



UNITED CAMPAIGNS FOR JUSTICE

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# Death in Prison Custody

**Report on the deaths of Katherine  
Woods and Tracy Logan**

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### The Deaths of Tracy Logan and Katherine Woods HMP Risley

Two young women hanged themselves in HMP Risley only days into sentences for non-violent offences. Tracy Logan, a 24-year-old drug dependent, took her own life on 24<sup>th</sup> August 1997, alone in a cell, days into a one-year sentence for theft. She was alone in her cell and hung herself from an upturned bed. Her death mirrored that of Katherine Woods in the same prison, who was also drug dependent, almost one year previously (19<sup>th</sup> August 1996).

Both these deaths raised important issues about:

- The treatment of drug dependent women prisoners;
- The quality of the inquest as a forum for investigating such deaths;
- The quality of health care in a prison context.

At the inquest into the death of Katherine Woods, the Coroner's interpretation of the remit of the inquest was so narrow that he would not allow the family's lawyer to ask any questions on the treatment and care of drug users, reception procedures, or indeed anything other than the physical means by which she came to her death - an interpretation which was supported by the lawyers for the Prison Service.

The inquest took two hours and many relevant witnesses were not called. Evidence was heard that Katherine had attempted to harm herself twice before and had threatened to kill herself whilst in police custody. Counsel for the family attempted to ask the Prison Doctor why she had not been put on a methadone programme and was forbidden to pursue that line of questioning by the Coroner. The jury then started to ask questions such as how she was treated and whether there was a better way to allow the health care staff to explore her state of mind. The Coroner was angry with the jury for asking such questions, telling them that their function was not to ask questions like that, explaining to them that they were there to help him and that in any case it was known how she died. The Prison Doctor denied the existence of any guidelines on the treatment of prisoners with drug addiction problems and said it was completely up to him to make a clinical decision as to how to treat a prisoner. The family felt completely bewildered and distressed by their experience of the inquest which they had been led to believe was the opportunity for them to ask questions about Katherine's death. The fact that another death occurred a year later in disturbingly similar circumstances again points to the inadequacy of the inquest as a forum for investigating prison deaths and the need for a wider form of inquiry.

Tracy Logan entered HM Prison Risley on Thursday 21 August 1997 having been sentenced that day at Bolton Crown Court to 12 months imprisonment for an offence of theft. A Nursing Officer saw her for reception assessment and also the doctor who is the Head of Health Care. She explained that she had a history of drug use, and that she was receiving a daily prescription of 50 mg of methadone from the Bolton Community Drugs Team, and the prison confirmed by telephoning the community Drugs Team that this was indeed true. Risley did not, and do not, offer methadone for Opiate withdrawal and instead she was prescribed dihydrocodeine and diazepam. Ms Logan was placed for that night in a shared cell and was seen the following morning by the Prison Governor, Ms Dawson, for approximately 10 minutes. She apparently gave no cause for concern at that interview.

Unfortunately, the Coroner chose not to call any other person to give evidence at the inquest who saw Tracy Logan thereafter, either on the Friday or the Saturday, apart from another inmate, Diane Edwards, who said that just before 4.30pm on the Saturday 23 August, she found Tracy Logan in her cell (by then a single cell) in a visibly distressed state, crying, and saying she was going to go on hunger strike, then saying she was going to kill herself – Ms Edwards said that prison staff would not have heard these words, but that the prison officer who then asked Ms Edwards to leave the cell because it was time for locking up would have seen how distressed Ms Logan was; the Coroner also called a night patrol officer who saw Ms Logan in her cell through the flap in the door at approximately 8.30pm, though neither spoke. She was not seen alive again and the next time that her cell was visited was for the roll call check by the same night patrol officer at approximately 5.30am on the 24 August.

It emerged at the inquest that during the afternoon of Saturday 23 August Ms Logan had been excited because she was receiving a visit that afternoon from her boyfriend who was bringing drugs to pass to her. This transmission was however prevented and nothing was passed to her. It was subsequent to this visit that Ms Edwards found her in tears. The discipline staff supervising visits, and the Duty Governor who was apparently alerted to the situation, were not called to give evidence of Tracy Logan's reaction to the failure of the plan, but Governor Dawson confirmed that information about the incident had been passed on to her. She indicated that had she been aware that Ms Logan was disappointed or distressed as a result she might have taken certain precautions. Significantly, one of the notes Ms Logan left indicated her inability to cope with the weekend – extended by the August Bank Holiday on 25 August 1997 – where there is no prisoner association.

From the prisoner's medical records examined at the inquest it was clear that the nightly dose of diazepam for the night of 23 August was not given, the letter *R* appearing in the space for the giving of that medication. It had to be presumed that the *R* meant 'refused'.

The nursing officer responsible for giving the medication was not called at the inquest so it was impossible to ascertain what had happened. However, there are really only two possible scenarios; either this prisoner, in the throes of drug withdrawal, refused in person to receive her medication, which in itself should have raised alarm, or she simply never requested the nightly dose by ringing her bell between 8.30pm and midnight which according to the night patrol officer who gave evidence was the system for prisoners requiring their nightly medication. If the latter were the case, this could indicate that she killed herself within the short time of the last glimpse of her at 8.30pm, her death being then undetected until approximately 5.30am the following day, and again her lack of a request for medication which to her would have been vital in the state that she was in should have aroused alarm so that her cell was then checked.

The reaction of the Governor and the Head of Health Care at the inquest to questions concerning the vulnerability of newly admitted inmates with serious drug addiction problems was to place the onus upon the prisoner to come forward and express feelings of vulnerability, of withdrawal, and of distress. It is almost inconceivable that a person in a state of withdrawal, in every sense of the word, would take the initiative and 'self certify' feelings of despair. It appeared to be believed that once a Yes/No checklist had been filled out on reception, no routine monitoring would follow as to indications of depression, anxiety, or withdrawal within the first few days of admission, and that the shared cell precaution would only operate as a matter of course for the first night.

Prison staff should have effective training in the use of and withdrawal from opiates – the worst withdrawal is likely to occur as the first days pass and not immediately on admission to prison, given that a drug user looking at the prospect of custody will have taken if at liberty whatever possible on the day of appearing at court.

Our general concern, and that of the family, is that prison staff should be more proactive in scrutinising new prisoners who are drug users and be alert to risks in terms of their welfare. In this particular case there was over emphasis also upon the two distinct pigeon holes of 'disciplinary' (the visit and drugs incident on the Saturday afternoon) and 'health', without sufficient cross communication.