need to before I do something daft... Thanks."
177. The officer removed the note, read it and asked what the matter was now. They started talking through the door and the officer told her to read her book. The note was not mentioned in the entries in the F2052SH. The night officer said that she usually recommended that the young woman should watch television, but her television had been removed in line with the basic regime compact. Another diversion would have been to have a cigarette, but she had not got any cigarettes. The night officer described the conversation as 'a bit of a wind up but in good humour'. They had then discussed the book the young woman was reading. The night officer thought the young woman was 'fine' when she left her, having given reassurances that she would continue to check on her.
178. The night officer was in the staff room two or three cells along from the young woman's cell when she heard the nurse come on to the wing. She heard the nurse talking to the young woman and the sound of the door being opened and closed as the young woman received her medicine. The night officer did not recall hearing the male senior officer who accompanied her saying anything. She recalled the time as after 10.00pm, but not more specifically.

179. According to their evidence at interview, the nurse and Senior Officer entered I Wing at about 10.00pm with the evening medications. The nurse said the young woman told her that she felt like self-harming. She said this was a nightly occurrence and she had reminded the young woman of that. She told the young woman that she knew where she was if she needed her, but it might take a while for her to get back to the wing because she needed to be escorted. She said the young woman queried her medication, as she usually did, and said she was expecting to be put on more painkillers. She said the Senior Officer then echoed what she had told the young woman, and that his tone when he spoke to her was 'firm'. The officer confirmed that the young woman had told the nurse that she felt like self-harming and had queried her medication. He said this was a nightly occurrence and she did not appear to be distressed. At interview, he said he had not spoken to the young woman.
180. At about 10.30 or 10.40pm, the night orderly officer came on the wing on his rounds. The night officer was patrolling the wing at about 10.45pm and went to check whether the young woman was calmer. They exchanged words about the young woman wanting a cigarette which the officer, a non-smoker, refused. She encouraged the young woman to read her book and left her sitting on her bed. At 11.00pm, the night officer found the young woman was crying again and talked with her then left her to settle. The night orderly officer was still on the wing and he checked with the officer as to the level of suicide and self harm monitoring the young woman was on. It was confirmed that she was on the normal level of supervision only. An entry was made in the record noting that the young woman was crying due to having no cigarettes.
181. At interview, the night officer recalled that the young woman had said she was fed up, sick of everybody 'having a go at her'. She had wanted a cigarette and asked the officer to borrow one from another prisoner. They spoke about what the matter was and the night officer recalled trying to alleviate any fears that the young woman might have about the impending move to another prison. Her ability to do this was hampered by her lack of knowledge of the position. The young woman said she wanted to go to the HCC, where she would lock herself in and then be sent to segregation. The night officer advised against that and also refused again to go round looking for cigarette ends, which the young woman had asked her to do. They returned to discussing her book until the officer went on her rounds, reassuring the young woman that her sleeping tablets would start working soon. The night officer felt that this was a fairly typical interaction with the young woman. The young woman was reminded that, if she worked, she would earn money to buy cigarettes and the young woman agreed to try and help herself more.
182. At about 11.17pm she had looked through the open flap and seen the young woman lying in the bed. At interview, the night officer said it was
- “... as if she'd flopped straight back across the middle of the bed, not lengthways, so her head was at the window. And I just like tapped on the door and like sort of went [called her name] but she was too still, normally she would just move a leg or ... something like that. I tapped again and I went

[called her name]. And with that I just shouted, I just shouted like not too loud and alarming to set the others off but enough for him to hear. And I tapped on the door again, I had the knife and the keys on us, by this point I was thinking we're going to have to go in here. And by this time I walked towards the staff room but then the orderly officer was coming down and I just went I think she's done something here. And he had his keys out straight away and he called for Hotel One [healthcare] like as we were going in, I took the handle and he was putting the key in. And in we went."

"And in we went and like I say she was lying across the bed so I went in and ... got her by the shoulders and brought her head round to the bed which is when I saw the ligature. She had like a T-shirt ... pale blue T-shirt thing round her neck.

183. The night officer recalled that the orderly officer used his radio to call for an ambulance to be summoned by the control room. The orderly officer's recollection at interview was that he had called for the ambulance one minute (or possibly more) after he had called for the nurse (Hotel 1). The control room log shows that a 999 call was made at 11.34pm. The officer could hear the nurse approaching the wing. She proceeded to use her ligature cutter to cut the ligature and then removed the rest from the young woman's neck and felt for a pulse. She tried to put the young woman in the recovery position. The nurse arrived with the assistant night orderly officer and the resuscitation bag. The nurse told the police that the radio call asked her to attend I Wing. She said that, although the call was not categorised as urgent, she had had no doubt that the reason for the call would be for the young woman. She took three to four minutes to get there, because she was in the main prison and had to be let through a number of gates.
184. The night officer described the young woman as having a very light tinge of blue about her. She said the night orderly officer was shaking his head because he had an idea she was dead. When asked if the ligature was tight, the night officer thought it was not. She had been able to get her hand underneath it easily to cut it. They commenced resuscitation. The paramedics arrived at 11.40pm and declared life extinct. During resuscitation, vomit had been projected from the young woman's mouth. The duty doctor had been called. He attended and certified death at 00.10am on 21 August. According to a statement made to the police a local general practitioner also attended and examined the young woman's body.

Informing the family

185. On the death in custody action checklist completed by the duty governor who attended the section entitled 'Next of kin or designated person informed' was blank. The section labelled 'Media Relations Unit – take care to give accurate information as to whether the prisoner's family have been informed' contained a

name but there was no entry in the time column. In his note of the hot debrief that he held at 4.30am, the duty governor recorded that:

“The police had informed the family and we expect a call soon. Night orderly officer will deal if duty governor has gone but duty governor will phone the young woman’s mother in the morning.”

186. At interview, the night orderly officer recalled that the young woman’s mother telephoned him at about 4.45am. He had quite expected this, as he had given Durham police the relevant information so that she could be informed of her daughter’s death. The Durham police had taken the written information from the night orderly officer to pass to the police in Sheffield who would make the visit. The night orderly officer said that the woman’s mother got straight through to him on the wing. He said he formed the impression that she had expected something to happen as it now had.
187. At a meeting on 2 November 2005, enlarged upon at a subsequent meeting on 24 October 2006, the woman’s mother told my FLO that she had not received a letter of condolence from the prison and had difficulty in obtaining help with the funeral expenses. She had not been consulted about how she would like to receive the young woman’s property, which arrived by courier. At the same meeting, she said she had experienced difficulty getting through to the prison, not having been given a direct line number. She also added that the young woman’s sister had eventually had a very helpful conversation with the deputy governor, but the duty governor had not called them back.

Events following the young woman’s death

188. The night officer had found what she thought might be a suicide note on the bed in the young woman’s cell and moved it to the desk. She later handed it to night orderly officer who thought, at interview, that there had been an envelope with more than one sheet of paper in. A copy of the document was passed to my investigator by the police. There was no envelope in the bundle of papers. There was a two page note in which the young woman clearly detailed her intention to kill herself and the reasons why. She mentioned a senior officer wearing the number 072 who had shouted at her. However, the date of the incident was unclear. The whole note was as follows:

“At approximately 10.00pm on [space] August 05 SO number 072 came with the nurse to give me my medication and I told the nurse that I felt like self harming. Then the SO 072 started shouting at me saying he was sick of me self harming and if I carried on I wouldn’t like where I was going. I’m now going to try and kill myself because I can’t stop self harming and he doesn’t understand that and when I told him that he agreed. He’s not the only one who on my wing has said they don’t understand self harmers. I’m fed up of trying to stop and having to do it all on my own with no one to talk to about it. I just hope that me killing myself will bring some awareness to this matter and people who self harm in prison get more help.”

189. At a second interview on 3 August 2006, an officer identified his identification number was 72. He also exhibited great shock over the note and its contents, which he said he had not been told about before the interview. He maintained that on no occasion in that week of night duty, or at any other time, had he ever spoken to the young woman. The officer suggested that there had been an episode to which the young woman might have been referring. He said that he had spoken forcefully, but it was about the young woman rather than to her. He recalled it as follows:

“On one occasion during the week, I pulled the door shut and it didn’t shut, I put the latch on, after a couple of nights I didn’t bother putting it on, because we were only there a minute and I pulled the door shut. This night there was a magazine lying and I thought it was a television magazine I opened the magazine and it wasn’t it was just a private. So I stepped back in the light because I was moving away from the cell I tripped the lock. The conversation carried on, I pulled the door and it had crashed and I went in and she looked at us and I didn’t say anything. The nurse had come out and she was saying to us, you know I’ve told her so many times and as I’m shutting the door I said, not to her, she won’t listen to anybody she will not listen to anybody, but I never spoke to her.”

190. At interview, the nurse said the officer had repeated the same advice she had given the young woman. She could not recall him shouting. She said he had not slammed the cell door at any time, but she recalled that the door was one of two or three which had a tendency to stick and therefore would have required force to shut it.

191. The bundle of papers also included a list that the young woman had prepared of people to be invited to her funeral and the music and readings she wanted. Also in the bundle was the note handed out to the night officer earlier in the evening.

192. The duty governor noted at the hot debrief that, following the immediate involvement of the Care Team, additional support would be necessary for all the staff and prisoners on I Wing. This was to be provided by the care team and chaplaincy. An extra officer was deployed to I Wing for the remainder of the night to support the officer and her colleague.

193. By the time of the hot debrief, three of the other five prisoners had been told what had happened as they were awake. The remaining two were to be told once they woke up. The chaplain assisted in breaking the news to the prisoners and supporting the staff. The action checklist following a death in custody indicated that, in line with recommended action in PSO 2710 Follow Up to Deaths in Custody, all prisoners on an open F2052SH had been interviewed during the night or at breakfast the following day.

194. At interview, one officer reported that she had not had contact with the care team, but said she did not mind about it. The nurse said she had experienced a lot of death having worked in cancer care previously. However, she had not had any immediate contact from her manager, although the care team had sent

her a letter offering help. A probation officer, told my investigators that she had never been offered support after any death at Durham. She had been shocked and distressed on hearing of the young woman's death from the television news.

Post Mortem Report

195. A post mortem examination of the young woman's body was carried out on 22 August. In his report of 20 October, he gave his opinion as to the cause of death as strangulation by ligature. He found no evidence of natural disease or poisoning which might have caused or contributed to the young woman's death. Particles of food in her airways had almost certainly moved there after death, when food is often regurgitated. Moreover, if resuscitation is performed, small particles can be blown into the periphery of the lungs. Toxicology showed only the presence of the young woman's prescribed medication within the therapeutic levels.

ISSUES

Family concerns

196. I now consider the issues identified by the family at their meeting on 2 November 2005 and, in some instances, enlarged upon at a subsequent meeting on 24 October 2006.

Why was the young woman a Restricted Status prisoner?

The young woman's restricted status was the decision of the category A review section at PSHQ on 29 March 2005, and was based on the details of her offence. Her case was submitted by the management of New Hall on 22 March 2005. The submission followed a review of her security categorisation in response to the alleged hostage incident on 11 March. The new category of 'restricted status' had been introduced in December 2004 alongside the use of category A for women prisoners. The young woman was deemed to be restricted status because of her potential danger to others. This was based on the nature of her alleged crime which was deemed to be 'horrific', the victim being unknown to the young woman and because she had 'specifically taken a knife out with her, to use on another person', as well as the recent potential hostage incident.

When asked on 30 November 2006, a manager at New Hall freely admitted, that the prison had wrongly omitted making a submission to PSHQ about the young woman when she was initially received there in July 2004. In his view, the presenting factors as to the nature of her alleged crime (as set out in the previous paragraph) were sufficient to justify being considered as a potential category A prisoner. He emphasised that submission of a case would not automatically result in category A status being allocated to a prisoner. For example, he believed that New Hall had submitted five or six cases over the past five years without any being made category A.

The explanation for making the young woman restricted status given by the High Security Directorate was based on the nature of her alleged offence plus the recent act of aggression towards the teacher which was seen as a potential hostage incident. However, I note that the public protection meeting at New Hall on 21 March was told that the incident had been 'quite gentle' even though the young woman had reportedly said she could 'rip the teacher's throat out'. She had let go of the teacher immediately when staff arrived and given no resistance. That said there was no doubt in the manager's mind that the situation was extremely frightening for the teacher and other staff.

I understand the need to report in the young woman as a potential category A prisoner. Indeed, I am in no doubt as to the extreme nature of her offence nor the extent of her challenging behaviour. The Prison Service exists to protect the public and it fails in this duty if prisoners are not appropriately categorised according to the risk they may pose to others. That said, I am extremely concerned that the system appears to have been so inflexible that it took no

account of the young woman's special circumstances: her youthfulness, her self-harming and other vulnerability, and the fact that the only place she could be located was the wholly unsatisfactory I Wing at HMP Durham, alongside five older women. My investigators met no-one who felt that the young woman should have been on I Wing, given her vulnerability. It may be that a categorisation system principally designed for men works very poorly when applied to the tiny number of women deemed 'highly dangerous' (the criterion for category A). But given the way the young woman presented, I do not believe it can be right that there was no alternative but to send her to such an unsuitable location as Durham I Wing.

Why was the young woman not held at a local prison?

New Hall was a local prison but, as I have discussed, once the young woman was given restricted status the only prison allowed to hold her was Durham's I Wing.

Why was there not more effective psychiatric assessment and intervention?

The management of the young woman's mental health is considered below.

Was the young woman's self harming appropriately monitored and managed?

The management of the young woman's self harming is considered below.

Contact with the family had not been handled well by Durham.

The question of family liaison in the aftermath of a death is addressed in Prison Service Order 2710, Follow up to deaths in custody. The PSO was updated on 6 January 2006. The version at the time of the young woman's death was less detailed on the issue of family liaison than the current one, which now recommends that the news of the death should be broken to the family face to face by a dedicated Family Liaison Officer, working alongside the chaplain, or Governor or most senior individual available together with the chaplain. No member of staff should be deployed alone. This option is recommended because it is what families and agencies that work closely with them say they prefer and expect; it shows that the death is being taken seriously by the prison. If face-to-face prison notification is not possible, there should be swift face-to-face follow-up.

In the young woman's case, the option of using the police to break the news was chosen by the duty governor and acted upon by a Principal Officer. The family were not given a dedicated number to contact and felt that getting through had been difficult, even though the night orderly officer believed that her mother had been put straight through to him.

The family had not received a letter of condolence from the Governor. They had difficulty in obtaining help with the funeral expenses, initially being offered only transport costs for the young woman's body to be returned to Sheffield. It took a week for the prison to decide what contribution they would make to

the funeral expenses. The prison suggested that they would bring the young woman's property to the funeral, which the family rejected as inappropriate. Following the funeral, some property was returned by courier without the required itemised list. They said they had to call the prison many times and were not provided with consistent information. The prison was represented at the funeral but sent no flowers. The letter they sent to the young woman's mother offered no condolences but simply stated that they were enclosing a cheque for her outstanding personal money.

The version of PSO 2710 extant in August 2005 required that the Governor should:

- send a letter of condolence and support to the family and invite them to visit the establishment.
- when the police have indicated the property is no longer required for their investigation, hand over personal effects including monies with care and sensitivity, for example all clothing must be clean and pressed, keeping a list of items handed over and obtaining a receipt.
- offer financial assistance with funeral expenses in appropriate cases ...

In the young woman's case, I judge that the Governor's actions, or those of the staff to whom he delegated the required action, fell below the standard expected by national instructions as set out in PSO 2710.

The family were upset by how quickly the news of the young woman's death was on Ceefax.

The Home Office Press Office releases information about deaths in custody (which may then appear on Ceefax and other news channels), providing that the next of kin have been informed. It is possible that members of the wider family would see the Ceefax item before the news had reached them from the next of kin. Her mother was told of her daughter's death before 4.45am on 21 August. The entry in the action checklist following the young woman's death is inconclusive as to when the Press Office were told the news.

On 24 October 2006, the family and their legal representative raised further issues of concern. These were:

Why was the young woman held in a men's high security prison during her trial?

Why was Women's Policy Group at Prison Service Headquarters not consulted about the decision to her in Wakefield?

When the young woman was held at Wakefield her family were not allowed to know her movements and they were consequently unable to visit her or provide property or money.

The young woman's family described the regime on I Wing at Durham as lacking systems and procedures, leading to a poor visiting environment.

(Visits for the few women prisoners took place in the wing.) They found it difficult to send her new clothes which would fit her and believed that some money and property they sent in did not reach her.

I have not addressed all these issues as I must confine myself to those matters that were material to my investigation into the young woman's death. However, I share the family's concerns about I Wing (as I have emphasised throughout this report), and greatly welcome the fact that it has now closed. Given that the women who were there with the young woman are now safely and successfully held at HMP Bronzefield, it is questionable whether I Wing should have been retained for as long as it was. As I have indicated, I think in any case that some way should have been found to have located the young woman elsewhere.

I may also say that the decision to locate the young woman in HMP Wakefield during the course of her trial strikes me as wholly undesirable. I have not investigated this matter for the reasons given above. I assume it was to save the cost and inconvenience (to the Prison Service and to the young woman herself) of moving her daily back and forth to Durham.

Suicide and Self harm management

197. At New Hall, following her return from Annesley House Secure Unit on 13 December, the monitoring of the young woman's suicide and self harming was of a predominantly high standard. Her self harming was prolific. Between 13 December and 29 March, there were at least 54 episodes – 40 ligatures, one suffocation, six foreign bodies inserted, one or more foreign bodies swallowed, two alleged overdoses, three fires and one opening of a previous injury. The records indicate that staff responded appropriately to each incident and maintained observations at very frequent intervals in line with national policy guidelines. Documentation was completed appropriately and, although there were two gaps in the papers provided to my investigator, these appeared to be an accident of photocopying rather than anything untoward. Reviews were attended by staff from a wide variety of disciplines and attempts were made to involve family in process. The young woman made frequent use of the Samaritans telephone and received the support of Listeners.
198. At Durham, her self harming reduced in frequency, although she made many threats to harm herself which she did not carry out. Between 30 March and her death, the young woman made some 23 acts of, or attempts to, self harm – tying ligatures on four occasions, cutting herself five times, opening an old wound six times, attempting suffocation twice, setting two fires (one doing serious harm to her leg), inserting a foreign body once, alleging she had overdosed twice and alleging she had swallowed bleach once.
199. The young woman was on constant watch from 30 March until 29 April, mainly because the visiting psychiatrist insisted – and despite the prison's lead doctor noting his disagreement in the F2052SH. This lack of agreement between senior doctors may have been disconcerting for staff. The attendance at a number of the young woman's reviews was unusual for a visiting psychiatrist. It

was good practice and a demonstration of her commitment to the young woman's welfare.

200. Maintaining a constant watch for over four weeks would undoubtedly have put a strain on the staff, in what was more than once described as a generally oppressive environment. However, the level of supervision the staff provided did not prevent the young woman taking possession of a cigarette lighter which was the responsibility of the staff and causing herself a not insignificant injury on 27 April. Reference was made on a number of occasions to the young woman's dislike of the intrusiveness of the level of supervision, which was an indicator that there would have been some tension for both parties in maintaining the watch for so long.
201. There was no evidence of the existence of a Listener scheme for the women on I Wing. This was unsurprising given the confidentiality required for such a scheme to operate, for which the situation on I Wing (where the total population capacity was eight women and the number on the wing usually less) was not conducive. Use of the Samaritans telephone was mentioned in the young woman's support plan on 31 March but there was no evidence of her using it.
202. The young woman subsequently remained on intermittent watch until 16 July. At times, the suicide and self harm monitoring did not reach the standard expected for compliance with national guidelines. Despite being on constant watch, there was a two week gap between reviews in April. Quite frequently when she was on constant watch, the entries were only those expected with intermittent observations. The young woman began self harming again on 17 June, having not self harmed since 27 April, but no review was held until five days later on 22 June.
203. The systematic documentation maintained by the safer custody co-ordinator, was impressive. He demonstrated active involvement with the young woman by visiting her and writing detailed notes of his interactions with her and his consequent advice to staff. However, it was disappointing to see that the support plan he wrote after leading a case review was as lacking in detail as many others written for the young woman. Support plans are known to be more effective when named members of staff are given accountability for their actions. On a number of occasions, staff were praised by managers in writing in the F2052SH for the good quality of their entries, when in fact the entries were not exceptional.
204. The minutes of suicide prevention team (SPT) meetings at Durham for January, March (twice), May and August 2005 were reviewed. I Wing was only represented at the January meeting and rarely sent apologies at the others. Female prisoners were mentioned in statistical reports but not in any other item on the agenda, despite the prolific self harming of the young woman and at least one other prisoner during the months covered, and despite previous deaths of women.
205. There were a number of inconsistencies of approach and between the entries in the various records – F2052SH, history sheet and wing observation book. It

is undoubtedly a problem for staff to judge what to write in which document, and to balance consistency with not being unduly repetitive. However, examples of inconsistency or entries being made in the less appropriate document included:

- ◆ describing the young woman's lack of motivation to normal tasks such as personal hygiene in the observation book on 4 April, but not in the F2052SH until 6 April, even though lack of attention to self care could be an indication of low mood.
- ◆ in June, noting the young woman's 'drastic mood swings' in the observation book, but not in the F2052SH.
- ◆ not recording when the young woman passed urine on the floor on 15 and 16 April in the F2052SH.
- ◆ refusing the young woman a rug hook in her cell until she complied with her compact on 12 July, then without any reported improvement in her compliance allowing a rug hook in her cell overnight on 14 July.
- ◆ recording criticisms of her cleaning in the F2052SH on 16 July.
- ◆ recording in the observation book on 25 July that the young woman had shouted many times in the night for the OSG and refused to talk to anyone else.
- ◆ recording in the F2052SH the young woman's justifications for staying in bed on 26 July
- ◆ querying on 17 August the young woman having a craft knife in her cell, which was subsequently found to be allowed, yet not mentioning it in the F2052SH despite her history of cutting.
- ◆ an officer speaking at interview of a note the young woman stuck on her door before 10.00pm on 20 August in which she asked for help 'before I do something daft', but not recording this event in the F2052SH or recording her conversation with the young woman which followed.

206. Another possibly difficult matter for the young woman was the use of the cell bell. In New Hall, she had been told to ring her bell when she felt like harming herself so that staff could help her. She referred to this in her note after the 'hostage incident'. In Durham on 30 April, staff recorded in the observation book that the young woman had pressed her cell bell every time she wanted to talk rather than waiting to be checked, even though she knew that staff 'passed her cell every 10 minutes'.
207. The views expressed by staff were sometimes subjective and contradictory too. For example, a nurse described the young woman as 'very moody' but in her personal officer's view she was not moody. There were, however, objective examples of the young woman demonstrating swings of mood, such as complaining of stomach pains one minute and laughing and joking the next. Or crying because she wanted her mother one minute, and the next asking for a cigarette or about TV programmes.
208. The question of whether the young woman was shouted at by an officer has proved impossible to resolve conclusively. The officer told my investigators that he never spoke to the women prisoners on the night medicine rounds. However, this was contradicted by the nurse during her interviews, when she

told my investigators that he spoke to them every night during her medicine round. Contrary to the officer's assertion that he spoke loudly about the young woman not to her, the prisoner who was in the cell next to the young woman's on the night she died, told my investigators that she heard the senior officer on duty with the nurse say that he was:

"really sick' of you and your self harming and the trouble you cause."

Two other prisoners spoke about the events of the evening of 20 August. One corroborated the allegation that the officer shouted at her and the other mentioned that he slammed the cell door. However, whatever in fact may have occurred, it is not clear how material it was to the young woman's state of mind on the night of 20 August, not least because the date on the note she left was incomplete.

Emergency response

209. The interview evidence as to the timing the young woman being found in a collapsed state and the call for an ambulance was at odds with the contemporaneous evidence in the control room log. The officer thought it was 11.17pm when she found the young woman. Another officer's call for the ambulance was logged at 11.34pm. The officer calling for the ambulance was already on the wing and went to the cell immediately. At the same time, he made a radio call asking for the nurse to attend I Wing. His recollection was that he asked for an ambulance to be called a minute later, perhaps over a minute. It is possible that the first officer was mistaken about the time she found the young woman. It is also almost certain that any delay there may have been made no difference to the young woman's fate. However, in other situations where resuscitation might be possible, any delay (for example waiting for the prison nurse to arrive before asking for an ambulance) could be the difference between life and death.

I Wing in context

210. It was evident from interviews and documents that Durham was going through a period of change in 2004-05, re-rolling from a high security prison with a women's wing to a community prison for men.⁶ The women's wing, which had held about 124 women, was closed and the majority of the prisoners transferred elsewhere, leaving just six women who required further work on finding a placement suitable to their individual situations. The six were moved into I Wing, an eight-bedded unit which had previously housed a Close Supervision Centre (CSC) for men.

211. Although the unit was clean and well decorated, the Chief Inspector had found in June 2005 that the environment was 'even less suitable than the one we inspected last year'. She reported that on all four of her criteria for a 'healthy prison' (safety, respect, purposeful activity and resettlement) the women's unit

⁶ Mooney, J. *From High Security to Community Prison: the re-role of HMP Durham*, in *Prison Service Journal* (159) May 2005.

scored poorly. There were plans to transfer some women to Low Newton when security improvements allowed, but there was no clarity among staff or prisoners about the progress of these plans. The principal officer responsible for I Wing said at interview that he had known 'all along' that the women would be moved by the end of September.

212. On 1 April, the acting Governor issued a Governor's Notice to Staff which informed them that I Wing was to become a satellite of Low Newton until such time as it closed. It would be managed by Low Newton and staffed by Low Newton officers together with some Durham staff. In the event, this arrangement did not go ahead, apparently because the staff at Durham made representations against it. While the young woman was on the wing she was described as not wanting to go to Low Newton and being concerned about the future. At one point, she was quoted as saying she would kill herself if she had to go to Low Newton. It is unlikely she would have had such a fear so soon after arriving at Durham unless she had been listening to the staff's concerns. It is impossible not to conclude that the staff's fears about their future had some impact on the prisoners, of whom the young woman was the youngest. She was the least experienced in prison life and, for this reason and many others, very vulnerable.
213. Staff were asked about morale on the unit in the first interviews conducted by my office. They described the uncertainty staff were experiencing. One of the young woman's personal officers described morale as not rock bottom, 'but it could be better'. She mentioned that prisoner relationships had been 'concerning', due to two with strong personalities and the others being intimidated and unwilling to speak up against anyone.
214. Management of the unit had passed to different staff in May. The principal officer told my investigator that he was given the task of managing I Wing mainly because 'there was no principal officer in charge of the area at the time and there was a lack of structured management'. He thought the senior officers and the staff felt somewhat isolated because they had not had a principal officer to refer to and there was not a designated governor responsible for that area. At the same time as his appointment, a governor was given the task of overseeing the wing until its closure.
215. From the interviews with staff, it was evident that the women's regime had been evaluated by a new head of learning and skills for the whole prison. He recommended that the wing staff should provide activities for the prisoners, instead of the three teachers who had attended previously. The recommendation may have been quite reasonable, given the very high staff/prisoner ratio on I Wing. On the other hand, the staff were not trained to deliver programmes of activities. From one interview a picture emerged of education being withdrawn at the end of July on resource grounds. The staff provided some handicrafts such as card making, and the computer room was made available to the prisoners for much of each day. The young woman liked drawing horses and making cards, but she was less interested in the IT facility. Some weeks later, after representations by the I wing manager, the plan was

modified and some teaching support reinstated. However, that was after the young woman had died.

216. The I wing manager described the situation on I Wing as one of 'surviving until the unit closed and there was accommodation found elsewhere for the women.' He described how they tried to improve the 'totally inadequate exercise yard' with plants and seats. (When I visited I Wing myself shortly after the young woman's death, I was shocked by how barren and lacking in stimulation the exercise area was.) They had an open door policy during the day, whereby the women could go out to tend the plants, sit in the sun, read and relax as they wanted. His views corroborated those of one of the governor grades who spoke to my investigators. He had been asked to 'look at' I Wing by the new Governor. His brief was to 'bring it back to life'; although he knew that the plan was to close it in September 2005. He and the I wing manager had worked together on the project. The governor grade said he thought that the staff on I Wing were 'jaded'. The plan to replace education classes taken by teaching staff with wing based activities run by staff had not been a success. The plan had been to improve the interaction between staff and prisoners but it had not worked. He thought staff had been there too long. It was a 'draining and directionless place'. He said there was no sense of community for prisoners. He said the staff did not get on with each other, let alone with the prisoners.

Management of the Incentives and Earned Privileges Scheme (IEP)

217. Prison Service Order 4000, Incentives and Earned Privileges, Earned Community Visits and Compacts, sets out a national scheme designed to put into practice the Prison Service's duty to look after prisoners with humanity and help them lead law-abiding lives in custody and after release. It reflects the commitment of Ministers and the Prison Service to a system of structured incentives, based on prisoners' behaviour and willingness to cooperate. It seeks to ensure that prisoners earn privileges by responsible behaviour and participation in hard work and other constructive activity. It has due regard for the special status of unconvicted prisoners and civil prisoners (who are not obliged to participate in work).

218. The PSO states that an IEP scheme is likely to be fully successful only if properly prepared for and introduced as part of well-planned and locally focussed regime approaches. As described above, Durham was going through a period of significant change in the summer of 2005. It is unlikely that the application of IEP in I Wing could be described as being part of a well focussed regime. In the HMCIP report of the inspection in June 2005, the inspectors reviewed the recommendations they had made on their previous inspection in 2004 with regard to IEP. They concluded that running a meaningful IEP scheme in such a small unit was problematic. They found that all the women were 'essentially on enhanced status but there as some evidence that informal sanctions were used'. In his interview, the governor said he did not agree with the use of IEP on I Wing. He thought staff struggled with the young woman's mental state and he believed she had not been happy with their response to her voices. He said that the head of mental health had been organising training to raise staff awareness of mental illness.

219. With her knowledge, New Hall had drawn up a plan for managing the young woman, following the public protection meeting they held after the hostage incident. The plan was to ensure the safety of the young woman, her fellow prisoners and the staff. The plan was not linked to the IEP scheme on which the young woman still remained at standard level. This was in keeping with the requirement of PSO 4000 that:

"the loss of an earned privilege must not be associated with guilt and punishment."

"A pattern of poor behaviour and/or performance must be judged against an establishment's published criteria for the earning and retention of particular privileges."

220. The New Hall plan included:

- ◆ two officer unlock
- ◆ one officer with the young woman at all times
- ◆ rub down search in and out of cell plus wand
- ◆ daily search of cell and check of inventory
- ◆ education in cell
- ◆ contact with chaplain weekly on HCC if appropriate
- ◆ 30 mins exercise daily
- ◆ 30 mins association daily
- ◆ no physical contact with staff or prisoners.

221. New Hall sent the plan, together with a comprehensive note about the young woman, the notes of the public protection meeting held on 21 March, and contact details of four of their key personnel, to Durham with the young woman. They also recommended making contact with the young woman's manager. There was no reference to these documents in the young woman's history sheet, F2052SH or the I Wing observation book.

222. It was not until 29 June that the staff on I Wing decided to draw up a compact with the young woman with the objective of motivating her to be active and to keep herself and her environment clean. The compact was clearly linked with the IEP scheme, referring specifically to downgrading from standard to basic level if she did not comply. It ran:
1. shower daily
 2. clean and tidy room daily
 3. make sure you are up and dressed for meals and meds
 4. follow correct procedures for disposal of dressings
 5. follow timetable
 6. at all times you must be polite and respectful to staff and fellow prisoners
 7. comply with prison rules
 8. failure to comply will result in downgrading to basic regime.
223. The young woman signed the behaviour and activity compact, but felt she was being picked on. The young woman frequently had to be cajoled into compliance. After a week or so she was given a verbal warning about her non-compliance, yet the next day at her self harm review she was described as 'adhering to her compact'.
224. There were many entries in records in July relating to her progress or otherwise in relation to the compact. On one occasion she was described as 'lazy, dirty and idle'. On 12 July, the young woman was refused a rug hook in her cell overnight 'until she started to comply with her compact'. On 14 July, without obvious evidence of improvement, the young woman was allowed to keep the rug hook until 8.00pm.
225. On 15 July, the young woman was warned that if she did not get up and clean her room her TV and radio would be removed. The threat was carried out at 3.15pm whereupon the young woman made toast, then cleaned, albeit poorly, but sufficiently to be given back her TV and radio within the hour. The loss of in-cell TV is part of the basic regime. PSO 4000 says that the loss of an earned privilege must be seen as a normal consequence of a general deterioration in behaviour and/or performance. It must not be associated with guilt and punishment. Schemes must operate by administrative action, with the prime aim of rewarding and thus encouraging good behaviour and performance by means of giving, withholding or removing privileges. A pattern of poor behaviour and/or performance must be judged against an establishment's published criteria for the earning and retention of particular privileges. The criteria must relate to standards of behaviour and levels of performance in respect of regime activities. In other words, a change in a prisoner's IEP entitlements should be made within the structure of the scheme. It should not occur on a temporary basis by the arbitrary decision of one officer. That might be construed as a punishment even though it was possibly intended to be motivating.
226. The struggle over compliance with the compact became a running issue over the following days. The rug hook became an issue again on 21 July when the

young woman was allowed to keep it overnight because she was 'doing really well'. On 22 July, in total contradiction, she was given a final warning for not complying with the compact. The young woman was told that the penalty would be downgrading to basic level of IEP. She made a real effort to shower and interact with others the following day.

227. On 27 July, the young woman's lack of interest in complying with her compact resulted in a regime assessment panel form recommending the young woman be downgraded to basic following her lack of compliance over a three week trial period. Her personal officers recorded that they made strong efforts to gain the young woman's understanding of what they were trying to do for her. On one occasion, the young woman's response was to try and justify why she should be allowed to stay in bed all day and not adhere to her timetable.
228. On 27 July, the young woman was 'downgraded' on the IEP scheme. The board was chaired by a governor grade in the absence of the wing principal officer. The young woman was placed on a specifically tailored regime referred to as 'semi-basic'. This was not in line with PSO 4000, although it was probably well intentioned. The very peculiar circumstances of I Wing made it difficult to line up the regime available there with the tenets of PSO 4000.
229. Whether the compact was implemented consistently by staff is questionable. One entry in the F2052SH described The young woman being locked in during the evening because she was 'on basic', while the compact allowed evening association. On another day, The young woman did not 'hand out' her TV in the morning so it was taken from her cell at 4.00pm. The young woman was unhappy, because although she was locked in at 6.00pm she did not get her TV until 8.00pm. That was in line with her compact.
230. According to records, the young woman continued to be at odds with staff over her TV and the standard of her cleaning and personal hygiene. However, at the F2052SH case review on 31 July the reviewers concluded that the young woman was much more positive and 'moving forward'. Her support plan identified support, but it did not mention the IEP situation or the compact drawn up by the wing staff despite its inevitable impact on her state of mind.
231. The young woman was reported to have spent most of the next two days sleeping despite numerous instructions from staff to get up. On 3 August, one of her personal officers recommended that the young woman should stay on 'basic' for a further week. On the same day, the young woman told another personal officer that she felt much more positive now. The young woman fulfilled her compact on 4 August. At her IEP review that day, chaired by the wing manager, it was agreed she would stay on the compact regime for a further week to give her a chance to prove herself.
232. Evidence points to the young woman not being able to accept that staff were trying to help her. The IEP board at which she was downgraded to a semi-basic regime indicated that the staff were really struggling to manage the young woman's behaviour and shape it to what they considered acceptable. A governor grade at the IEP board said that, given her history of self harm, he

recognised the risk of appearing to her to be punishing her. However, at her next review the wing manager downgraded the young woman further (to the basic regime) and this was continued on 18 August. The records show that the young woman had acknowledged that she had not made the required effort. On 20 August, staff recorded that she was in bed all day, again making no attempt to clean herself or her cell. There was no indication that staff had thought she might be depressed or asked the nursing staff for advice.

233. The attempts by the staff of I Wing to modify the young woman's behaviour appear to have been unsophisticated and one-dimensional. They embarked on a scheme which contained only 'sticks', without any motivating 'carrots'. However, the evidence indicates that the options were limited, compared with those in the men's prison such as moving to another wing. From the evidence, it appears that staff may not have been completely confident of the provisions of PSO 4000. For example, the PSO says that the prisoner on basic regime can have one visit of one hour or two visits of half an hour every 28 days. However, at interview one officer said:

"She didn't actually get onto full, full basic I don't think at all. We didn't stop visits and if she was on the full basic she would have had like a half hour visit instead of the full visit, we still let her have her visits."

234. By mid-August, the staff had exhausted their options, having put the young woman on the basic regime without any improvement in her behaviour. When asked at interview what they would or could have done next, the wing manager admitted he did not know.
235. At New Hall, the young woman's management was strongly influenced by health professionals. The plan for managing her after the hostage incident was drawn up by a truly multi-disciplinary team, including psychology. There is no record of I Wing staff taking any advice, or having any discussion at all, with healthcare staff. There was some awareness among staff that the young woman was on medication, but no knowledge of its possible impact on her behaviour. One of the other prisoners mentioned when interviewed that she thought the young woman's 'strong' medication affected her ability to get up in the morning. There was no evidence that wing staff ever asked the nursing staff if the medication had any such side effects. When asked at interview whether they were aware of the side effects of her medication, they told my investigators it was a medical matter and none of their business.
236. When my investigator spoke to her, the CPN commented that she was vaguely aware of the difficulties over the young woman's hygiene and motivation on the wing. The wing staff had never asked her for her opinion. She felt that the young woman would open up when at 'arms length' from I Wing. She had provided the young woman with tapes and a Walkman for relaxation. I Wing staff removed the privilege of in-cell television, yet the CPN described watching television as a significant coping mechanism for the young woman. She suggested that gaining attention was itself another coping mechanism. She said the important message from the young woman's behaviour was that she had needs which needed to be addressed.

237. There was evidence that the young woman was a regular writer of letters to friends and family. She also made a substantial number of phone calls (five or six per day) according to the records at Durham. Staff noted that her mood improved after speaking on the phone. On the basic regime, access to the telephone was restricted due to the small amount of time out of cell allowed. It was noticeable in the telephone records that the young woman had made 16 telephone calls on 10 August, three on 11 August, none from 12 – 15 August, and two on 16 August, after which she made no further calls.
238. Records about the young woman's behaviour and the staff's interventions indicated a lack of consistency and even contradiction in spite of the very small size of the unit. The use of the IEP scheme without reference to the management of the supervision of the young woman's suicide and self harm risk was unhelpful and could even have been harmful. The clinical reviewer questioned whether there had been any consultation between discipline staff and healthcare staff prior to attempting behavioural modification by withdrawing privileges. He commented that at best such actions were unlikely to help The young woman's mental state and clinicians might have counselled against this course of action. The CPN was skilled in cognitive behaviour therapy and could have advised very usefully. It was unfortunate that her contract did not allow her time to do in-depth work with the young woman.
239. In summary, a young woman, recognised as mentally unwell, was left without access to basic diversions and support mechanisms such as radio and television. She had access to only £2.50 a week to purchase tobacco (for which she had demonstrated a dependence), telephone calls and stamps. Her pleas for tobacco from her fellow prisoners, cigarettes from staff and even for cigarette butts, as described by an officer at interview, paint a picture of the young woman in a desperate state.

Probation

240. The young woman had very regular sessions with the probation officers at New Hall. They were in contact with her home probation officer and her solicitor. At Durham, the young woman resisted approaches from probation and there was no meaningful contact before or after her trial.

Lifer management

241. The records show that at both New Hall and Durham the requisite documentation was completed for the young woman. The documentation was of a satisfactory standard and documents were usually completed on time and in accordance with PSO 4700, The Lifer Manual.

Mental Health

242. The young woman was the subject of at least 20 psychiatric examinations relating to her court case and three assessments for Rampton Hospital. These were in addition to her consultations with the visiting psychiatrist, and the

prison's medical staff. The young woman was originally found unfit to plead by in September 2004. On 25 October 2004, she was transferred to Annesley House secure unit. While she was there, another psychiatrist assessed her. Both psychiatrists noted that, with about six months' treatment, she could be fit to go to trial. Annesley House took the young woman off all medication for a period the better to assess her mental state. On 13 December, she was returned to New Hall. In a letter the consultant psychiatrist wrote that he had diagnosed 'emotionally unstable personality disorder of the borderline type'. He said they had stabilised the young woman on anti-psychotic and mood stabilising medication. There was no further treatment they could offer at that time. However, he believed that the young woman might require further periods in a secure hospital in the future. The New Hall doctors continued the medication prescribed at Annesley House. The psychiatrists made some adjustments at Durham and the young woman was at one time noted to have said she felt she was improving.

243. The young woman was originally referred to the National High Secure Women's Services Directorate, Rampton Hospital, by the Senior Nurse/Acting Commissioning Manager, on behalf of the Clinical Director, Wathwood Regional Secure Unit, in a letter dated 22 March 2005, requesting an assessment regarding the appropriateness of her admission to conditions of high security. She was in New Hall at that time. A Consultant Forensic Psychiatrist, and a Specialist Registrar in Forensic Psychiatry, assessed the young woman at Durham on 27 April. She was also assessed by a Consultant Clinical Psychologist and an Assistant Psychologist, on 1 June 2005. At the time of the young woman's initial referral for assessment, she was on remand charged with murder.

244. The Admission Panel at Rampton Hospital, considered the joint report at its meeting on 13 June. A second joint report had not been submitted. In discussing the young woman's circumstances, the panel acknowledged that her legal status had altered between the point of referral and the time of her case being heard. The panel reached the following conclusions:

"In the light of the young woman's changed legal status, that the index referral to Rampton Hospital should be considered null and void.

"A referral of the young woman to Rampton Hospital for an assessment regarding her suitability for admission as a sentenced prisoner should be initiated following consultation with her local Regional Secure Unit and the Mental Health In-Reach team providing services at HMP Durham."

245. The young woman was re-referred by the Senior Forensic Nurse Adviser, on behalf of the Visiting Forensic Consultant Psychiatrist, on 1 August 2005 and assessed on 10 August on I Wing. He had the opportunity to discuss the young woman with I Wing staff and with the CPN, as well as interviewing the young woman for approximately an hour. The consultant psychiatrist learnt of the young woman's death prior to drafting his report.

246. In his report submitted on 16 November, the consultant psychiatrist reported that the young woman did not meet the criteria for admission to the National High Secure Women's Services Directorate, Rampton Hospital. He wrote that she did not meet the criteria for either the classification of psychopathic disorder or mental illness. He believed that the priority on 10 August was for the young woman to be supported in making the transition to Low Newton and to be assisted in coming to terms with her situation. He felt that the risk of self-harm had been attenuated and she was not behaving violently, due mainly to the protective setting of the prison environment and her compliance with her medication. He therefore concluded that detention for treatment was not necessary for the young woman's health or safety or with a view to the protection of others. It was his intention to file a report for the Rampton Hospital Admissions Panel indicating that the young woman was not eligible for admission as she was not detainable under the Mental Health Act. His report would also have indicated that a further review within six months would have been appropriate given her complex presentation.
247. With regard to the young woman's mental health, the findings of the clinical reviewer were that:
- The prison system was presented with a huge challenge in managing the young woman. Although psychiatric opinion differed, there was no doubt that her extremely frequent self-harming and aggressive and impetuous outbursts were very difficult to deal with. Forensic psychiatric opinion differed but latterly the young woman would appear to have been more overtly psychotic. I Wing at HMP Durham was oppressive and was rightly the subject of criticism by the Chief Inspector of Prisons. It was a most unsuitable environment for a prisoner with serious mental health problems such as the young woman.
 - It is hard to understand why it was necessary for the Rampton Admissions Panel to regard a referral made whilst on remand as null and void because of her subsequent conviction. Re-referral and recommencement of the whole process resulted in avoidable delays. It was confusing that the standard NHS practice of responding to identified and prioritised need did not take precedence over a change in legal status.
248. There is some degree of discrepancy between the findings in the report regarding the young woman's self harming, her compliance with her medication and the suitability of her environment, and the records kept by the prison staff. It is difficult to see how an assessment of one hour's duration could be fully comprehensive without close consultation with key members of staff and access to the patient's clinical and custodial records. It was of some consolation to read that she would have been re-assessed in six months, but sadly that was too late.

Other issues arising from the Clinical Review

249. The Medical Director at Durham has been a proponent of improving medical and nursing record keeping in prisons. He pioneered a new clinical record that was introduced nationally about two years ago. However, the clinical reviewer

found that the state of the young woman's clinical record highlighted the need to address again the issue of clinical record keeping in prisons. He recommended the introduction of a précis of key information, regularly updated and prominently displayed, as found in General Practice patients' notes. He recommended a review of what is filed, and where, if a clinical record is to be a safe and manageable document. Making information more accessible by summarising, reducing the volume of the operational clinical record and ensuring chronological filing, would make every record safer and more manageable.

250. On the question of equitable care, the clinical reviewer said it was difficult to imagine how, latterly, the young woman could have been managed in a community setting and as a consequence, in this respect, custodial care was superior. Although a very difficult patient, for the most part the young woman received competent and even compassionate care from the healthcare teams supported by mental health in-reach services.
251. One of my investigators drew the clinical reviewer's attention to a letter of complaint from a prisoner in I Wing. The prisoner highlighted the value of some kind of unit for disturbed prisoners such as the young woman who are either awaiting transfer to a secure hospital or regarded as unsuitable for such a transfer. She said how distressing it was to other prisoners to witness frequent acts of self-harm. The clinical reviewer expressed a great deal of sympathy with that view, because witnessing self-harm can be very distressing. He concluded that units like I Wing were unlikely to contribute in any positive way to the management of prisoners with mental health problems. A unit dedicated to their care could result in a more focused approach to their management.

Conclusions

252. The circumstances of the charge the young woman was facing at the time of her first remand in July 2004 should have resulted in her case being submitted as a potential category A prisoner following her first reception at New Hall. This did not happen, but even if it had there was no reason to suppose that she would have been made potential category A in practice. At the time of the young woman's re-categorisation, I Wing at Durham was the only location in which women prisoners with restricted status could be held. A movement order for the young woman's transfer to Durham on 30 March 2005 was issued immediately by the High Security Directorate following her categorisation as restricted status on 29 March. There was some evidence that her precipitate transfer surprised staff at both prisons and prevented any detailed planning for her reception at Durham. The young woman arrived when Durham was in some degree of turmoil because of its rerole as a male community prison.
253. New Hall had taken pains to provide detailed and balanced information about the young woman and their management of her. They stressed her vulnerability as well as detailing the 'hostage' incident. Information reached the wing staff via the I Wing Staff Observation Book, where an entry warned of her 'potential problems'. These were identified as potential hostage situations, self harming and manipulation of staff. It advised, 'there should be no physical

contact by anyone, no in cell association and she was never to be on her own with probation, chaplain or education.’ Her personal officers displayed little and varying knowledge of The young woman on arrival, despite their responsibility for her welfare. However, her ‘dangerousness’ was mentioned by wing officers at interview.

254. Although Durham was the only prison designated to hold restricted status women, I Wing was patently unsuitable for its purpose. Evidence for this conclusion arises from the report by the Chief Inspector of Prisons that I have cited in part in my foreword. The Chief Inspector wrote:

“The Prison Service itself was well aware that the situation was having a seriously damaging effect on the few remaining prisoners. Three months before this inspection, representatives of the women’s team at headquarters had noted that distress levels were very high among the women and there was a real risk of suicide unless significant changes were made quickly. In the three months before the inspection, four women accounted for nearly a third of all self harm incidents among the prison’s total population of over 700; and seven of the fifteen most serious suicide attempts in the prison as a whole had been carried out by women.”

“Previously, we described the 100 or so women at Durham as being out of the line of sight of the overall management of the prison. This remained the case for the six who remained; and the conditions in which they were held had deteriorated. Urgent action is needed to ensure that women prisoners are no longer held in such isolated and alienating conditions.”

255. I have indicated at several points in this report my concern that the designation of the young woman as restricted status led ineluctably to her being sent to Durham. The system is inflexible and bureaucratic, and arguably too reliant upon an algorithm drawn up principally for male prisoners. Certainly, the special needs and vulnerabilities of women prisoners do not seem to be sufficiently acknowledged in the process. Moreover, it would appear that the actual decision to move the young woman was made at a relatively junior level. In any future case, I would like to see much more effective oversight of such decisions by the Women’s Team in Prison Service Headquarters as well as drawing upon the insights of those who actually know the woman concerned. I have added a new recommendation to the Director General, reflecting my concerns on these matters.
256. The use by the wing staff of the IEP scheme as a form of behaviour modification was crude and misguided. Moreover, it was done without consultation with other key disciplines such as healthcare staff and the visiting psychiatric services. In the view of the clinical reviewer, the reliance on IEP was unhelpful and possibly harmful. I agree. Being on basic regime cut the young woman off from, or reduced her access to, the distractions which were helping her to cope, i.e. tobacco, television and telephone calls respectively.
257. Suicide and self harm management at Durham was not perfect. It was mainly compliant with the guidance set out in PSO 2700, although there were

occasional lapses such as missing reviews and a lack of detail in the support plans. The staff were trying to strike the difficult balance between surveillance and normalisation. Until the night she died, none of the young woman's self harming had come anywhere close to death. She had done herself serious harm with the fire that burned her leg and the foreign bodies inserted into her arm, but these actions were not life threatening. There was insufficient contribution in the F2052SH by healthcare staff generally although the visiting psychiatrist's contribution was especially significant.

258. The circumstances on I Wing were unlike any other prison for women, in that each prisoner had three personal officers. The records show that the officers spent significant time and energy on the young woman although their efforts did not yield any tangible improvement. The surprising thing was the differing perceptions they had of her, despite being part of the same team. One great disappointment was the separation of her healthcare from the care on the wing. Wing officers did not appear to be expected to seek advice from nursing staff. The nursing staff were never consulted about the potential risks of the IEP regime the staff were using in their attempt to modify the young woman's behaviour. From previous investigations, I know that this situation is not uncommon in prisons but it is unfortunate. Medical confidentiality, while deserving respect, must not be used as a barrier to necessary communication in the prisoner-patient's interest. As I wrote in my 2005-06 Annual Report, "Disclosure of confidential medical information should normally only take place with the patient's consent. However, disclosure without consent may be made if it is considered essential to protect the individual or anyone else from death or serious harm." It would be helpful if this were better known across the Prison Service.
259. It is possible from the evidence to conclude that there was a delay of 17 minutes between finding the young woman collapsed on her bed and calling the ambulance. However, from the interviews that have been conducted I can conclude that staff entered the cell reasonably promptly, called for the nurse on duty in the prison to attend at the same time, and asked for an ambulance to be called within the next minute or possibly a little more. Resuscitation was initiated swiftly by the nursing staff and officers present. The paramedics arrived within six minutes of the call for an ambulance and pronounced life extinct. It is unlikely the delay, if any did occur, was significant in the outcome for the young woman.
260. The way in which the young woman's family were informed of her death was not in keeping with best practice. Prison management also failed to deal satisfactorily with their continuing liaison with the family and in particular failed to send a letter of condolence.
261. With the speed of media communications, there is a risk of family and friends seeing news of the death of a loved one on Ceefax (or similar text based news services) before being informed by the next of kin. The current instructions to Governors require the Press Office to be told whether or not the family has been informed of a death. There is a requirement that the next of kin must have been told before the news is released. However, this may not provide a

sufficient safeguard against the distress of other friends and relatives learning the news of death on Ceefax.

262. There is no doubt that the young woman presented an enormous challenge to all the staff that were responsible for her management and welfare. There were many instances of her being treated with immense care and attention at Durham and New Hall. I was particularly impressed with the flexible and coherent multi-disciplinary approach evident in the records of her time at New Hall.
263. The young woman's mental health had been the subject of numerous assessments, including seven weeks as a patient at Annesley House Medium Secure Unit. There was little consensus about her diagnosis among the many psychiatrists she saw. In consultation with the Director of High Security about security issues, the Women's Team at PSHQ were making strenuous efforts to move each of the women in Durham to the most suitable destination given their individual circumstances. It is possible that they were placing some reliance on the young woman being accepted by Rampton Hospital. The other alternative for the young woman might have been the long-planned Primrose Project⁷ to be established at Low Newton for women with dangerous and severe personality disorder. I cannot predict whether the young woman would have met the criteria for the Primrose Project. The High Security Directorate was insistent that the security at Low Newton had to be improved before women with restricted status could be moved there. From conversation with the operational lead for the Primrose Programme, my investigator is aware that the programme did not actually commence until autumn 2006. There was thus no obviously suitable facility to which the young woman could be transferred in the late summer of 2005.
264. After the young woman's death, arrangements were made at some speed for the restricted status prisoners to be transferred to HMP Bronzefield in Ashford, Middlesex. The continued use of I Wing for the small number of women who were difficult to place elsewhere was a source of great concern to the Chief Inspector of Prisons in July, a month before the young woman died. The impact of the associated uncertainty on the women imprisoned there and the staff running I Wing created an unacceptable risk that a serious untoward event could happen. In my view, the placement of a young woman with an unstable mental condition into such a situation should have been avoided.

⁷ The Primrose Project (now the Primrose Programme) is a joint initiative between the Department of Health, the Home Office and the Prison Service for women with dangerous and severe personality disorder.

RECOMMENDATIONS

265. Since women are no longer held at Durham, the circumstances and environment of I Wing no longer exist. However, this investigation has also raised issues pertinent to the women's estate generally and to HMP Durham as a whole. I also endorse the recommendations of The clinical reviewer in his clinical review. On that basis the recommendations are:

1. **The Governor of Durham should ensure that, within three months of receiving this report, the local contingency plans for a death in custody and the follow up to deaths in custody are reviewed and, where necessary, revised to ensure the ambulance service is called immediately and to make them compliant with PSO 2700 and PSO 2710.**
2. **The Governor of Durham should take action to ensure that, within three months of receiving this report, the standard of support plans written for prisoners who are being monitored due to their risk of suicide or self harm is compliant with best practice as set out in PSO 2700 [and the Assessment, Care in Custody and Teamwork (ACCT) guidance which now applies].**
3. **The Governor of Durham should take action to ensure that, within three months of receiving this report, he is assured that relevant staff understand and apply the guidance contained in PSO 4000 Incentives and Earned Privileges, Earned Community Visits and Compacts, taking due notice of the need to involve other disciplines appropriately.**
4. **Consideration should be given by the Director of Prison Health and the Prison Service Women's Team, within three months of receiving this report, to the feasibility of providing a specialist unit within the female estate to accommodate women prisoners with disturbed behaviour or mental health problems. This would be in addition to the implementation of the current Primrose Project which should be given higher priority and achieved within six months of this report.**
5. **Consideration should be given by the Medical Director at Durham and Durham and Chester le Street PCT, to introducing into all prisoners' clinical records a précis of key information, regularly updated and prominently displayed, as found in General Practice patients' notes. This should be achieved within six months of receiving this report. At the same time they should review what is routinely filed, and where, in order to make every record safer and more manageable. The results of this work should then be made available to all providers of healthcare in prisons.**
6. **Consideration should be given by the Prison Service Press Office to establishing a reasonable delay between the death in custody and releasing the news, beyond the requirement that the next of kin have**

been informed and ensuring families are advised that a press release will be issued.

- 7. The Director General of the Prison Service should ask the Director of High Security Prisons and the Head of the Women's Team to review the implications of this report. In particular, how a more flexible approach to decisions on restricted status can be made, reflecting such factors as age, vulnerability and the appropriateness of the available accommodation.**

Response from the Prison Service

266. The Prison Service responded to my revised draft report on 29 January 2007. Five of the recommendations were accepted. Three had been completed and a further one was due for completion by 31 January. The recommendation which was rejected was number six which sought to change the timing with which the Press Office released details of a death in custody. (The full text of the Action Plan is attached as Annex D.)
267. In respect of the rejected recommendation, I understand the need for the Prison Service Press Office to balance the need for openness and accountability alongside treating bereaved relatives with respect. In another recent report, I have said that it must be shocking to learn of the death of a relative from Ceefax, and that this must add significantly to the distress. In that report, I have proposed that Prison Service staff who break the news of a death to next of kin should also advise them that a press notice will be issued, and for it to be suggested that they contact other family members as quickly as possible. This may offer the best way forward in what is necessarily a very sensitive area.
268. I attach particular importance to my final recommendation, made to the Director General of the Prison Service, which has been partially accepted. The Prison Service response says that flexibility in the use of restricted status is not appropriate but the need for full involvement of the Women's Team in decisions about restricted status is accepted. The response adds that work is in hand to draw up a procedure to ensure that the particular needs of individual women who are subject to restricted status are understood and taken into account in decisions about location and case management. The target date for completion of this work is 31 March 2007 and I await the outcome with keen interest.