

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Ms Margaret Atkinson a prisoner at HMP Low Newton on 2 February 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

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

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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

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

Ms Margaret Atkinson was found unconscious in her cell at HMP Low Newton on 24 January 2016, after tying a ligature around her neck. Ms Atkinson never regained consciousness and died in hospital on 2 February. She was 47 years old. I offer my condolences to Ms Atkinson's family and friends.

Ms Atkinson had spent long periods as an inpatient in psychiatric hospitals but had never been to prison before October 2015. Staff at Low Newton made considerable efforts to help Ms Atkinson cope with being in prison and looked after her with commendable care and patience. They recognised that she was at risk of suicide and self-harm and used Prison Service monitoring procedures almost continually to manage her risk. The investigation found some areas for improvement in the operation of those procedures but I do not consider these contributed towards her death.

Ms Atkinson was always at long-term risk of suicide and frequently tied ligatures made of clothing around her neck without harming herself. However, such behaviour is risky. When Ms Atkinson tied clothing around her neck on 24 January, she appears to have caused herself fatal damage in the space of a very short period when no one was observing her. The staff, who knew Ms Atkinson's pattern of behaviour well, had little reason to consider the incident was different from previous occasions and I recognise it would have been difficult for staff to have identified that Ms Atkinson was at imminent and high risk of suicide at the time. However, I consider that staff should always remove ligatures from prisoners as soon as possible, and should constantly observe them when they have tied items around their neck, until the ligature is removed.

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

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# Summary

## Events

1. On 30 October 2015, Ms Margaret Atkinson was convicted of assault and taken to HMP Low Newton. This was her first time in prison. She had been diagnosed with bipolar disorder and emotionally unstable personality disorder and had a history of attempted suicide and self-harm. Until shortly before she went to prison, she had spent a number of years in a psychiatric hospital. Prison staff monitored her using Prison Service suicide and self-harm prevention procedures, known as ACCT. Ms Atkinson was prescribed antipsychotic medication.
2. Ms Atkinson's behaviour was volatile and difficult to manage. From 1 November, she was admitted to the prison's healthcare unit where she remained until she was released from court on 20 November. On 1 December, Ms Atkinson was remanded to Low Newton again. Her behaviour became very difficult to manage and managers decided that two officers needed to be present whenever she was unlocked from her cell. Staff managed her under ACCT procedures again. Ms Atkinson frequently tied ligatures around her neck but these were loosely tied and did not cause her any harm. A psychiatrist assessed Ms Atkinson and monitored her response to medication. On 17 December, Ms Atkinson received a suspended sentence and was released from court.
3. On Christmas Eve, Ms Atkinson received another short prison sentence for minor offences and returned to Low Newton. She was admitted to the healthcare unit. Again, because of her unpredictable behaviour, two officers had to be present when she was out of her cell. On 30 December, staff began ACCT procedures again when Ms Atkinson tied a ligature around her neck, after a visit from her partner. Staff held multidisciplinary case reviews over the following weeks and assessed her risk to herself as either low or raised. She continued to tie loose ligatures around her neck but these did not cause her any harm.
4. On 23 January 2016, managers decided that Ms Atkinson no longer needed two officers present to unlock her, as she had seemed to settle. Later that day, Ms Atkinson again tied clothing round her neck and said she was anxious about her partner visiting her that afternoon. Afterwards, she told staff the visit had gone well. Later, she tied clothing around her neck twice more.
5. On the evening of 24 January, Ms Atkinson's behaviour became difficult. She disturbed others by playing music very loudly and pressed her cell bell continually for no reason. She tied clothing around her neck and attached this to the window. Staff observed her and all said that this did not appear to be wrapped tightly around her neck or tied taut to the window. They continued to check her frequently over the next sixteen minutes and said she responded by talking, blinking, smiling or moving.
6. The staff decided to unlock Ms Atkinson's cell and remove the clothing from around her neck. They went into the cell and removed the ligature from around her neck and from the window. When Ms Atkinson did not respond, they believed she was pretending to be unconscious. A nurse then noticed Ms Atkinson was urinating and established that she was not breathing. The staff

immediately began cardiopulmonary resuscitation and requested an ambulance. Ms Atkinson was taken to hospital where a CT scan found she had a brain injury. Police informed Ms Atkinson's partner that she had been taken to hospital. Sadly, Ms Atkinson did not regain consciousness and died at the hospital on 2 February.

## Findings

7. Ms Atkinson had significant mental health problems and her behaviour was often volatile and difficult to manage. She received appropriate clinical care and support from the mental health team at Low Newton and the staff made significant efforts to help reduce her risk to herself. She was managed under ACCT procedures almost continually during the time she was at Low Newton. The investigation found some good practice in the management of ACCT procedures, including multidisciplinary case reviews and continuity of the staff involved, who evidently knew Ms Atkinson well and cared for her. While we also identified some areas for improvement, such as the need for more effective caremaps, more focused assessments or risk and recording of potential triggers for self-harm, we do not consider that these contributed towards her death.
8. When staff found Ms Atkinson with a ligature tied around her neck on the evening of 24 January, they did not regard it as unusual behaviour; this was something Ms Atkinson had done a number of times before and she had never come to any harm as a result. Staff continued to check her and eventually decided to unlock her cell and removed the ligature. We recognise that the circumstances in which Ms Atkinson managed to cause herself fatal harm were very unusual and would have been difficult to anticipate, but we consider that that prison staff should always remove ligatures as soon as possible when a prisoner had tied something around their neck and should constantly observe them until this is done.

## Recommendations

- The Governor and Head of Healthcare should ensure that when prisoners tie ligatures, staff remove the ligatures as soon as possible. Until this is done, staff should constantly observe them and be ready to intervene immediately if necessary.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular that:
  - Case reviews take full account of all known risk factors and triggers when determining a prisoner's risk of suicide or self-harm and that levels of observations reflect that risk.
  - ACCT caremap actions are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary at each case review.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Low Newton informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. Another investigator visited Low Newton on 9 February. He obtained copies of relevant extracts from Ms Atkinson's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Ms Atkinson's clinical care at the prison. The investigator and clinical reviewer interviewed ten members of staff at Low Newton in March.
12. We informed HM Coroner for Durham and Darlington of the investigation, who gave us the hospital report into Ms Atkinson's death. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Ms Atkinson's parents and her partner, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Ms Atkinson's partner asked the following questions:
  - What happened to Ms Atkinson after he visited her on 23 January?
  - How was Ms Atkinson's bipolar disorder treated and managed?
  - Did Ms Atkinson give any indication that she would self-harm?
  - Was Ms Atkinson having delusional thoughts and, if so, were prison staff aware of these?
14. Ms Atkinson's mother received a copy of the initial report and indicated that she was satisfied with the findings.
15. The National Offender Management Service (NOMS) also received a copy of the report. They accepted all the recommendations.

## Background Information

### HMP Low Newton

16. HMP Low Newton, near Durham, holds up to 329 women. The population includes women on remand, prisoners serving short and long sentences, and some high security prisoners.
17. G4S is the main healthcare provider at Low Newton, responsible for 24 hour primary care, clinical care for substance misuse and administration. Tees, Esk and Wear Valleys NHS Foundation Trust provide primary and secondary mental healthcare, and subcontract some services to two other providers, Rethink and Mind. Spectrum provide GP and pharmacy services. The different providers meet once a month at an operational governance meeting chaired by the Governor.

### HM Inspectorate of Prisons

18. The most recent inspection of Low Newton was in October 2014. Inspectors found a complex prison holding a challenging and very vulnerable population. There were extremely high levels of need, with half of the women requiring mental health treatment. The inspection team noted that, in many ways, the service the prison offered more closely resembled that of a hospital than a prison. Mental health services were generally very good. Levels of care for women at risk of suicide and self-harm were generally good. The inspectors found that staff were humane and caring but a more coordinated approach was needed to manage women with complex needs.

### Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2015, the IMB reported that Low Newton offered a safe and supportive environment and that there was a good atmosphere in the prison. The Board described the support available for women at risk of suicide and self-harm as robust.

### Previous deaths at HMP Low Newton

20. Since 2010, we have investigated five deaths at Low Newton. Two were from natural causes, one was caused by an apparent overdose and two were self-inflicted. Our investigation into the previous self-inflicted deaths found that ACCT case reviews did not fully consider new information about increased risk of suicide or self-harm and ACCT caremaps were not meaningful or well managed. We identified similar issues in this investigation.

### Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the

prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

22. Ms Margaret Atkinson had a long history of mental health problems, dating back to 1990. She had had extensive contact with community mental health services and had been legally detained under the Mental Health Act (1983) for seven years. Ms Atkinson had diagnoses of bipolar disorder and emotionally unstable personality disorder. Bipolar disorder is marked by extreme shifts in mood, energy, thinking and behaviour. There are 'highs' marked by periods of mania, greatly elated and excitable states and 'lows' or periods of depression. People with a personality disorder may find coping with demanding situations difficult. They often find it difficult to establish and maintain positive relationships with others. There are different types of personality disorder but generally, the individual's traits (thoughts, feelings or behaviour) are extreme or unusual in some way. Emotionally unstable personality disorder is characterised by dramatic, emotional or erratic behaviour.
23. In August 2015, after some years as an inpatient, Ms Atkinson was discharged from a psychiatric hospital to a supported housing complex for people with mental health problems. A community psychiatric nurse (CPN) told the investigator that Ms Atkinson's behaviour in the community was often bizarre and impulsive and she had not engaged with psychotherapy. Ms Atkinson had a history of suicide attempts and self-harming behaviour.
24. On 30 October 2015, Ms Atkinson was convicted of assault and taken to HMP Low Newton. This was her first time in prison. The CPN contacted the prison before Ms Atkinson arrived to give them information about Ms Atkinson's mental health problems. At an initial health screen, Ms Atkinson said that she was prescribed fluoxetine (an antidepressant) and aripiprazole (an antipsychotic used to treat bipolar disorder). She said she had taken an overdose a week earlier and had previously tied ligatures around herself and self-harmed by cutting. Ms Atkinson said she was pregnant but tests showed this was not the case.
25. When Ms Atkinson arrived, the mental health team manager began Assessment Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures. She was aware of Ms Atkinson's history of suicide attempts and self-harm and was concerned about how she would react to being in prison for the first time.
26. The next morning, 31 October, Ms Atkinson told an officer who was assessing her as part of ACCT procedures, that she was in shock about being in prison but did not have any current thoughts of suicide or self-harm. The officer noted that it was difficult to complete the assessment as Ms Atkinson spoke in different voices and acted bizarrely. At a case review immediately after the assessment, Ms Atkinson said that, although she had no current thoughts of suicide or self-harm, she often acted impulsively when she self-harmed.
27. The case review set the level of observations at twice hourly and staff were asked to have two conversations each day with her. Staff recorded four caremap actions; for her to be assessed by the mental health team, to be supported during her first time in prison, to be encouraged to take her medication, and to be offered support in relation to a previous assault. Although some required

ongoing action, all were marked as complete that day. The next case review was scheduled for 4 November.

28. On 1 November, staff held two unscheduled multi-disciplinary ACCT reviews, the first when they were concerned about Ms Atkinson's mental health. Ms Atkinson refused to attend the review and was verbally abusive towards staff. Staff increased observations to four times an hour and moved her from the first night centre to the prison's healthcare unit where she remained for the rest of her time at the prison. This meant that healthcare staff became responsible for managing the ACCT procedures.
29. Ms Atkinson's partner visited her that afternoon and she appeared angry after the visit. A nurse told the investigator that she allowed her to use the office telephone to call her partner but Ms Atkinson tied a cloth around her neck when she went back to her cell. She removed it when asked, and the staff held another ACCT case review. Ms Atkinson said she was upset with her partner, as she believed he was having an affair. She said she felt low and was hearing voices.
30. The mental health team manager completed a care and management plan. Mental health staff regularly updated this plan to help all staff understand Ms Atkinson's mental health problems and how best to manage them. The plan was accessible to all staff in the wing office and included that staff should see Ms Atkinson in pairs because her behaviour was unpredictable and aggressive. It set out the arrangements for Ms Atkinson's meals, time out of her cell and how to manage her risk to herself.
31. On 2 November, a prison GP prescribed aripiprazole, valproic acid (a mood regulator) and fluoxetine. The next day, Ms Atkinson spat at a nurse. On 4 November, staff held another ACCT case review. Ms Atkinson said she felt suicidal and planned to hang herself. Staff assessed her as a raised risk to herself but her level of observations remained the same.
32. On 8 November, staff at an ACCT case review reduced Ms Atkinson's observations to twice hourly. Ms Atkinson was taking her medication. She said she had fleeting thoughts of harming herself but was interacting with staff and watching television to distract herself from such thoughts. Ms Atkinson's partner visited her that day.
33. On 9 November, a psychiatrist assessed Ms Atkinson. He recorded that Ms Atkinson had been difficult to manage, made false allegations about staff and talked about things which did not appear to be normal, such as claiming relationship with famous people. He noted she could be aggressive, abusive, threatening and generally agitated. The doctor concluded that she might be hypomanic. (Hypomania is a form of bipolar disorder involving an elevation in mood.) He also noted evidence of a personality disorder.
34. The psychiatrist stopped Ms Atkinson's prescription of fluoxetine, as he considered this might have contributed to elevating her mood. He assessed her as a low risk of suicide and self-harm. Ms Atkinson refused to take her prescribed valproic acid, as she said she was pregnant and he offered her an alternative antipsychotic and mood stabiliser, olanzapine. Ms Atkinson declined

olanzapine, as she knew a potential side effect was weight gain. After the consultation, he discussed Ms Atkinson's care with the CPN and members of the prison's mental health team.

35. On 10 November, Ms Atkinson's partner visited her. On 13 November, healthcare staff held an ACCT case review at which Ms Atkinson said she had thoughts of harming herself but had not acted on them. She agreed to go to the prison dining hall for her meals, as a way of getting out of her cell more.
36. On 16 November, the psychiatrist reviewed Ms Atkinson and noted that she was calmer and had no thoughts of suicide or self-harm. He recorded that she should continue with her current medication. On 17 November, Ms Atkinson's partner visited her. At 4.00pm, healthcare staff held an ACCT case review, at which Ms Atkinson said she was anxious about her court appearance and losing her flat. On 20 November, Ms Atkinson appeared at Magistrates Court and received a suspended prison sentence. She was released from court.
37. On 1 December, Ms Atkinson returned to Low Newton, after breaching an antisocial behaviour order and assaulting a police officer. A prison GP prescribed her aripiprazole and valproic acid. Staff began ACCT procedures as Ms Atkinson said she could hear a voice telling her to hang herself. They set observations at twice hourly.
38. During the night, Ms Atkinson acted in an increasingly chaotic and bizarre manner. On 2 December, she threw water over another prisoner, was abusive to staff and punched an officer in the face through the door medication hatch. Managers decided that two officers should be present whenever she was unlocked from her cell. This restricted the time she was able to spend out of her cell. Ms Atkinson was guaranteed one hour out of her cell each day, but officers said they tried to arrange more than this. On 2 December, Ms Atkinson was constantly banging on her door and screaming and staff were unable to interview her for an ACCT assessment. A multidisciplinary team held an ACCT case review without Ms Atkinson. The case review assessed her as being at raised risk of harm to herself and increased observations to four an hour.
39. On 3 December, Ms Atkinson tied curtains around her neck, rang her cell bell and told the officer who answered that she wanted to die. At 7.50am, staff held an ACCT review without Ms Atkinson and kept observations at four an hour. Over the next few days, Ms Atkinson continued to be disruptive. Staff held daily ACCT case reviews, which resulted in no change in her level of assessed risk or observations.
40. Staff told the investigator Ms Atkinson's behaviour was very erratic; she could have quite settled periods when she would engage well with staff and then have periods when she was difficult to manage. She often rang her cell bell to talk to staff and banged on her door to get their attention. A nurse said it was difficult to explore issues with Ms Atkinson, as she would change the subject or make delusional statements about the famous people she claimed she knew or were related to her. This made it difficult for staff to assess Ms Atkinson's risk to herself. Staff spoke to Ms Atkinson about the dangers of her tying items around her neck. Ms Atkinson sometimes said it was just a way of expressing her

feelings but at other times said that she wanted to die. When staff tried to discuss alternative methods of coping, Ms Atkinson changed the subject.

41. On 7 December, the psychiatrist reviewed Ms Atkinson. He considered that she had emotionally unstable personality disorder but that it was unlikely she was suffering from a relapse of bipolar disorder at that time. He assessed that she was at low risk of suicide and self-harm, and suggested that the frequency of observations should be reduced.
42. Also on 7 December, a custodial manager interviewed Ms Atkinson for a belated ACCT assessment. Ms Atkinson said she did not see the point in living. She said that her partner abused her and they had now finished their relationship.
43. On 9 December, the Head of Healthcare asked another psychiatrist to assess Ms Atkinson, as staff were concerned about her behaviour. He concluded that Ms Atkinson was suffering from both personality disorder and bipolar disorder and that she should be assessed for a transfer to hospital. The mental health team in the community was responsible for completing this assessment.
44. On 14 December, the first psychiatrist reviewed the other psychiatrist's assessment and did not agree that Ms Atkinson was suffering a relapse of bipolar disorder. He did not consider that Ms Atkinson's symptoms met the criteria for urgent treatment under section 48 of the Mental Health Act and therefore he thought she did not need to be transferred to hospital. He considered her risk of suicide and self-harm was low and that her behaviour and risk could be managed in prison. He noted that it was important to have a joint approach with healthcare staff and prison custodial staff working together. He later attended an ACCT case review, which reduced Ms Atkinson's observations to twice hourly.
45. On 17 December, Ms Atkinson appeared at court and received a suspended prison sentence. She was released from court.
46. On 24 December, Christmas Eve, Ms Atkinson was sentenced to 162 days imprisonment for failing to answer police or court bail and further minor offences. She returned to Low Newton and was admitted to the healthcare unit again. The court warrant noted that her conditional release date was 13 March 2016. A prison GP assessed Ms Atkinson and noted she had no thoughts of suicide or self-harm. She became abusive and threatening towards the doctor and he ended the consultation as a result. Because of her unpredictable behaviour, it was again decided that two officers needed to be present when she was unlocked from her cell. On 27 December, Ms Atkinson made sexual comments towards an officer and hit his backside.
47. On 30 December, Ms Atkinson's partner visited her. In her cell afterwards, she tied a ligature around her neck and attached it to the window. Staff began ACCT procedures and moved Ms Atkinson to a safer cell. (Safer cells are designed to have minimal ligature points to help prevent prisoners hanging themselves.) At an ACCT assessment the next morning, Ms Atkinson said she had suicidal thoughts because of the voices she heard and asked for a radio to distract her from these voices. Ms Atkinson said she had not received any medication since returning to prison.

48. A nurse held an ACCT case review that afternoon. The mental health team manager and two officers were also present. No triggers for suicide or self-harm were recorded. There was one caremap action for staff to give Ms Atkinson a radio. This was marked as complete that day. Staff assessed Ms Atkinson as a raised risk to herself and set observations at four times per hour.
49. That afternoon, a prison GP prescribed Ms Atkinson aripiprazole. The psychiatrist told the investigator that sometimes such a gap in medication can cause deterioration in a person's mental health but he did not think this had been the case for Ms Atkinson. The next day, at an ACCT case review, Ms Atkinson was more positive and said she had no thoughts of suicide or self-harm. Staff decided to move Ms Atkinson from the safer cell to a 'step-down' cell with a television. This was a cell with perspex along one wall so that staff could observe Ms Atkinson more easily. Staff added this action to the caremap and marked it as complete.
50. On 2 January 2016, Ms Atkinson tied a sheet around her neck. On 3 January, at an ACCT case review chaired by a nurse, Ms Atkinson said she was feeling better. Staff reduced observations to twice hourly from four times an hour and assessed her as low risk of suicide and self-harm.
51. On 4 January, the psychiatrist asked another psychiatrist to assess Ms Atkinson for a second opinion. That day, Ms Atkinson told a resettlement worker that her relationship with her partner was very abusive. When the worker tried to discuss this with her, Ms Atkinson changed the topic of conversation and asked if she could go outside for a cigarette. She noted this information in Ms Atkinson's prison record.
52. On 6 January, a nurse noted that Ms Atkinson engaged well at an ACCT case review and said she had no thoughts of suicide or self-harm. Her level of observations and assessed risk to herself remained the same. Staff moved her to a standard cell in the healthcare unit. The next day, Ms Atkinson tied some clothing round her neck, which she removed when asked. At an ACCT case review, she told a nurse that she would not do it again. On 8 January, a nurse held an ACCT case review. Ms Atkinson said she felt low and wanted to use the Samaritans' telephone. (A portable dedicated telephone used to call the Samaritans.) There was no change in staff's assessment of Ms Atkinson's risk to herself or the level of observations required.
53. On 12 January, another psychiatrist assessed Ms Atkinson and discussed Ms Atkinson's diagnosis with the first psychiatrist. Both psychiatrists agreed that Ms Atkinson was not suffering from a relapse of bipolar disorder at the time. The second psychiatrist suggested that healthcare staff at the prison and the mental health team, who had been responsible for Ms Atkinson in the community, should hold a joint review. Ms Atkinson's partner visited her that day.
54. On 13 January, Ms Atkinson asked to speak to someone from the mental health team. When an officer told her the team was busy at that time, she said that she would kill herself. She went under the bed and tied a t-shirt around her neck. The mental health team manager went immediately to the cell. Ms Atkinson came out from under the bed. She had not tied the t-shirt tightly around her neck and removed it when the manager asked her to. Ms Atkinson said she had not

intended to kill herself. The manager encouraged her to use other, less dangerous, coping strategies. A nurse held an ACCT case review that afternoon, which assessed that Ms Atkinson's risk of suicide or self-harm had increased from low to raised, but kept the observations at the same frequency of two an hour.

55. On 15 January, the police arranged to visit Ms Atkinson at the prison on 26 January to question her about an alleged further offence committed on 1 December. Ms Atkinson confirmed that she wanted legal representation for when the police questioned her. At an ACCT case review that evening, Ms Atkinson told a nurse that she had no thoughts of suicide or self-harm.
56. On 18 January, the psychiatrist agreed with the mental health team manager that he and the community mental health team would review Ms Atkinson on 1 February, as his colleague had recommended. This was to ensure that they had an appropriate plan to manage Ms Atkinson after she was released. Staff also held a multidisciplinary meeting and agreed that Ms Atkinson should have her meals in the central dining hall, with two officers accompanying her. This would be reviewed on 22 January. Ms Atkinson said she was happy about this. That afternoon, a nurse chaired an ACCT case review. Ms Atkinson said she had occasional thoughts of suicide and self-harm but could not identify what triggered these or any ways of coping with them.
57. Ms Atkinson was disruptive during the night. She shouted, played loud music, pressed her cell bell and refused to be quiet. The next day, 19 January, Ms Atkinson tied a t-shirt around her neck which she tied to a window. Staff moved her to a step-down cell, where they could observe her more easily. A nurse held an ACCT case review. The review assessed her risk to herself as raised and increased observations to four an hour.
58. On 22 January, staff held a further multidisciplinary meeting to discuss Ms Atkinson's progress and decided that it was no longer necessary to have two officers present when she was unlocked from her cell. A nurse chaired an ACCT review that afternoon, at which Ms Atkinson said she had no thoughts of suicide or self-harm. The review assessed her risk to herself as low and reduced the level of observations to two an hour. Ms Atkinson moved from the step-down cell to a standard cell that day.

### **Saturday, 23 January**

59. A nurse told the investigator that Ms Atkinson had a good morning on 23 January. She had talked to staff and seemed fairly calm. At 12.00pm, an officer locked her in her cell for the lunch period.
60. Shortly afterwards, staff found Ms Atkinson had tied clothing loosely around her neck. She removed the clothing from around her neck when asked to do so. At 1.10pm, a Supervising Officer held an ACCT case review, at which Ms Atkinson said she was anxious about a visit from her partner that afternoon but wanted the visit to go ahead. The review considered her risk remained raised but increased her observations to four an hour. After the visit, Ms Atkinson told the mental health team manager that the visit had gone well and she had talked to her partner about their plans after she was released.

61. Later, Ms Atkinson tied clothing around her neck twice. Staff noted that she had not tied this tight. No intervention was needed and Ms Atkinson removed the clothing when asked. The mental health team manager told the investigator that she believed that Ms Atkinson had just wanted to talk to staff. A nurse said that Ms Atkinson had seemed in a good mood later that day; she had been singing, dancing and playing music in her cell.

### **Sunday, 24 January**

62. On 24 January, the mental health team manager told the investigator that Ms Atkinson seemed settled and positive. She was happy that she could have more time out of her cell, as there was no longer a requirement to have two officers present when her cell was unlocked. A nurse said that Ms Atkinson had interacted more that day and talked about her feelings. She thought that her mood was improving and she had no concerns about her risk to herself.
63. Around 8.00pm, the nurse on night duty began her shift and gave Ms Atkinson her medication and a hot drink. She said Ms Atkinson was her usual self; she had wanted to stand and chat with her and had rung her cell bell unnecessarily.
64. The night manager that evening had an officer assisting her. For security reasons, most staff at night do not carry standard prison keys but have cell keys in a sealed pouch for use in an emergency. They were the only two members of staff with full sets of keys for the whole prison.
65. Around 9.00pm, the officer went to the healthcare unit to check the nurse for a routine check. The hatch on Ms Atkinson's door was open and he went to speak to her. He said they shared a joke and then closed the hatch. He told the nurse he would be back in about an hour and left the unit.
66. At 10.10pm, the night manager went to the healthcare unit to take the nurse for a night medicine round in the prison. The officer staffed the healthcare unit in the nurse's absence. He told the investigator that Ms Atkinson was playing her music loudly and ringing her cell bell unnecessarily. He asked her to turn the music down but she refused and, after warning her, he turned off the electricity supply to the sockets in her cell. Ms Atkinson continued to press her cell bell. He said that when he went to speak to her she smiled but would not speak to him. He said this happened repeatedly.
67. CCTV footage from around 10.00pm that evening in the healthcare unit showed Ms Atkinson repeatedly pressing her cell bell and the officer responding to it. There were no times on the footage but the investigator was able to gauge the elapsed time between events.
68. When the officer next checked Ms Atkinson, she had tied some prison clothing together and wrapped it loosely around her neck, with one end on the windowsill. He said that the material leading up to the windowsill was not tight. Ms Atkinson was sitting on the bed frame and the mattress was on the floor. He asked Ms Atkinson to remove the clothing from around her neck. He said she smiled, but did not reply. She was writing on some paper. He understood that this was typical behaviour for Ms Atkinson and waited for the night manager and the nurse to get back.

69. Ten minutes later, shortly after 10.40pm, the night manager and the nurse returned and went to Ms Atkinson's cell with the officer. The cell door had a large medication hatch and a smaller observation panel. They looked through the observation panel and noted that Ms Atkinson was in the same position. The night manager said that when the officer looked through the medication hatch, Ms Atkinson pretended to be unconscious. As the corridor was dimly lit, she thought it was unlikely that Ms Atkinson could see her or the nurse looking through the observation panel. She said that Ms Atkinson then opened her eyes and laughed and joked with the officer, but still refused to give him the clothing from around her neck. The staff agreed that this was typical of Ms Atkinson's behaviour. The CCTV records show that they had been looking into Ms Atkinson's cell for three minutes.
70. The night manager was called to attend an incident elsewhere in the prison and, when she left, the officer continued to check Ms Atkinson and talk to her. He said that she moved to sit on the floor. He asked if she was better and she smiled at him. He said the clothing leading to the windowsill was still not tight. The nurse also spoke to Ms Atkinson and asked her to move away from the pipes on the wall so she did not burn herself. They then moved away from the door and stopped looking in, but said that they could hear Ms Atkinson moving papers.
71. CCTV showed that the nurse and the officer went back to the cell just under three minutes later. The nurse said she asked her again to take the clothing off her neck but she did not reply. The officer told the investigator that she had moved away from the pipes since their last check and appeared to blink and smile at them. He told the investigator that he did not think Ms Atkinson was in any distress or danger otherwise he would have unlocked the door straightaway and gone into the cell. He radioed for the night manager to come back to the healthcare unit, as he wanted to unlock Ms Atkinson's cell to remove the clothing from her neck along with any spare clothing she had, for her safety and to allow him to return to his other duties. He was no longer watching her.
72. The night manager arrived less than a minute later. She said she looked through the observation panel and could see Ms Atkinson sitting on the floor with her back to the wall. She immediately unlocked the door and began speaking to Ms Atkinson. CCTV shows that from the moment all three staff first observed Ms Atkinson at around 10.40pm, sixteen minutes had passed. At least one member of staff had observed Ms Atkinson through the observation panel for ten of these minutes. She had been checked twice for over a minute each time in the last five minutes.
73. The officer went into the cell and asked Ms Atkinson to take the clothing from her neck but she did not respond. He said Ms Atkinson was sitting upright, and staring at him. He removed the clothing from the window which he said was just been resting there. The three staff all said that the clothing had not seemed tight around Ms Atkinson's neck and did not appear to be pulled tight up against the window.
74. The night manager was unable to untie the knot in the material around Ms Atkinson's neck and it was too thick to use an anti-ligature knife, but as it was

relatively loose, she was able to ease it over Ms Atkinson's head. She and the officer thought that Ms Atkinson was pretending to be unconscious. She was still sitting up and they asked her to move onto the mattress where she would be more comfortable. She did not respond, so they began to lift her, when the nurse noticed Ms Atkinson was urinating. She then realised it was an emergency.

75. The staff moved Ms Atkinson onto the mattress on her back. The nurse checked her and established that she was not breathing, had no pulse and her pupils did not react to light. The nurse said that Ms Atkinson was warm, looked pink and had no ligature mark around her neck. The officer began chest compressions and the nurse gave two rescue breaths before leaving to get the emergency equipment bag, which was in an office nearby.
76. Two minutes after going into the cell, the night manager left the cell to phone the communications room to ask them to call an ambulance. (An emergency radio code was not necessary as she, the officer and the nurse were already there and no other members of staff on duty in the prison had keys to attend.) The communications room called an ambulance immediately. Information from North East Ambulance Service indicates that the call was at 11.00pm.
77. The nurse returned very quickly with the emergency bag. She inserted an airway and attached an Ambubag to administer oxygen. She attached a defibrillator but this did not advise a shock. The night manager went to one of the wings and handed over officer's keys to another officer so he could get other staff, including a healthcare assistant to attend. The ambulance arrived at the prison at 11.04pm and reached Ms Atkinson's cell very quickly. (CCTV shows that paramedics arrived at Ms Atkinson's cell eleven minutes after the night manager had first unlocked the cell.) Paramedics took over emergency treatment and at 11.45pm, took Ms Atkinson to hospital. Ms Atkinson was sedated and attached to a ventilator in hospital. A CT scan showed damage to her brain caused by hypoxia (deficiency of oxygen).

## 25 January onwards

78. The night manager had telephoned the duty governor to inform her of what had happened, and the duty governor went immediately to the prison. After paramedics took Ms Atkinson to hospital, the duty governor looked for the contact details of her next of kin but these were not recorded in her prison record. (Ms Atkinson's partner had been recorded as her next of kin in her ACCT document, but this had gone with her to hospital. The duty governor did not have access to it and was unaware of this.)
79. At 1.00am, the police telephoned the duty governor for information about what had happened and asked for details of Ms Atkinson's next of kin. At 1.30am, she called the police back and gave them Ms Atkinson's partner's telephone number but she had no address for him. The police then telephoned Ms Atkinson's partner and told him that she had been taken to hospital and was seriously ill. Ms Atkinson's partner telephoned the prison for more details and at 3.30am, the duty governor explained what happened. She agreed that someone would telephone him later in the morning to arrange for him to visit Ms Atkinson, as he wanted to wait until then.

80. At 8.30am on 25 January, an officer was appointed as the family liaison officer. She telephoned Ms Atkinson's partner and later collected him from his home and drove him to the hospital. Ms Atkinson remained on life support and her prognosis was poor. That afternoon, the prison telephoned Ms Atkinson's mother and informed her that she was in hospital.
81. On 28 January, the Governor formally released Ms Atkinson on temporary licence and the officers escorting her left the hospital. On 1 February, a CT scan showed no activity in Ms Atkinson's brain. After consulting Ms Atkinson's family, the doctors removed life support. Ms Atkinson died the next day, 2 February. The family liaison officer offered her condolences and support to Ms Atkinson's family.
82. The prison contributed to the costs of Ms Atkinson's funeral, in line with Prison Service instructions. Several members of prison staff attended.

### **Support for prisoners and staff**

83. After Ms Atkinson was taken to hospital, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Another debrief was held two weeks later. The staff care team also offered support.
84. The prison posted notices informing other prisoners of Ms Atkinson's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Atkinson's death.

### **Post-mortem report**

85. There was no post-mortem examination, as Ms Atkinson died in hospital and donated her organs. A report, prepared for the coroner, by a doctor at the hospital concluded that Ms Atkinson had died from a brain injury caused by hanging.

# Findings

## Managing Ms Atkinson's risk on 24 January

86. On the night of 24 January, an officer found that Ms Atkinson had tied trousers around her neck, which were attached to the window for at least sixteen minutes before officers decided to unlock her cell. We have considered whether the staff acted appropriately in response. All three staff were adamant that this clothing never appeared tight around her neck or taut up to the window. During these sixteen minutes, staff spent ten of them directly observing her. At one point, she moved from sitting on her bed to the floor and then moved away from the wall. At a final check, less than a minute before they unlocked her cell, the officer said he thought that Ms Atkinson smiled and blinked at them.
87. When they unlocked the cell, all three members of staff still did not consider that anything was amiss. The night manager said she had cut hundreds of ligatures from around the necks of women prisoners and had dealt with four or five in her current period of night duty, so she was very experienced with dealing with such situations. She removed the clothing from Ms Atkinson's neck by slipping it over her head but she did not consider that she was dealing with an emergency, as it did not appear tight.
88. We recognise these were unusual circumstances, but at some stage Ms Atkinson must have pulled the clothing around her neck sufficiently tightly to cause asphyxia. While staff had observed Ms Atkinson for most of the time she had the clothing tied around her neck, there were gaps of some minutes when she was not watched. It seems that Ms Atkinson must have tied the ligature more tightly during one of these gaps in observation.
89. We understand that Ms Atkinson often tied clothing around her neck and that she had never previously harmed herself in this way at Low Newton, so the staff had little reason to believe she was at immediate risk of suicide. It is possible that Ms Atkinson did not intend the outcome of her actions, but tying ligatures around the neck should always be regarded as high risk behaviour. We accept that staff took what they believed were reasonable steps to protect Ms Atkinson, but we consider that one of the lessons to be learned from this sad incident is that when prisoners tie ligatures, the ligatures should be removed from their cells as soon as possible, and staff should watch them constantly until that can be done. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that when prisoners tie ligatures, staff remove the ligatures as soon as possible. Until this is done, staff should constantly observe them and be ready to intervene immediately if necessary.**

## ACCT procedures

90. Ms Atkinson was managed under ACCT procedures almost continually while she was at Low Newton. As she lived in the healthcare unit, the nurses in charge chaired her ACCT reviews, which were well attended, and nearly always multidisciplinary. Staff had a good knowledge of Ms Atkinson and did their best

to reduce her risk to herself and manage her behaviour in challenging circumstances.

91. The investigation identified some areas for improvement in the management of ACCT procedures, although we accept that it is unlikely in this case that better management of the process would have prevented Ms Atkinson's death. Ms Atkinson was always at long term risk of suicide and tying ligatures around her neck was very risky behaviour, which staff needed to take very seriously. However, there was little about Ms Atkinson's behaviour on 24 January, to indicate that she was at immediate and high risk of suicide or to differentiate it from previous occasions when she had placed apparently loose ligatures around her neck.
92. We consider that ACCT caremaps were not fully effective. Prison Service Instruction PSI 64/2011, which governs ACCT procedures, states that caremap actions should be detailed, time-bound, and aimed at reducing the risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress. They should be reviewed and updated at each case review. The only caremap action during Ms Atkinson's last period of ACCT monitoring from 31 December was for her to have a radio, which was achieved that day. Other caremap actions were also marked as completed on the day they were identified, even though some required ongoing action from staff. No new actions were identified after 31 December.
93. We recognise that staff made some efforts to reduce Ms Atkinson's risk to herself, such as by discussing alternative coping strategies to tying ligatures. Ms Atkinson had detailed mental health care and management plans and there were separate multidisciplinary meetings about her management. We consider these could have been better incorporated into ACCT procedures and reflected in caremaps.
94. Ms Atkinson told staff that she had a volatile and potentially abusive relationship with her partner. This was never recorded as a possible trigger for self-harm. During the last period Ms Atkinson was in prison, her partner visited her three times. She tied a ligature around her neck either the same day or the day after all of these visits. While Ms Atkinson also tied ligatures at other times, this was a potential trigger for self-harm. We know that staff were aware of difficulties in the relationship, but said she usually seemed happy after a visit and it was difficult to get her to talk about these problems. We consider this should have been included in the triggers and caremap section of her ACCT record and discussed at ACCT case reviews.
95. Staff who the investigator spoke to seemed to be confused about what issues and actions were appropriate for caremap. Most believed that all caremap actions had to be completed immediately, which prevented them from adding ongoing issues, which they could not address straight away. The Head of Safer Custody said he was aware of this misunderstanding and had clarified this in an email to staff about appropriate caremap actions.
96. Many of the assessments of risk at ACCT case reviews did not appear to reflect the extent of Ms Atkinson's risky behaviour. During the last period of ACCT monitoring, Ms Atkinson was assessed as a low risk at seven of the thirteen case

reviews, even though she had tied a ligature round her neck on the same day as some of these reviews. On 13 January, a case review raised Ms Atkinson's level of assessed risk from low to raised when she tied a ligature, yet maintained the level of observations at two an hour - the same as when her risk was low. On 23 January, at the last case review, Ms Atkinson had tied a ligature that day and staff increased her observations to four times an hour. However, staff still assessed her as at low risk. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular that:**

- **Case reviews take full account of all known risk factors and triggers when determining a prisoner's risk of suicide or self-harm and that levels of observations reflect that risk.**
- **ACCT caremap actions are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary at each case review.**

### **Clinical care**

97. The clinical reviewer concluded that it was difficult to provide care and mental health services for Ms Atkinson who could be bizarre, disruptive and aggressive. The mental health team wrote detailed care and management plans and held multidisciplinary team meetings. Psychiatrists tried to diagnose Ms Atkinson, which was particularly important, as a relapse of her bipolar disorder might have resulted in a transfer to hospital for treatment under the Mental Health Act. The psychiatrist concluded that Ms Atkinson was suffering from both personality disorder and bipolar disorder. Neither two other psychiatrists agreed with this assessment and did not consider that a transfer to hospital was necessary. Both agreed her symptoms were more likely a result of her personality disorder.
98. The clinical reviewer noted that Ms Atkinson was offered appropriate mental health support and her continuity of care was good. She was appropriately prescribed medication. She concluded that Ms Atkinson's care was equivalent to that she would have received in the community.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations