

**PRESS RELEASE 30 JUNE 2005**  
**VERDICT RETURNED IN EMMA LEVEY INQUEST - DEATH IN**  
**HMP DOWNVIEW**

The jury in the inquest of Emma Levey who died in HMP Downview in November 2003 today delivered a verdict that "Emma Levey took her own life whilst the balance of her mind was disturbed". They added that "Emma repeatedly requested further psychiatric care but was unable to receive this as Downview had no regular psychiatrist..." In fact the psychiatrist had left the prison in August and had not been replaced. The jury heard that because of health service re-organisation the GP at the prison could not access any consultant psychiatric advice from the NHS.

Emma Levey was a 24-year-old woman. She was found hanging by a ligature on 4 November 2003 in her cell by prison officers and pronounced dead in hospital shortly afterwards.

The inquest jury in Esher, Surrey heard evidence over 8 days which showed that:-

- Emma had been hearing voices, feeling paranoid, self-harming and feeling suicidal for some weeks before her death.
- Despite it being recognised that Emma needed to be assessed by a psychiatrist there was no psychiatric support at the prison because of recruitment problems. Organisational difficulties between the prison and the Primary Health Care Trust meant that there was a lack of referral service at the time.
- As a result of this it was not possible to prescribe the anti-psychotic medication which Emma was asking for and had previously helped her in prison.
- There was a serious failure of health screening and assessment by staff both at HMP Holloway (where Emma was moved from) and HMP Downview to record or carry out any suicide or self-harm prevention assessments.
- Specifically there was a failure to locate Emma's old medical notes which would have confirmed her account that she had previously been prescribed anti-psychotic medication.

Pearleen Levey, Emma's mother said:

"I hope the Prison service and the Health Service will make changes so that other women in Emma's position can receive the help that they need so that other parents can be spared the heartache which my family has suffered".

Deborah Coles, Co-Director of INQUEST, said:

"Emma's inquest raises the issue once again that women will continue to die while prison is used inappropriately as a place to house those with mental health problems. It continues to be alarming that prisons fail in a basic duty of care when responsible for society's most vulnerable women."

Jocelyn Cockburn - Solicitor for Emma's family said:

"This case demonstrates shocking failures in the systems designed to protect vulnerable women prisoners withdrawing from drugs and suffering from mental health problems. Where psychiatric care is not available in a prison because of recruitment problems then temporary psychiatric cover should be provided from outside or the prisoner should be transferred to a prison with a psychiatrist. It is as simple as that."

INQUEST Lawyers Group members Jocelyn Cockburn of Hodge Jones and Allen Solicitors and Steve Cragg of Doughty Street Chambers represented the family.

Notes to editors:

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts.