

PRESS RELEASE

For immediate release 24 November 2006

INQUEST INTO THE DEATH OF LOUISE DAVIES AT HMP NEW HALL

HM Coroner for West Yorkshire (Eastern District), Mr. David Hinchliff,
sitting at: Wakefield Coroner's Court
71 Northgate
Wakefield
WF1 3BS

The inquest into the death of Louise Davies at HMP New Hall is due to start on Monday 27 November 2006 at 10.00am and is listed for seven days.

Louise Davies died in the segregation unit of the prison on 18 April 2004 aged 32. She had a long history of mental health problems and was a prolific self harmer. At the time of her death Louise was the subject of the prison's suicide watch procedures because of the high and immediate risk she posed to herself. Two days before she died, Louise was twice discovered with ligatures around her neck. On the day of her death officers spoke to Louise after an apparent suicide note was found outside her cell door. However, only 28 minutes later she was found unconscious with a ligature around her neck, and despite attempts to resuscitate her she was pronounced dead at 7.45pm.

Louise's family have a number of concerns which they hope the inquest will examine. They are:

- The appropriateness of housing Louise in a prison and what alternative forms of custody were available to the courts;
- why such a vulnerable woman was being held in the segregation unit and the effects such a location had on her mental health;
- why her vulnerability increased dramatically after she was moved from HMP Bullwood Hall three weeks before she died;
- how officers responded to Louise's numerous self-harm and suicide attempts and whether their responses were in accordance with prison policy.

The family are being represented by barrister Mark George from Garden Court North Chambers, Manchester, instructed by INQUEST Lawyer's Group member Fiona Borril of Lester Morrill Solicitors, Leeds.

Notes to editors:

Louise was the fourth woman to take her own life at HMP New Hall within a 14 month period. Since her death there have been four more self-inflicted deaths at the prison with two of the women having similar histories to Louise of mental health difficulties and personality disorders with repeated self-harming. At the end of the inquest the family will consider inviting the Coroner to make Rule 43 recommendations regarding

the provision of appropriate accommodation for women with such complex problems who are designated as not fit to be managed within the community.

Self inflicted deaths at HMP New Hall 1994-date

Name	Date Of Death	Age	Status	Mode
Kelly Hutchinson	01/05/2006	22	Convicted	Hanging
Victoria Robinson	02/02/2005	26	Remanded	Hanging
Mandy Pearson	12/10/2004	37	Convicted	Hanging
Marie Walsh	29/07/2004	29	Convicted	Hanging
Louise Davies	18/04/2004	32	Convicted	Hanging
Petra Blanksby	24/11/2003	19	Remanded	Hanging
Jessica Adam	21/06/2003	22	Convicted	Hanging
Helena Price	14/02/2003	27	Convicted	Hanging
Jacqueline McPartline	18/08/2002	32	Convicted	Hanging
Miranda Cox	26/01/2002	41	Remanded	Hanging
Victoria Winterburn	04/01/2002	21	Remanded	Hanging
Sheena Creamer	07/08/2000	22	Remanded	Hanging
Teresa Lohinski	07/03/1999	22	Convicted	Hanging
Michelle Wilcox	30/05/1998	32	Convicted	Septicaemia
Michelle Pearson	05/07/1994	23	Convicted	Hanging

Source: INQUEST monitoring

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.

Further Information	www.inquest.org.uk
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