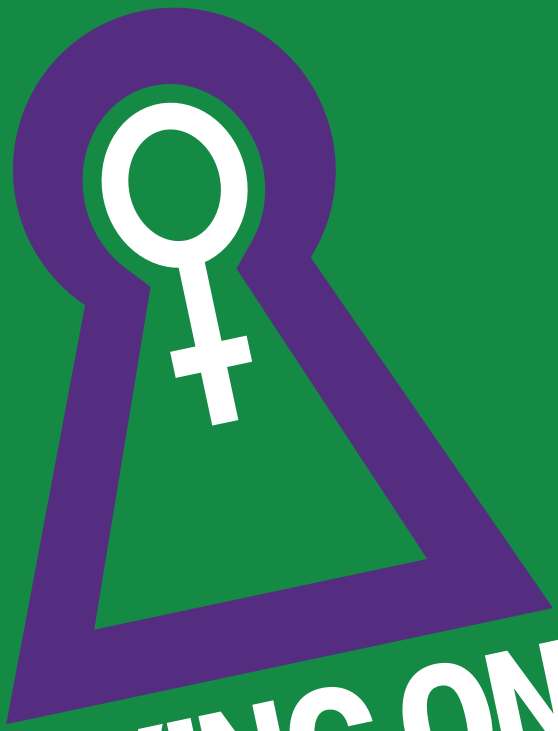
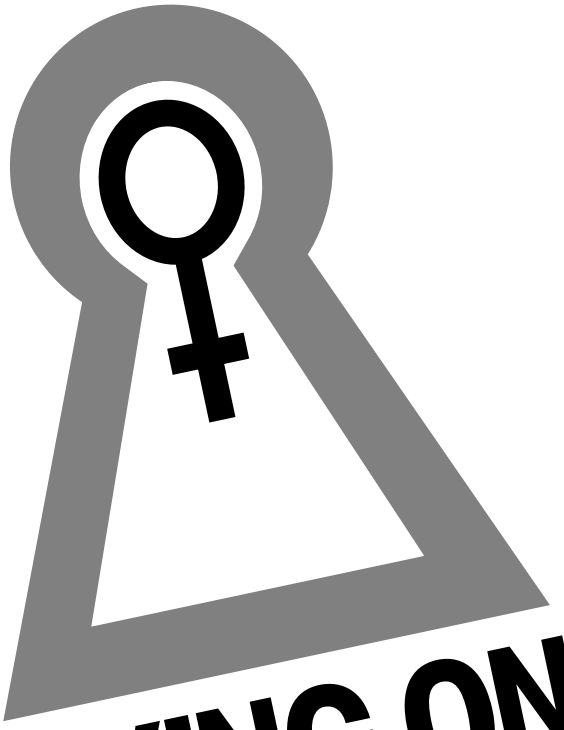


DYING ON THE INSIDE

Examining Women's Deaths in Prison

Marissa Sandler
and Deborah Coles



DYING ON THE INSIDE

Examining Women's Deaths in Prison

Marissa Sandler
and Deborah Coles

Dying on the Inside: Examining women's deaths in prison

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN 978 0 9468 5822 4

First published in 2008 by:

INQUEST
Working for truth, justice and accountability
89-93 Fonthill Road, London N4 3JH, UK
Tel: 020 7263 1111 Fax: 020 7561 0799
Email: inquest@inquest.org.uk
Website: www.inquest.org.uk

Design and layout by: Smith+Bell (www.smithplusbell.com)

Printed by: Russell Press, Nottingham (www.russellpress.com)

DEDICATION

This report is dedicated to the memory of Chris Tchaikovsky, former Director and founder of the pressure group Women in Prison, who died in May 2002. Chris was an inspirational woman to work with and her campaigning ensured that women's imprisonment emerged as a significant issue which had been ignored by successive governments.

We recognise that [my sister] was no angel but she was a loving human being, who was in an extremely vulnerable mental and physical state. Whatever the rights and wrongs of [her] circumstances all people have the right to health care and any institution takes upon itself a duty of care of its inmates. It is obvious that [my sister's] state of mind deteriorated so far within a very short time upon admittance to prison that it led to her taking her own life. While a number of factors contributed to [my sister's] decline and ultimate death within prison, we recognise that blame cannot be placed at the feet of any individual, rather that there is clear evidence of institutional neglect by the Prison Service that led to the tragedy.

[My sister] entered prison where her drug and other medical conditions were recognised but a catalogue of systemic errors within the management of her care, which can only be interpreted as institutional neglect, resulted in her tragic death. These systemic errors include:

• Significant deviations from rigorous prison procedures within a short period of time, including lack of medical risk assessments by appropriate medical staff; lack of adherence to self-harm (suicide prevention) assessments and punishment adjudications in contravention of protocol for someone in [my sister's] condition.

• Contradictory procedures. Local prison policy for managing drug addiction was at variance to national and expert medical opinion. With hindsight, it appears almost naïve that the prison itself felt it could detox a habitual drug abuser of 14 years within an 8-day period rather than undergo a maintenance and testing regime as is strongly advised elsewhere.

• The general care regime. This covers a number of areas, which through a lack of any better explanation can only be considered vindictive, such as unauthorised withholding of anti-psychotic medication, frequent moving of cells (four times in two weeks), segregation and cellular confinement.

The inquest into [my sister's] death has taken 18 months to come to

be held. During all of this time the Prison Service has attempted to stall and delay the process even to the point of certain documents not being made available until during the inquest itself. Furthermore, during the inquest many attempts were made (with some success) by the various Prison Service counsel to withhold evidence (or prevent witnesses) being made available to the jury or discussed in open court… The large legal team put forward by the Prison Service meant that the focus of the inquest process was altered from the intended open manner to determine all of the facts to an adversarial conflict with parties within the Prison Service protecting their own positions. It is certainly interesting to note that both the women's prison and detox unit at the prison involved has now ceased to exist. Obviously with two deaths in two weeks the Prison Service has made its own mind up about what could be done.

On my sister's behalf we wish to see justice done, not only for her but also for the many other women who die in this way in prison each year and for her orphaned son.

■ ***Statement of the family of a 35-year-old woman who died in prison made at the conclusion of the inquest into her death.***

Acknowledgements

This report would not exist without the unique contribution and courage of the families who have shared their experiences with us in the hope that their voices will be heard and listened to and action taken so other families will not suffer in the same way. We thank them all.

We are also grateful to the broad spectrum of professionals who contributed their views and expertise. We have drawn on the experience of the INQUEST casework team whose day to day work with bereaved families has been crucial to the project – thanks to Gilly, Catherine, Scarlet and Naomi. We also thank INQUEST volunteer Fiona Wallace and our part-time administrative assistant Aisha Lepo. We have discussed the report with and received comments from academics, lawyers, prison inspectors, and other voluntary and statutory organisations. We thank them for their observations, encouragement and interest.

We are also indebted to our readers, lawyers Fiona Borrill and Ruth Bundey; academics Professor Joe Sim and Professor Phil Scraton; and to Helen Shaw and Sian Griffiths, INQUEST's Co-Director and Casework Service Manager. And last but not least we thank our Information Worker Richard Fontenoy for his patience and attention to detail in proof reading and co-ordinating the report's production.

We are grateful to the Atlantic Philanthropies for the grant that made this project possible.

Throughout the report the women who died are identified only by age at time of death. This is in keeping with the wishes of some of the families that the women's names should not be used.

Contents

Reflections in a Small Mirror
(1991) by Lucy Edkins

The illustrations throughout this book are selected from Lucy Edkins' series of pencil and charcoal studies of women she encountered whilst at HMP Holloway in 1991. Lucy currently works as an artist in north London. These and other works can be viewed at www.lucyedkins.com.

Introduction

Preface

This report provides incontrovertible evidence of serious human rights abuses of women in prison and highlights the abject failure of the criminal justice system in dealing with women in trouble with the law.

Since 1990 there have been 89 self-inflicted deaths in women's prisons. Other deaths have occurred in circumstances that give rise to serious concern. Behind the statistics is a story of preventable tragedy. The high level of distress and vulnerability among women prisoners is well documented and yet the persistent theme running through the histories of the women who have died is the lamentable failure of the criminal justice system to enforce its own duty of care. This situation is compounded by the system's drive towards utilising prisons as places of punishment where support services are ill-equipped and under-resourced.

The report highlights how neglect and complacency have been institutionalised within women's prisons as the same issues repeat themselves with depressing regularity year after year. These issues, as revealed by evidence at inquests, include: appalling conditions; the systemic neglect of women's physical and mental health; inadequate healthcare; repressive regimes and systems of punishment; use of segregation and isolation for suicidal women; overuse of force; failure to implement suicide prevention guidelines; lack of staff training; and poor communication.

Despite reports from the prison watchdog Her Majesty's Inspectorate of Prisons, official reports, academic research and critical verdicts and recommendations transmitted by coroners and juries following individual deaths which have raised profound concerns relating to the conditions and treatment of women in prison, there has been no coherent policy or change in practice. This highlights the lack of institutional and political will to radically alter the current situation. In turn it raises questions of responsibility and culpability as to why the Ministry of Justice (and previously the Home Office) and senior prison management have never been brought to account for individual and collective failures.

Political platitudes about 'learning the lessons' are not followed up by meaningful action, with the result that the families of those who have died lose confidence that there will ever be effective change. The phrase 'lessons will be learned' is increasingly devalued as it has become a normal part of bureaucratic and political language in response to criticism from a range of different groups and organisations.

Instead easy platitudes are utilised in an attempt to block further critical comment and meaningful reform, for example by refusing to accept the clear recommendation of Baroness Corston that non means-tested funding should be available for legal representation for any family bereaved following a death in custody. It has been at inquests where families have been properly represented that a more challenging series of questions have been asked and where a body of evidence has been built up exposing the reality of imprisonment for

women. Given that it has been estimated the Labour government spent £187 billion on law and order in the ten years between 1997 and 2007, continuing to means test bereaved families for funding their legal representation is nothing short of scandalous.

Before January was complete, 2008 had already seen its first self-inflicted death, involving a young mother found hanging in Styal prison. In the context of the deepening prison crisis, overcrowding, diminished resources for supportive interventions, lack of staff training and general neglect, prisons are a place where the right to life remains under serious threat. The government pursues contradictory penal policies that on the one hand intensify the relentless expansion of the prison estate with the building of super Titan jails while on the other telling magistrates to make better use of alternatives, but without the investment in resources to ensure these are properly funded so that prisoners receive the appropriate support from probation and other agencies.

In looking at the history of women's imprisonment it is deplorable that the same issues of concern which were apparent in the 1980s are as prevalent today as they were then. This ongoing abuse of human rights requires a fundamental rethink of the way women are dealt with by the criminal justice system. Abolition of prison for women and investment in radical community-based alternatives should be prioritised if the needless deaths of women in prison are to be avoided. Addressing the complex reasons behind why women enter the criminal justice system – poverty and social inequality – should also be a priority. Until urgent action is taken by the state, both in terms of radical policy implementation and developing and enforcing systems of individual and collective responsibility and accountability for the women in its care, then the damaging and fatal consequences of imprisonment will continue.

Deborah Coles
Co-Director, INQUEST
March 2008.

Background to the report

The tireless campaigning of the charity Women in Prison (WIP), founded in 1983, led to the recognition that women prisoners have specific experiences and needs.

WIP drew public attention to the issue of deaths of women prisoners with an article in *The Abolitionist* in which they listed all known deaths in women's prisons between 1974 and 1983. The article identified six in particular as cause for concern, raising issues of medical negligence and inadequate supervision.[1]

1983 also saw the publication of the first in-depth analysis of women in prison, Pat Carlen's seminal work *Women's Imprisonment*.[2]

The Women's Equality Group of the Greater London Council presented a similar set of case studies of women known to have died in prison between 1974 and 1985.[3] Based on these case studies they outlined a number of recommendations to prevent further deaths. Unfortunately, many of the recommendations made in this publication continue to be made more than two decades later, including that women with physical and mental health problems should not be imprisoned.[4]

As women's deaths in prison began to be examined as a group, concerns about systemic inadequacies regarding the treatment of women in prison were raised, prompting calls for further research and action on the issue.

In 1999 a report published on self-inflicted deaths in prison by a penal reform lobby group found:

"There has been little research on the subject of female suicides and the Prison Service guidelines on special considerations for women prisoners at risk of suicide are extremely limited".[5]

As the numbers of deaths of women in prison began to rise alarmingly in the late 1990s[6] INQUEST became increasingly concerned about the treatment of prisoners and conditions within the women's estate. Time and again bereaved families told stories of women dying in poor conditions, following inadequate treatment and medical neglect and focussed the organisation's attention on the issue. Alongside political and parliamentary work it became clear that there was a need to examine and document these experiences in detail.

This is a hugely under-researched area. Whilst there is an extensive body of work on women's imprisonment, there are very few reports looking exclusively at the deaths of women in prison and nothing that gives voice to their families.[7]

---

1. *The Abolitionist*, Number 15, no.3, 1983, p14.
2. *Women's Imprisonment*, 1983
3. *Breaking the Silence: Women's Imprisonment*, 1985, pp150-154.
4. *Ibid.*, p155.
5. *Desperate Measures: Prison Suicides and their prevention*, 1999, p11.
6. See Figure 2, page 13.
7. See appendix B for details of this research.

Dying on the Inside

Dying on the Inside provides a comprehensive examination of women's deaths in prison from 1990-2007. It is the report of our Women's Deaths in Prison project which took place during 2005-2007.

The unique contribution of this report is to bring to the discussion the views of the bereaved families.[8] Many of them had expressed concerns at the woman's mental and physical state during her imprisonment, but were ignored and unheard until it was too late.

The families involved with INQUEST and this research have a valuable and unique perspective and a genuine commitment to ensuring further deaths do not occur.

INQUEST hopes that the findings, recommendations and conclusions of this report provide an in-depth understanding of the circumstances of the deaths and a blueprint for preventing further tragic loss of life.

Principal objectives of the project

This evidence-based report was shaped by the following project objectives:

- To identify the key issues in relation to the deaths of women in prison by a review of INQUEST's cases and the prison investigations and inquests held.
- Proactive outreach work to try to establish contact with the families of all the women who died during the project period to offer access to INQUEST's casework service.
- To identify what issues these and other custody deaths raise about the treatment of women within the criminal justice system.
- To look at what alternatives to custody are available for women and why they were not used.
- To identify the practical and emotional needs of bereaved families including young children following such deaths.
- To ensure that proposed changes to the investigation of prison deaths and the inquest system address the problems raised by the current methods of investigation.

In keeping with one of INQUEST's main objectives, the aim of this project is to advance knowledge, activate progressive reform and to improve practice.

Structure of the report

The report is divided into six parts:

Part 1 discusses the women who have died in prison, identifying common factors. This part also highlights key statistical trends.

---

8. While the Prisons and Probation Ombudsman (PPO) interviewed families during the writing of his report into the deaths in HMP & YOI Styal between August 2002 and August 2003, this is the first report where the perspective of families are central to every issue discussed. See section 5.4.2 of this report for further discussion of the PPO report on Styal.

Part 2 considers the circumstances surrounding the imprisonment of the women who died. It focuses on the decision to imprison and its consequences. This part examines the role of the courts, other agencies and the media in these women's lives.

Part 3 examines the treatment and care afforded to the women. It identifies any failings in the care provided on both an individual and systemic level, and discusses how they contributed to the women's deaths.

Parts 4 and **5** look at the post-death investigation process. Both critique the current investigation and inquest process with a focus on the ability to learn lessons at all stages.

In **Part 6** the report makes conclusions and recommendations that INQUEST hopes will prevent further loss of life.

The role of INQUEST

Since the early 1980s INQUEST has documented cases, supported bereaved families, liaised with lawyers, lobbied government and submitted evidence to inquiries and commissions on the deaths of women in prison. Through its specialist casework service and policy work, INQUEST has sited the specific circumstances of the deaths in a broader social and political context to ensure that a more challenging and critical series of questions are asked about the issues raised by women's deaths. Working alongside families, INQUEST has been instrumental in drawing national and international attention to the lack of independence in the investigation process, to abuse and neglect by custodians, and to institutional indifference and complacency.

Casework

Our casework service aims to empower families to play a meaningful role in the intrusive and complex investigation and inquest processes. Family involvement, particularly when the family has legal representation by members of the INQUEST Lawyers Group,[9] has ensured broader examination of key issues. The integration of casework with policy work and campaigning has helped ensure that information enters the public domain.

---

9. The INQUEST Lawyers Group is a panel of lawyers organised by INQUEST across England and Wales that provides preparation and legal representation at coroners' inquests for bereaved people; promotes and develops knowledge and expertise in the law and practice of inquests; provides training; and acts as a forum for the exchange of ideas and experience. INQUEST publishes the journal *Inquest Law* which informs practitioners about recent legal and policy developments relating to the inquest system and the investigation of sudden deaths.

Investigations by and legal advocacy on behalf of the state frequently focus on the individual pathology of the deceased in an attempt to blame them for their own death. INQUEST's involvement with families and their lawyers has had a significant impact on the conduct of inquests and the scrutiny of women's deaths because of the knowledge we can share with the legal team about the circumstances of individual deaths and the broader political and policy context in which they have occurred. This has often assisted and informed the way coroners have chosen to conduct inquests.

In some cases, INQUEST's input and/or intervention has had an important role to play in influencing the final outcome of the inquest, shaping the way the coroner has approached their power to report matters to the authorities concerned.[10] For example, at the conclusion of the inquests into the series of deaths in Styal prison, INQUEST raised the option of recommending a public inquiry into women's deaths in prison with the coroner through lawyers instructed on behalf of the family of an 18-year-old woman. Although the public inquiry call was rejected by the government, the comments made by the coroner about his concerns regarding the disproportionality of sentencing practices applied to women sent to Styal directly influenced the government's decision to conduct a review into vulnerable women in prison.[11]

INQUEST has a unique body of knowledge from which to comment on deaths in custody and the issues they raise.

"[INQUEST]… will raise key issues with relevant agencies, government departments, MPs and other interested organisations. Recommendations for reform come from working with families following a contentious death. In this way the experience of casework directly informs the lobbying and policy work and the collective experiences of bereaved families are taken forward."[12]

Deaths of women in prison raise issues that go beyond the regimes and conditions to which they were subjected and extend to sentencing policy and allocation, mental health provision, child care and family disruption, social exclusion and poverty among many other issues. The impact of this work has resulted in other organisations, the media and Parliament engaging more with the issue of deaths of women in prison and with the wider debate on the specific circumstances and needs of female prisoners and the appropriateness of custody for women.

---

10. Rule 43 of the Coroners Act 1984 allows coroners to announce at the end of an inquest that they intend to report the circumstances of death to those authorities who have the power to take action to prevent the recurrence of such fatalities. See section 5.7 of this report for further details of rule 43 reports.

11. At the conclusion of the sixth inquest, the coroner, Nicholas Rheinberg, said that while he lacked the powers to order a public inquiry into sentencing policies which have seen the female prison population in England increase from 2,600 to 4,000 since 1997 and the number of self-inflicted deaths reach record numbers, his "private view" was that there is a "disproportionality of sentencing practices in respect of the women who are sent to Styal."

12. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody,* 2007, p122.

Monitoring

INQUEST monitors deaths in custody and the investigation and inquest system to identify trends and patterns and has been at the forefront of ensuring this information has been made available, analysed and in the public domain. It conducts research, develops policy and campaigns for greater accountability and better treatment of families following a death in custody. In challenging discrimination, INQUEST has drawn attention to shared features of deaths within particular groups of people, for example young people in prison, children in detention, women in prison, working class men, people from black and minority ethnic communities and people with mental heath, drug and/or alcohol problems.

The inquest process

After every death in prison a coroner will preside over an inquest held before a jury, who decide the inquest verdict.[13] Inquest proceedings and evidence are aimed at answering four questions: who, where, when and how did the deceased come to their death?[14]

The inquest[15] is the mechanism by which the UK meets its obligations under article 2 of the European Convention on Human Rights (ECHR) that there is an effective, official investigation into a death involving the state. Recent judgments in the House of Lords reflecting the incorporation of the ECHR into domestic law via the Human Rights Act 1998 have affected the conduct of inquests into deaths in prison.

Following the judgment in *Middleton*,[16] inquests into deaths in prison are now expected to consider *by what means and in what circumstances* the deceased died, allowing juries to return narrative verdicts that can take into account a range of factors contributing to the death and help identify precautions that should have been taken to prevent it. This provides an opportunity to learn from and prevent further deaths,[17] as do any rule 43 recommendations the coroner makes.

Properly conducted inquests have a potentially important role to play in preventing further deaths of women in prison by drawing attention to circumstances which, if they remain unaddressed, may lead to further deaths.[18] However, families are often frustrated by the process. There are often lengthy delays between the death and the inquest and frequent problems with pre-inquest disclosure of information resulting in sensitive matters being revealed to families for the first time at the inquest hearing. Coroner's approaches to the conduct of the inquest vary considerably and there is inconsistency in the use of their powers to make rule 43 reports.

---

13. Section 8(1) *Coroners Act* 1988.
14. Section 11 *Coroners Act* 1988 and rule 36 Coroners Rules 1984.
15. For a detailed discussion on the inquest system and its impact on families see *Unlocking the Truth: Families' experiences of the investigation of deaths in custody*, 2007, *op cit*.
16. *R (Middleton) v West Somerset Coroner* [2004] 2 WLR 800.
17. *Ibid*.
18. *Inquests – An information pack for friends, families and advisors*, 2003.

Inquests do not fully explore issues of procedure and policy. Deaths are considered in isolation from one another without an overview of the systemic factors which may have contributed to a pattern of similar deaths; the findings of previous inquests or inquiries into deaths involving similar factors or within the same institution are very often not considered.[19]

The restricted remit of the inquest also means that it does not enable an in-depth analysis of sentencing policy and allocation. Therefore a key concern of families, as to why the women were imprisoned in the first place, is outside the scope of the inquest and further frustrates the learning process.

19. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit*, p75.

Part 1: Trends, facts and figures

1.1 Introduction

In this part of the report we discuss the trends in women's deaths in prison between 1990-2007. We discuss the overall increase in self-inflicted deaths among women in prison during this period and consider whether the number of women dying is reflective of an increasing female prison population. We compare the rates of women's deaths in prison with both the rate of men dying in prison and women dying outside prison. We also look at women's deaths in prison in other parts of the UK.

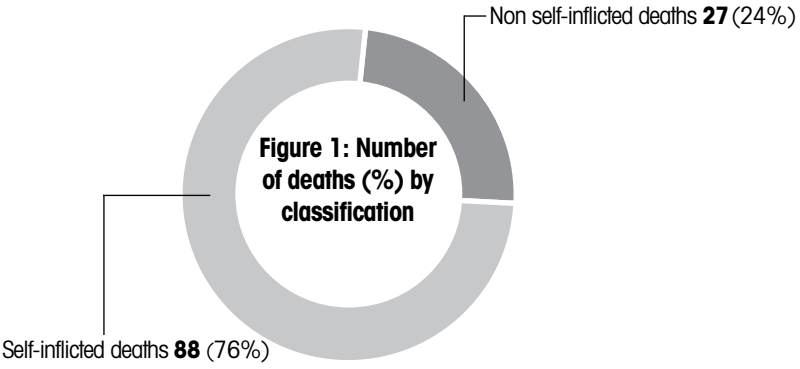
We also provide a statistical snapshot of who is dying in prison. Women dying in prison are not a homogenous group. However, they share a number of common characteristics that have been identified and set out in this part of our report.

1.2 Women dying in prison: why the concern?

"Prison is a very blunt instrument to deal with the complex reasons for female offending and we need a more sophisticated, more subtle and more complex response to it in the 21st century. Clearly prisons cannot keep women safe. They are killing themselves."[20]

Between 1990 and 2007, 115 women died in prisons in England.[21] The majority of these deaths (88) were self-inflicted. For this reason self-inflicted deaths have been the primary focus of research on women's deaths in prison and the development of strategies to prevent women dying in prison. We maintain this focus in our report.

Figure 1: Number of deaths (%) by classification



20. Baroness Walmsley addressing the House of Lords: *House of Lords Hansard*, debates for 28 October 2004, column 1454.

21. There are no prisons in Wales housing women. Women have died in prison in Northern Ireland and Scotland. See section 1.5 below for further discussion of these deaths.

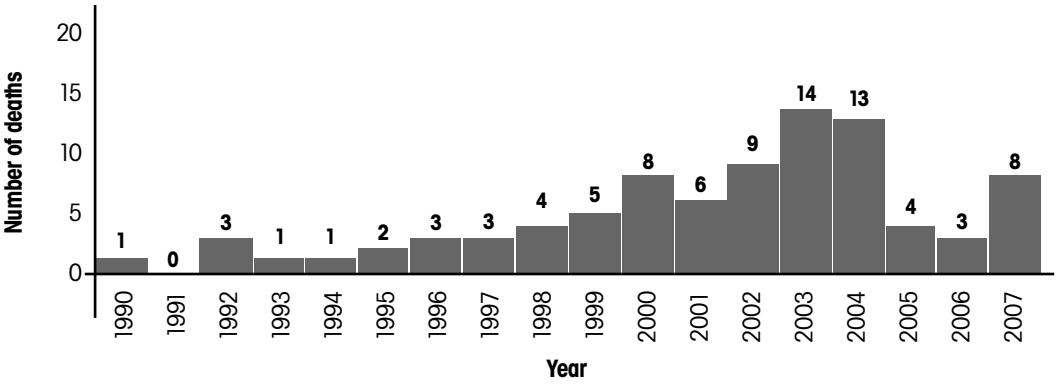
1.2.1 Defining 'self-inflicted'

Deaths in prison are initially classified by the Prison Service according to outcome – 'self-inflicted' or 'natural causes'. 'Self-inflicted' is used to describe deaths that appear to be directly caused by the actions of the deceased, whether the action causing the death was deliberate or accidental.

A system that classifies deaths according to outcome does not allow the context in which death has occurred to be taken into account. In trying to understand deaths in custody, context can be very important. For example, a hanging or overdose intended as a cry for help will still be classified as self-inflicted death should it turn fatal, though the term 'other non-natural death' was used briefly for cases where intentionality was not apparent, especially in advance of the investigation and inquest.

1.3 Recent trends

Figure 2: Total number of self-inflicted deaths of women in prison by year, 1990-2007



The average female prison population more than doubled between 1990-2007.[22] Between 1994 and 2004 alone it increased by 147%.[23] As Figure 2 indicates, the number of self-inflicted deaths began to slowly but steadily rise from 1998, peaking in 2003-04.

The increase in the female prison population

Record levels of prison overcrowding have been experienced across the prison estate since the Labour government took office in 1997. The female prison population almost doubled between 1997 and 2006.[24] Overcrowding has been identified as a key factor placing the

22. The female prison population was 1,597 on 30 June 1990 and 4,283 on 30 June 2007: Statistics from Home Office Research and Statistics Directorate available at http://www.homeoffice.gov.uk/rds/ and Ministry of Justice http://www.justice.gov.uk/publications/populationincustody.html

23. *Offender Management Caseload Statistics 2004,* 2005, p97.

24. The female prison population was 2,680 on 30 June 1997 and 4,283 on 30 June 2007 (Including remand and sentenced prisoners): Statistics from Home Office Research and Statistics Directorate and Ministry of Justice, *op cit*.

safety of prisoners at risk.[25] In 2006, the overall prison population was almost 20,000 higher than when Labour came to power. In November 2006 the prison population hit a grim landmark when the number of people in prison reached 80,000 for the first time ever. [26]

Although deeply concerning, the increase in the female prison population alone does not explain the increase in the number of self-inflicted deaths across the women's prison estate as the rate of these deaths has been disproportionate to the size of the female prison population. For example, between 1999 and 2004 women made up 6% of the average annual prison population and 11% of all self-inflicted deaths.[27] In 2003, when the highest number of deaths of women prisoners in one year was recorded (14), women made up 6% of the prison population and 15% of all self-inflicted deaths.[28] In 2004, 13 women died in prison. In this year, women made up 6% of the average annual prison population[29] and 14% of all self-inflicted deaths.

Comparing men and women

Between 1990 and 2004 the self-inflicted death rate among people in prison was higher for women than men.

Table 1: Self inflicted death rate of men and women

Year	Number of male self-inflicted deaths	Male self-inflicted death rate (per 100,000 men)	Number of female self-inflicted deaths	Female self-inflicted death rate (per 100,000 men)
1996	62	117	2	88
1997	65	111	3	112
1998	81	135	3	97
1999	86	140	5	154
2000	73	119	8	239
2001	67	107	6	160
2002	86	129	9	209
2003	80	117	14	316
2004	82	117	13	290

Source: Safer Custody Strategy paper.[30]

25. 'Soaring prison population sparks safety fears', 2006, see also oral evidence presented to the Home Affairs Select Committee on Prison Suicides and Overcrowding, House of Commons, 8 November 2005.
26. 'Soaring prison population sparks safety fears', *op cit*.
27. Interview with Louisa Snow, HM Prison Service, 1 September 2005.
28. *Deaths in Custody: Third report of session 2004-2005 Vol.1, 2004*, p19.
29. *Offender Management Caseload Statistics 2004, op cit*, p97.
30. The Safer Custody Group has not included figures in this table for 2005 because they are based on unpublished population data and subject to change. The Strategy paper was published in 2006.

In December 2004 the Joint Committee on Human Rights (JCHR) published a report of their inquiry into deaths in custody. INQUEST provided both oral and written evidence to the Committee drawing attention to the issues arising from women's deaths. The JCHR's report concluded that women in prison are at special risk of self-inflicted deaths and self-harm.[31]

Research has continually found that the negative impact of imprisonment on women's relationships with dependent children, partners and other family members places them at greater risk of suicide in prison than men.[32]

Rates of death in prison and outside

Comparing suicide rates between women in prison and the community is problematic for two reasons. First, outside prison deaths are not classified as 'self-inflicted' or 'non self-inflicted'. Rather, a more narrow definition of suicide is used, making any comparison inaccurate as different groups are being compared.[33] The number of women who died in prison will be larger due to the use of the broader definition of 'self-inflicted'.[34] Second, the concentration of individuals identified as being at risk of suicide in prison immediately elevates prisoners' overall risk of suicide.[35]

Risk of self-inflicted death increases when there is previous abuse suffered, substance abuse, mental illness, previous self-harm, prior suicide attempts and negative life events including domestic violence, relationship breakdowns and bereavement.[36] A disproportionate number of women in prison present characteristics known to increase suicide risk, and prison can act as the final straw.[37] This is not to suggest that these women's deaths were inevitable or unavoidable. In fact, it is the appalling conditions in which these women were placed, and the psychological impact of this environment on already vulnerable women, that made prison a deadly environment for them.

---

31. *Deaths in Custody: Third report of session 2004-2005 Vol.1, op cit,* p22.
32. 'Suicide among women prisoners', 1994, pp1-9.
33. In the community suicide is defined as "coroners' verdicts of suicide and undetermined deaths."; *Safer Custody Report for 2001: Self-inflicted deaths in Prison Service custody, op cit*, p21.
34. *Ibid*. Also referred to during interview with Louisa Snow, HM Prison Service, 1 September 2005.
35. *Ibid*, p23.
36. *Safer Custody Report for 2001: Self-inflicted deaths in Prison Service custody,* 2002, p21-27; 'Self-inflicted deaths of women in custody', 2003, p35; Interview with Louisa Snow, HM Prison Service, 1 September 2005; Interview with Natasha Vronmen, 7 December 2005; Interview with Kimmett Edgar and Juliet Lyon, 6 December 2005; Learning from 'Near Misses': 'Interviews with women who survived an incident of severe self-harm in prison', 2005, p58; 'Childhood sexual and physical abuse and adult self-harm and suicidal behaviour: A literature review', 1998, p799.
37. Interview with Louisa Snow, HM Prison Service, 1 September 2005; Interview with Kimmett Edgar and Juliet Lyon, 6 December 2005; 'Self-inflicted deaths of women in custody', *op cit*, p35; 'Learning from 'Near Misses': Interviews with women who survived an incident of severe self-harm in prison', *op cit*, p58.

A 2001 study attempted to make a more accurate comparison by contrasting death rates among male prisoners, male community offenders and men in the community.[38] The study found relatively similar self-inflicted death rates among prisoners and community offenders. Both groups exceeded the self-inflicted death rate of men in the community by seven to eight times. A similar analysis on the rates for women in prison, women offenders in the community and the broader female community would be useful.

Recent decreases

In 2005 there was a notable decrease in the number of women dying in prison. In general, fluctuations in the numbers of deaths from year to year should be interpreted with caution due to the small sample size. Prior unsustained decreases were experienced in 1990 and 2001. This pattern looks set to repeat – in 2006 three women died in prison while in 2007 eight women took their own lives.

Alternatively the decrease in 2005 may reflect the introduction of various measures to address the problem, including:

- higher levels of observation of women in prison;
- increased use of segregation, force and special cells to prevent suicide;
- greater awareness and emphasis on suicide prevention;
- improved drug detoxification regimes;
- greater capacity across the women's prison estate.

Concern was expressed that a calmer atmosphere in some women's prisons may be the result of increased use of medication to sedate women. A Women In Prison (WIP) caseworker who visited Bullwood Young Offender Institution (YOI) in 2005 described the women as looking very medicated and the prison as being "really quiet in an eerie way". This is uncharacteristic of a YOI, which is usually a very noisy place.[39]

1.4 Who is dying?

Women dying in prison are not a homogenous group, yet they share a number of common characteristics. The following analysis is based on self-inflicted deaths of women between 1990-2007.

YOUNG

FACT: Women dying in prison are young

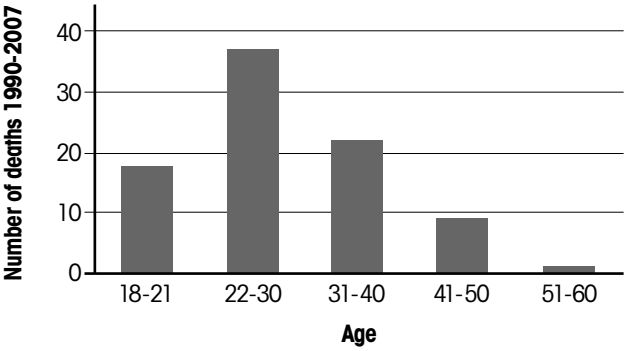
Over half (63%) of the women who died between 1990 and 2007 were aged 30 years and under and just over a fifth (21%) were

38. Community offenders were defined as individuals serving community sentences or receiving post-custodial supervision: *Rates and causes of death among prisoners and offenders under community supervision,* 2001.
39. Interview with Cathy Stancer, 25 November 2005.

between 18-21 years of age. There have been no deaths of women under 18 years of age.

The average age of the women who died was 28, and 20 was the most common age at which women died in prison.

Figure 3: Number of self-inflicted deaths by age, 1990-2007



WHITE

FACT: Women dying in prison are predominately white

The majority of women (88%) who died in prison were white.[40] Black women accounted for 12% of self-inflicted deaths of women in prison.[41]

Between 1998 and 2002 black women were under-represented in numbers of self-inflicted deaths, relative to their proportion of the female prison population. During this period, black women accounted for 18-24% of the female prison population.[42]

This is not to deny that overall, black women are both over-represented and marginalised within the female prison population. In 2003, they made up 26% of the female prison population,[43] yet less than 4% of the general population.[44] They have unique needs that are often neglected and are frequently the victims of individual and institutional racism.[45] For a more detailed discussion of the experiences of the black women who died in prison see section 3.3.9 of this report.

---

40. For the purpose of this research 'white' refers to women who were identified as 'UK white' and 'white'.
41. For the purpose of this research 'black' refers to women who were identified as 'black African', 'black Caribbean', 'UK black' and 'UK Asian'.
42. *Statistics on Women and the Criminal Justice System A Home Office publication under Section 95 of the Criminal Justice Act 1991*. Statistics were collated from 1999-2003 publications.
43. *Offender Management Caseload Statistics, op cit*, p113. Breakdown by ethnic group is not available from 2004 onwards.
44. *Black and Ethnic Minority Women in the UK*, 2005, p1.
45. Interview with Olga Heaven, 8 June 2006.

UK NATIONALS

FACT: Foreign nationals are less likely to die in prison

Two percent of women who died between 1990 and 2007 were foreign nationals.

As indicated in Table 2 below, between 1995 and 2006 foreign national women accounted for between 14-21% of the female prison population.[46] During this period, foreign nationals were under-represented in numbers of self-inflicted deaths relative to their proportion of the overall female prison population. See section 3.3.10 for a more detailed discussion on the experience of foreign national women in prison.

Table 2: Foreign national women in prison 1995-2006[47]

Year	Total female prison population, as at 30 June	Number of foreign nationals
1995	1,998	318 (16%)
1996	2,305	318 (14%)
1997	2,672	386 (14%)
1998	3,120	467 (15%)
1999	3,207	493 (15%)
2000	3,355	520 (15%)
2001	3,713	696 (19%)
2002	4,394	884 (20%)
2003	4,349	904 (21%)
2004	4,452	816 (18%)
2005	4,514	873 (19%)
2006	4,463	915 (21%)

Source: Offender Management Caseload Statistics, 2005.

HOUSED IN LOCAL PRISONS

FACT: Women are dying in local prisons

98% of self-inflicted deaths took place in local women's prisons.[48] For further discussion on deaths in local prisons see section 3.3.3 of this report.

Due to the increase in deaths from 2002, table 4 identifies prisons where self-inflicted deaths occurred during 2000-2007.

46. *Offender Management Caseload Statistics 2006*, 2007, p103. Statistics are not available on the number of foreign national women in the prison population for 1990-1994.
47. Statistics for 2007 were not available at date of publication.
48. The remaining deaths took place while women were in the care of the Prison Escort and Custody Services (PECS).

Table 3: Number of self inflicted deaths by establishment, 1990-2007

Prison	No. of self inflicted deaths
HMP New Hall	15
HMP Holloway	15
HMP Styal	11
HMP Eastwood Park	9
HMP Brockhill	8
HMP Durham	8
HMP Bullwood Hall	3
HMP Risley	3
HMP Send	3
HMP Edmund's Hill (HMP Highpoint for women)	2
HMP Low Newton	2
HMP Buckley Hall	1
HMP Downview	1
HMP Drake Hall	1
HMP East Sutton Park	1
HMP Foston Hall	1
HMP Highpoint	1
HMP Peterborough	1
Other	2

Table 4: Number of self inflicted deaths by establishment, 2000-2007

Prison	No. of self inflicted deaths
HMP New Hall	12
HMP Styal	10
HMP Eastwood Park	9
HMP Durham	7
HMP Holloway	7
HMP Brockhill	6
HMP Send	3
HMP Bullwood Hall	2
HMP Edmund's Hill	2
HMP Buckley Hall	1
HMP Downview	1
HMP Foston Hall	1
HMP Highpoint	1
HMP Low Newton	1
HMP Peterborough	1
PECS	1

NON-VIOLENT OFFENCES

FACT: Women dying in prison are charged/convicted with a diverse range of offences

Many of the women who died were sent to prison for non-violent offences. Over a quarter of the women who died were convicted/ charged with theft and handling stolen goods. Among women who died while on remand, this figure was almost a third. Many of these women may not have gone on to receive custodial sentences.[49]

Table 5: Number of self-inflicted deaths by offence type, 1990-2007

Offence type	All Deaths[50]		Remand/ Unsentenced Deaths	
	Frequency	%	Frequency	%
Theft and handling stolen goods	25	26	12	29
Violence against the person	25	26	9	22
Other criminal offences[51]	19	19	6	15
Drug offences	10	10	3	7
Robbery	8	8	4	10
Burglary	7	7	4	10
Fraud and forgery	4	4	3	7
Total	98	100	41	100

Note: The total number for frequency of offence type is greater than the total number of women who died in prison as some women were charged with more than one offence.

IN EARLY STAGES OF CUSTODY

FACT: Women are more likely to die in the early stages of custody

Almost a quarter (22%) of women were known to have died within the first week of their imprisonment and 40% were known to have died within the first three months.[52] In at least six cases (7%), women died within the first 24 hours of entering prison.

49. Between 1998 and 2002 theft and handling stolen goods was the most common offence type amongst women received into prison yet only the second or third most common offence category amongst sentenced women. (Drug offences were consistently the most common category followed by either violence against the person or theft and handling stolen goods): Home Office Research Development and Statistics Directorate *Statistics on Women and the Criminal Justice System A Home Office publication under Section 95 of the Criminal Justice Act 1991*. Statistics were collated from 1999-2003 publications.
50. Includes convicted and sentenced women and women on remand.
51. Includes property offences (arson and criminal damage), driving offences and court related offences.
52. These figures may increase as length of time in prison prior to death was unknown in 44% of cases.

This trend may be partially explained by the disproportionate number of deaths among women on remand, who usually spend shorter periods of time in prison.[53] Regardless, it highlights the early stages of custody as a period where women are at an increased risk of dying. For a discussion of why women are more likely to die in the early stages of custody see section 3.3.1 of this report.

ON REMAND / UNSENTENCED

FACT: A disproportionate number of women are dying while remanded/unsentenced[54]

Between 2000 and 2007 women on remand made up 20-25%[55] of the total female prison population and 31% of the women who died.

This is of serious concern given that in 2003 for example, 59 per cent of women on remand did not receive a custodial sentence and one in five was acquitted altogether. It is also a cost to the state that these women are imprisoned for relatively minor offences.

SERVING LONG OR LIFE SENTENCES

FACT: Women serving longer or life sentences are dying

At least 72% of sentenced women who died were serving sentences of one year or more, life being the most common sentence – 20% of sentenced women were serving life sentences when they died.[56]

Research has identified prisoners serving life and longer sentences as being at high risk of suicide.[57] This is due both to factors that contributed to them committing the crime, e.g. mental health issues, experiences of abuse, and also to being given a very long or life sentence. Life prisoners are rarely set an earliest date of release, which may exacerbate the sense of despair that can accompany a life sentence.[58]

The women often killed someone who they were intimately involved with. The associated emotional impact of this and lack of access to counselling or support may place them at increased risk of suicide.

---

53. 'Self-inflicted deaths of women in custody', *op cit*, p29.
54. The remand population consists of persons awaiting trial and convicted persons awaiting sentencing: *Lacking Conviction: The rise of the women's remand population,* 2004, p13.
55. *Offender Management Caseload Statistics, 2007,* p100 and *Population in Custody Monthly Tables*, June 2007, p5.
56. The length of sentence of one woman was unknown. For the purpose of this calculation only she was removed from the total sample.
57. 'Self-inflicted deaths of prisoners serving life sentences', 2002, p30; *Safer Custody Report for 2001: Self-inflicted deaths in Prison Service custody, op cit*, p23; interview with Louisa Snow, HM Prison Service, 1 September 2005; interview with Cathy Stancer, 25 November 2005.
58. Interview with Jo Opie, 15 November 2005; interview with Harriet Wistrich, 25 November 2005.

Women serving life or long sentences for murder have often killed a violent or abusive partner. In these circumstances there should be scope to reduce a charge of murder to manslaughter or for acquittal. This may result in more appropriate responses to these women's actions. The organisation Justice for Women campaigns for this legal reform as part of its work supporting and campaigning for women who have fought back against or killed violent male partners. Southall Black Sisters does similar campaigning work around cases involving Asian and African-Caribbean women.

The majority of women in prison serve very short sentences, making women serving long or life sentences an easy group to identify and target in suicide prevention strategies. For example, in 2003 nearly two-thirds (63%) of women in prison were sentenced to custody for six months or less and 72% were sentenced to less than one year.[59]

The family of a woman who had died in prison while serving a long sentence suggested that women serving life sentences should have the opportunity to appear before the Mental Health Act Tribunal annually, as opposed to every two years. This may provide more tangible goals and decrease feelings of hopelessness.

Another family suggested that women serving long sentences,

> "…should be moved to other suitable secure accommodation when danger of self-harm has passed. At this stage, they should be given some kind of meaningful employment and occupational training towards maintaining a stable and worthwhile existence after their eventual release."

HOUSED IN SINGLE CELLS

FACT: Women housed in single cells are at greater risk of dying.

At least 68% of women who died were housed in single cells.[60] In cases where women were housed in shared cells or dormitories they usually died when housed in these cells alone or when other prisoners were out of the cell.

HANGING THEMSELVES

FACT: Women die by hanging themselves

89% of women who died self-inflicted deaths in prison hanged themselves.

Hanging or self-strangulation is the most common method of self-inflicted death for men and women in prison.[61] While women use a

59. *Offender Management Caseload Statistics, op cit,* p84.
60. One woman died in the reception area. For the purpose of this calculation only she was removed from the total sample. In 18% of cases cell type was unknown. Controlling for unknown cases, 83% of women who died were housed in single cells.
61. 'Self-inflicted deaths of women in custody', *op cit,* p30; *Safer Custody Report for 2001: Self-inflicted deaths in Prison Service custody, op cit*, p35.

variety of means to hang themselves, in 15% of cases between 1990 and 2007 women hanged themselves from cell bar windows. Despite this, during this period some prisons continued to have windows with bars.

Five women hanged themselves from curtain rails in their cells. The investigation into the death of a 36-year-old woman in 1999 recommended that curtain rails be removed from cells. Since then a further four women have hanged themselves from such rails in their cells. This highlights a failure to implement life saving measures.

MOTHERS

FACT: Women dying in prison are mothers.

At least one-third of women who died were mothers with between one and six children.[62] This means at least 50 children lost their mothers between 1990 and 2007. The children were aged between 5 months and 16 years at the time of their mother's death. For further discussion on imprisoning mothers see section 2.6 of this report.

ALREADY 'AT RISK'

FACT: Women already at risk of suicide are being put in prison

Research has found that most women who died in prison were at risk of suicide due to factors pre-dating their entry into prison.[63] For example, half of the female remand prison population had tried to kill themselves the year before entering prison.[64] Previous suicide attempts are one of the best indicators of future suicide.[65] Likewise, a disproportionate number of women in prison are at risk of self-inflicted death due to mental health issues.[66]

DRUG MISUSE

FACT: Women dying in prison have a history of drug misuse

At least 40% of women who died were drug misusers when they arrived at prison or had a history of drug misuse.[67] This is a very conservative

62. These are conservative estimates as it is unknown in 46 out of 88 cases (52%) whether the woman who died had children. Prior research has found that between 60-66% of women prisoners were mothers with dependant children under the age of eighteen: *House of Commons Hansard*, Written Answers for 16 May 2003, Column 499W.
63. 'Learning from 'Near Misses': Interviews with women who survived an incident of severe self-harm in prison', *op cit*, p58; 'Self-inflicted deaths of women in custody', *op cit*, pp27-35.
64. *Psychiatric Morbidity among Prisoners in England and Wales*, 1998, p18.
65. Interview with Louisa Snow, HM Prison Service, 1 September 2005.
66. 'Learning from 'Near Misses': Interviews with women who survived an incident of severe self-harm in prison, *op cit*, p60.
67. In 52% of cases it is unknown if the women had a history of drug use. In only 7% of cases were women known not to have used drugs. Due to rounding the total percentage does not equal exactly 100%.

figure as it is estimated that at least 80% of women arriving at prison misuse drugs.[68]

1.5 The problem in other parts of the UK

Northern Ireland

There have been two self-inflicted deaths in Mourne House women's unit at Maghaberry Prison. The Northern Ireland Human Rights Commission conducted research into the human rights of women in prison in 2003.[69] The resulting report was extremely thorough and critical. It described a regime that:

"…neglected the identified needs of women and girl prisoners…compromised their physical and mental health care and that failed to meet minimum standards of duty of care."[70]

In 2004 women from Mourne House were moved to Ash House, a unit within Hydebank Wood Young Offender Centre, which holds young men aged 15 to 21.

The move occurred despite criticism from the HM Chief Inspector of Prisons and the Chief Inspector of Criminal Justice in Northern Ireland, Anne Owers. She recommended that the Northern Ireland Prison Service abandon the proposed move and,

"…urgently seek the help of prison services in other jurisdictions that have developed policies and practices to meet the specific needs of women; and to train and support a separate manager for the women's unit at Ash House. In the longer term, given the increased number of women and girls in custody, [Northern Ireland Prison Service] *needs to plan for a discrete and suitable separate location in which they can be held safely and purposefully."*[71]

Scotland

Between 1990-2005 ten women died at Cornton Vale prison.[72] Seven of these deaths took place between June 1995 and December 1997, resulting in a review of community disposals and the use of custody for women in Scotland. In 1998 the Prisons and Social Work Inspectorate of Scotland published a report of their review – *Women Offenders – A Safer Way*.

---

68. Interview with Jan Palmer, HM Prison Service, 1 September 2005; this estimate was provided during evidence given by Jan Palmer at a number of inquests involving women dying in prison.
69. For an in-depth discussion of the conditions of the women's prison in Northern Ireland see *The Hurt Inside: The imprisonment of women and girls in Northern Ireland,* 2005.
70. *Ibid*, p11.
71. *Report on an unannounced inspection of the imprisonment of women in Northern Ireland Ash House, Hydebank Wood Prison 28-30 November*, 2005, p6.
72. Cornton Vale is Scotland's only all female prison. Women are also held at Aberdeen, Dumfries, Greenock and Inverness prisons.

Wales

There are no women's prisons in Wales. Women from this area are imprisoned in England, often at a great distance from their families.

1.6 Conclusion

INQUEST's research into women's deaths in prison has revealed a number of trends over an eighteen year period. Every year women with common characteristics die in similar situations. It highlights the persistent failure of the criminal justice system and its focus on punishment and incarceration. Continuing to lock up women when we have this knowledge is a failure to protect the from a life-threatening situation and is a breach of article 2. This research demonstrates the need for more effective responses to women in the criminal justice system and for preventing further deaths in prison.

Part 2: The decision to imprison

> "Most of the women in prison should be receiving care, treatment and rehabilitation in a non-punishment setting. As long as the system continues to send ill, desperate and very needy women to these places, the problems will continue." (Mother of an 18-year-old woman who died in prison)

"So many prisoners – especially women – arrive in prison suffering the extreme health and social effects of poverty, addictions and physical and sexual abuse".[73]

2.1 Introduction

Bereaved families often felt that from the outset prison was an entirely unsuitable and inappropriate environment to place the women who died. In this part of the report we discuss the decisions that led to their imprisonment. We examine the inappropriate use of prison as a response to self-harm, suicide attempts and mental illness and the consequences when women are imprisoned in these circumstances. We also look at the decision to imprison mothers and hold women on remand. Once women had been imprisoned they often found themselves in a cycle of offending and imprisonment that was impossible to break. We consider this cycle, and that despite the ineffectiveness of prison in keeping women out of the criminal justice system, prison continues to be a central response. In this context, we consider the role of the courts, media and other agencies.

2.2 Imprisonment as a response to self-harm and attempted suicide

> "She had been punished for punishing herself. It is simply wrong that she was in prison instead of receiving the necessary and proper help for her deep-seated problems. We only hope that lessons will be learnt to prevent a similar tragedy happening again and for the government to realise that it cannot use prison as an NHS dumping ground for vulnerable women with mental health problems."(Sister of a woman with a long history of self-harm who died in prison)

A number of women who died had been imprisoned in circumstances surrounding an attempt at self-harm or suicide.

- A 19-year-old prolific self-harmer died while on remand. The woman had been charged with arson with intent following a serious self-harm/suicide attempt – she had set fire to her bed while she was in it.
- A 23-year-old woman was trying to kill herself by jumping off a cliff when stopped by a police officer. The woman threatened to kill the officer if she prevented her suicide attempt. The woman received a

73. Carlen, P. 'Introduction: Women and punishment' in Carlen, P. (ed) *Women and Punishment: The Struggle for Justice*. Quoted in *The Hurt Inside: The imprisonment of women and girls in Northern Ireland,* 2004, p32.

two-year prison sentence for making threats to kill. She hanged herself in prison.

2.3 Imprisonment as a response to mental illness

> "Mummy, why aren't they taking me to a hospital?" (An 18-year-old woman who died in prison, speaking to her mother after receiving a custodial sentence)

> "They shouldn't really be doing [the crime] but there is also the fact that she was mentally ill while she did it and needs proper help and support and not locking them away for seven years for 24 hours a day. Anyone, if they haven't got mental health problems will go mad in prison, so imagine someone with mental illness or a personality disorder". (Sister of a 19-year-old woman who died in prison)

> "Many people in prison have serious mental health issues. People with these kinds of problems should not be subjected to the isolation of the prison regime. They should be placed into suitably-designed secure psychiatric units, where they can receive the proper help that they need towards repairing their lives. Prison staff in general do not have the experience, nor should they be expected to have, to deal with these types of problems." (Father of a 35-year-old woman who died in prison).

Mental illness is one of the most significant indicators of future suicide.[74] Placing women with mental illness in prison is knowingly putting a group of people at high risk of killing themselves in the care of the Prison Service.

Seven women who died were in prison for arson offences.[75] Arson is a known indicator of mental health problems.[76] There is also evidence to suggest arson is related to previous abuse and of a possible complex relationship between arson and suicide.[77] Despite this, harsh prison sentences were imposed in some of these cases.

- A 28-year-old woman who suffered brain damage as a child set fire to her room in a psychiatric unit. The judge ignored a pre-sentence report which said she had definite personality disorder and sentenced her to life in prison. She hanged herself one month prior to her release, having been in prison for almost nine years.
- A 30-year-old woman set fire to her house and then presented herself to police. The woman was unable to cope with life outside institutions having spent many years in secure hospitals. She was sentenced to three years imprisonment. She hanged herself after being in prison for less than six months.

---

74. Interview with Louisa Snow, HM Prison Service, 1 September 2005.
75. A total of eight women have died in prison after being charged and/or convicted of arson. One death was of suspected natural causes, the remainder were self-inflicted.
76. Interview with Cathy Stancer, 25 November 2005.
77. Interview with Louisa Snow, HM Prison Service, 1 September 2005.

Case study

A 32-year-old woman suffered from mental health issues since her teenage years. At the age of sixteen she was taken into local authority care as her family was unable to continue looking after her. On a number of occasions she used fire-setting as a way of seeking attention.

Following an incident where she set fire to the curtains in her flat, she was charged with arson and sentenced to life imprisonment with a minimum term of 18 months. The psychiatric report prepared for the court suggested that the woman had a severe personality disorder which was untreatable. No medical recommendations were made.

The woman spent most of her time in prison in segregation. On the evening when she died, there was only one officer on duty in the segregation unit. This meant that even if the officer on duty had recognised that there was an emergency when the woman was seen lying on the floor of her cell with a ligature around her neck, the officer was unable to enter the cell until colleagues arrived because of internal directives for officers not to enter cells alone.

At the inquest into the woman's death, the coroner made it clear that he intended to carry out a full article 2 inquiry. He positively encouraged exploration of the issue of the lack of alternative facilities for women with mental health issues. The jury returned a short narrative verdict that the woman had strangled herself but did not intend to die. Rather, it was an attention seeking act. The jury added a comment that prison was "unsuitable" for someone with this woman's problems because it could not provide the constant supervision and monitoring that she required.

Case study

A 26-year-old woman with a severe personality disorder was on probation when she was the victim of ongoing racial harassment by her neighbour. She complained to the council who failed to respond.

The neighbour came into the woman's flat and tried to touch her. The woman hit back with an axe. She was arrested and bailed to her mother's house.

On bail, the woman attacked her mother who had arranged for a psychiatrist to see her daughter. Prior to the appointment the woman again attacked her mother who called the hospital. She was told her to call the police as they would section her daughter into hospital care.

Instead, police arrested her daughter. She was remanded at a prison which at that time had no hospital wing. For two days the woman's mother did not know where her daughter was being held. The woman hanged herself after nine days in prison.

Families often felt prison was used as the "too hard basket" into which women with mental illness were dumped. Seventy per cent of female sentenced prisoners have two or more mental health disorders. This is 35 times the level in the general population.[78]

HM Chief Inspector of Prisons, Anne Owers, has also expressed concern that prison is being used as life's "too difficult tray". In 2007 she gave evidence at the inquest into the death of a 37-year-old woman who died in HMP New Hall in 2004 that "care in the community was being replaced by care in custody". The woman had a long history of mental health problems.

SmartJustice director Lucie Russell believes prison is being used as the ultimate social service for people we should be treating in the community.[79]

78. *Safer Custody News*, 2004, p1.
79. Interview with Lucie Russell, 7 December 2005.

Women at home caring for children are often isolated from society making it easy for their mental health issues to remain unnoticed until a dire situation arises. These women are less likely to have access to agencies that can intervene and provide appropriate help at an earlier stage.[80]

The Fawcett Society's Commission on Women recommended that a defendant or offender appearing to have mental health problems should not be remanded in custody in advance of a medical report on the impact of the incarceration on their health.[81]

Families suggested that psychiatric assessments be made in alternative establishments:

> "Get someone properly psychiatrically assessed in either a secure unit or a secure psychiatric hospital for one to two weeks before their sentence so it gives someone enough time to see their behaviour and how they are. If they did that it would come out when people are faking it and stuff like that. … They need to look at the vulnerability of the person because it's not just about self-harm as it is about the vulnerability and how they cope in general…If it's decided the person can cope, they should go to prison. If they can't, like [my sister], then they should be going to either a secure unit or a properly well-equipped psychiatric unit." (Sister of a 19-year-old woman who died in prison)

It is unacceptable that prison be used as a dumping ground for women with mental illness. Prison should not be used as a place of safety for women awaiting psychiatric reports or a facility for drug detoxification, health care and medium term psychiatric care.

2.3.1 The use of secure hospitals

There is widespread acknowledgement that courts need to divert seriously mentally ill women away from the criminal justice system and into appropriate mental health facilities.[82] The courts will send women to secure hospitals if they believe it is appropriate. However there are concerns about the suitability of some of the facilities; in particular those with a high emphasis on security and discipline and inability to provide women with a safe environment. The charity Women in Secure Hospitals (WISH) has found that women in high security facilities experience forced medications, seclusion, forced feeds and physical restraint by male staff. Failure to comply with this regime can result in women having their date for discharge set back. In this environment, women described feeling unsafe and more prone

---

80. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.
81. *Women and the Criminal Justice System – A Report of the Fawcett Society's Commission on Women and Criminal Justice System*, 2004, p35.
82. For example the government's strategy for women offenders acknowledges the need for magistrates' courts to divert mentally ill women to hospital. See discussion in *Troubled Inside: Responding to the mental health needs of women in prison,* 2003, pp4-5.

to self-harm and deteriorating mental health. The physical restraint by men was particularly harrowing for women who had been victims of sexual abuse.[83]

The mother of an 18-year-old woman believes her daughter's fatal drug overdose in prison was intended as a cry for help so that she would be moved from prison to a psychiatric hospital.

> "During her six months on remand in 2002 the prison psychiatrist did say to [my daughter]… that if she was sentenced in January 2003 she would go to a secure psychiatric hospital, but of course that didn't happen…When the police investigation was taking place I asked this of the investigating officer and his reply to me was that a senior officer at Styal prison had said to him that "there was no mechanism for sending her elsewhere." I will never forget those words. And I thought at the time, well that absence of mechanism has cost my daughter her life."

Problems often arose when it could not be decided whether the woman had a mental disorder as defined in the Mental Health Act (1983).[84]

Only when a woman has a definable mental disorder, and it is believed that her disorder can be improved with treatment, will she be sentenced to a secure hospital. If a woman is diagnosed as having a personality disorder, whether paranoid, antisocial, obsessive-compulsive or a combination of these, generally psychiatric opinion is that this personality disorder cannot be treated and therefore the woman cannot be sent to hospital for treatment. In these cases, it is not uncommon for the woman to be sent to prison.

Case study

A 41-year-old woman was in prison on remand when she died. At the inquest into her death, evidence was given by a doctor from a secure hospital that the woman displayed symptoms of both psychiatric and personality disorders. He noted that personality disorders are more difficult to deal with than mental illness and it can be hard to distinguish between the two.

Admittance to a secure hospital is also dependent on meeting other criteria, for example, that it is in the interests of the individual's own health or safety or with a view to the protection of others. Despite having been arrested numerous times for behaving aggressively and violently towards her neighbours, the court did not believe this woman met any of these criteria. She was remanded in prison and staff did not have the appropriate training, resources or time to deal with her erratic behaviour. The doctor believed that as a remand prisoner this woman could have been sent to hospital for assessment. The jury agreed. They returned a narrative verdict stating that the woman's problems should have been dealt with outside the prison system.

---

83. See www.womenatwish.com.

84. Section 1 of the Mental Health Act (1983) defines mental disorder as "mental illness, arrested or incomplete development of the mind, psychopathic disorder and any other disorder or disability of the mind".

2.4 The impact of imprisonment on women with mental illness

> "Everything they did seemed to exacerbate her distress, when in fact she wanted ways of alleviating the distress. But see they are in prison not a psychiatric unit… [my daughter] needed help, treatment, care, rehabilitation. They were totally not up to it." (Mother of an 18-year-old woman who died in prison)

Women can become deeply distressed and depressed as a result of the separation from family and the isolation they experience in prison. They are typically more likely to be carers or involved in family on a daily basis. The unfamiliarity of the prison regime has a particularly negative impact on the mental state of women in prison as illustrated by alarming rates of self-harm, suicide attempts and suicide.[85]

High rates of self-harm are further indicators of the distress being experienced by women in prison. Between January and July 2005 women made up 6% of the prison population, yet accounted for 58% of all self-harm incidents.[86] In 2005, women accounted for 45% of prisoners successfully resuscitated following serious self-harm incidents.[87] In evidence presented to the Home Affairs Committee on prison suicides and overcrowding, Juliet Lyon, director of the Prison Reform Trust, stated:

"People are not only dying in prisons but also injuring themselves repeatedly every single day. The levels of self-harm are extraordinary, particularly in Young Offender Institutions and women's establishments. The latest figure that we have from the Women's Team is that 587 out of every 1,000 women in prison injure themselves repeatedly while they are in custody".[88]

Case study

A severely mentally-disturbed 20-year-old woman was in prison for murder. She was given the highest security rating (restricted status) and transferred to a prison where she was one of only six women being held. In this isolated, heavily restricted environment she became incontinent and increasingly depressed. She was a prolific self-harmer and continued to self-harm in prison, where she eventually took her own life. In the last week of her life she had been downgraded to basic regime, staff having removed her television and radio, knowing these had been a major distraction from voices telling her to harm herself. At the inquest into her death psychiatric evidence was provided that this woman's paranoid schizophrenia meant that she was not in control of her own behaviour and therefore incapable of complying with instructions. Prison staff appeared ignorant of her condition and interpreted her behaviour as "lazy, idle and dirty." To downgrade her to basic regime was in effect punishing her for behaviour she could not help.

The relationship between self-harm and suicide risk is discussed in more detail in section 3.6 of this report.

Unsurprisingly, when women entered prison already suffering from mental illness families witnessed a further deterioration in their mental health.

---

85. See section 1.3 of this report for rates of self harm amongst women in prison.
86. *Safer Custody News*, 2005, p1.
87. *House of Commons Hansard,* Written answers for 2 October 2006, column 2625W.
88. Oral evidence given before the Home Affairs Select Committee on Prison Suicides and Overcrowding, House of Commons, 8 November 2005.

The sister of a 19-year-old woman with a long history of self-harm who was in prison for arson with intent described how out of control her sister's self-harming became in prison – she self-harmed 93 times in 130 days. The woman died while in prison.

> "It was horrendous – she stuck a bloody pen in her leg. To my knowledge she'd never done that before. I mean she'd done awful things, inserted things into her skin, but that was quite shocking really and she was quite proud of it."

Experts agree that prison can be a life-threatening environment for women from mental illness.

"Prison is not the right place for women with severe personality disorders. Especially if they self-harm, as they are more likely to do so in prison."[89]

Families and experts identified aspects of the prison environment that contributed to the further deterioration in the mental state of women suffering from mental illness. These included:

Being in a cell alone for long periods of time

> "You've got your time in a cell that was like a shoe box...You've got no one in there really who gives a shit, some people might but if you're locked in your cell for 23 hours what have you got? All you've got is the bad thoughts going through your head and stuff like that and a lot of people can't cope in prisons because isolation is not a very good thing and I suppose if you are forced into it, it's worse." (Sister of a 19-year-old woman with a long history of self-harm)

Families described women being locked in their cells, often alone, for up to 23 hours a day. Given the mental state of these women, it is difficult to see how this environment is conducive to anything but the most self-harming behaviour.

High risk of retraumatisation

As discussed, a disproportionate number of women in prison are victims of physical and sexual abuse, childhood abuse, domestic violence and rape. Research has found that women with a history of abuse may find that some aspects of prison life will increase their levels of distress and place them further at risk of suicide.[90]

"An environment where women are expected to comply with authority without question, in what may often seem arbitrary disciplinary matters, while being isolated from their families and support networks, may remind many of abusive situations either in childhood or their adult lives. Fears of bullying, aggression and/or sexual assault

---

89. A doctor giving evidence at the inquest into the death of a 41-year-old woman who died in prison.

90. *Abuse, Interventions and Women in Prison: A Literature Review*, 2003, p6.

from other prisoners and/or staff alongside informal norms which inhibit the making of complaints may do likewise."[91]

In the early-mid 1990s in particular, women in prison were subject to "new degradations and pains"[92] as prisons focused on preventing escapes and a crackdown on illicit drugs.[93]

"There were lurid stories about Holloway's new Dedicated Search Teams (dressed in tracksuits and baseball caps) making women submit to the most intimate and intimidating strip searches… and about Mandatory Drug Testing in some of the women's gaols not only requiring women to urinate in front of two female officers, but in requiring them to do so with their hands held up well above their heads."[94]

The mother of an 18-year-old woman who died in prison described how the establishment's inability to respond appropriately to her daughter's experience of sexual abuse contributed to her death.

> "My daughter decided to tell the truth at her trial and her co-accused lied all the way through. That effectively meant she was giving evidence against her co-accused, an acquaintance of hers, which makes her a 'grass' and prisoners don't like someone who is a grass – it puts you at risk of attack, etc., so then the court, in its wisdom, sent the two back to Styal prison, so my daughter was at risk on the way back, before she even got to the prison.
>
> Word spreads fast about things like that so that I think even before she got out of the prison van, from what I can remember, prisoners had threatened to cut her up so that no other man would ever look at her.
>
> Now having said that, they basically didn't have anywhere suitable for an 18-year old severely depressed teenager who needed to be kept safely from women who might attack her. The only place that vulnerable women could go to, those who are at risk because they are child murderers or sexual abusers, was a place called Butler House.
>
> Now my daughter knew that the sex offenders were put into Butler House. I gather it was guarded by barbed wire and apparently… she had asked to go to Butler House and all I can say is that if she did she must have been in a highly stressed state, if only because she knew she had been sexually abused as a little girl and she knew potentially there were sex offenders at Butler House but she was so desperate to be kept away from the other women because she was a grass and I gather the prison staff decided that Butler House wasn't suitable for her, so what

91. *Ibid*, pp5-6.
92. *Analysing Women's Imprisonment*, 2004, p15.
93. *Ibid*.
94. *Ibid*, pp15-16.

> was left? The punishment block, the segregation block, which is where they took her on the Friday night.
>
> I gather she was strip searched twice. I think once arriving at the prison and again arriving at the segregation block. She was locked in a small room on her own with what I would describe as sensory deprivation, no radio, no TV, nothing, no cell mate, totally on her own in a silent room, and the only way she had to communicate with staff, so we were told at the inquest, was through a crack in the door."

This woman died in the segregation block less than 24 hours after arriving in prison.

2.5 Prison: an ineffectual solution

"Prison can be a kick up the arse for some women. For others, particularly those who have been abused and treated badly their whole lives it is just an extension of this."[95]

Self-inflicted deaths highlight that for some women prison is nothing more than the last straw in a situation of hopelessness and self-destruction. Research shows that anything positive that can be done in prison can be done in a less distressing environment. Maintaining prison walls and keeping women in and locked up requires a huge amount of time and effort.[96] Arguably these resources could be better used assisting women to stay out of contact with the criminal justice system.

2.5.1 The unbreakable cycle

> "You cannot lock somebody up with a problem and then expect them to come out and be fine. They've got to adjust to life outside. My daughter had been away the first time for a year." (Mother of an 18-year-old woman who died in prison)

Over one-third of the women who died had been in prison on a prior occasion.[97] High rates of re-offending and reconviction suggest that prison is rarely an effective way of addressing offending behaviour.[98] To the contrary, it often becomes part of a cycle of offending, conviction and imprisonment which is difficult to break and life-threatening. For women with substance addictions this cycle is particularly hard to break.

Prison life is so unique that skills learnt in prison rarely translate well to life outside. Many women return to the same community and environment they were in prior to prison, particularly if they have

95. Interview with Natasha Vromen, 7 December 2005.
96. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.
97. This is a very conservative estimate as in 55% of cases it is unknown if the women had been in prison on a prior occasion.
98. Fifty-seven percent of women released from prison in 2001 were reconvicted for a standard list offence within two years: *Offender Management Caseload Statistics 2004, op cit*, p133.

children. The high rates of domestic violence experienced by women who have been imprisoned means this may be accompanied by them returning to an abusive relationship.

Even if the woman wants a fresh start, it can be difficult to find suitable housing or a job. Residential drug services may not be an option if children are not allowed to live on the premises.

This cycle also puts women's lives at risk outside prison. Women prisoners between 25 and 29 years of age are 69 times more likely to die from drug-related causes in their first week post-release than women of the same age in the general population. In this period they are also more likely to die than men prisoners – who are 29 times more likely to be involved in drug related deaths than the general male population of the same age.[99]

A 39-year-old woman died in prison. At the time of her trial, her probation officer assessed the woman's chance of re-offending as high unless she successfully addressed her drug problem:

"[The woman] *would appear to have become enmeshed in a cycle of drug-related offending and to date has neither the ability nor opportunity to take positive steps to break that cycle. Her situation appears to have been compounded by a number of distressing domestic events and a lack of stability in her life."*

Even among young women who died in prison, at least half had been in prison on a previous occasion.[100]

In general, 61% of young women are reconvicted for a standard list offence within two years of release from prison.[101] Research has identified young people in prison as "an extremely needy and challenging group of older teenagers who are at the very margins of society and one of the most excluded groups in the prison system."[102]

A Prison Reform Trust report stressed the importance of assisted transitions from custody to the community to reduce the high rate of reconviction among young people.

"Young adults will need help with housing, advice, financial support and management, guidance on training and employment opportunities and parental support. They may have substance misuse problems or mental health disorders and will need to be linked up with community treatment services. Yet despite multiple needs and the high risk of re-offending, support and aftercare is poorly co-ordinated and at best, services are patchy."[103]

---

99. *Drug-related mortality among newly released offenders 1998 to 2000, 2005,* ppiv-v.
100. The Home Office defines women aged 18-20 as young offenders.
101. Standard list offences include all 'indictable only' and 'triable either way' offences and some of the more serious 'summary' offences such as common assault and driving while disqualified or under the influence of drugs or alcohol. *Offender Management Caseload Statistics 2004, op cit,* p133.
102. *A Lost Generation: The experiences of young people in prison*, 2004, p5.
103. *Ibid*, p31.

Realistic expectations, especially among young people, about life outside prison are also important to avoid returning to a life of drugs and crime. For women serving longer sentences robust resettlement regimes, allowing town and home visits once a week, have been found to be very helpful in setting realistic expectations of life outside.[104] INQUEST recommends prioritising resettlement assistance for women following a period in prison.

Women's care/support plans do not follow them into the community, so any therapeutic interventions started in prison are not sustained once they are released. The impact is social exclusion and deterioration in mental health – often the very circumstances that contributed to their offending in the first place.

- Follow up support in the community post-detoxification is often not adequately followed through for women. Inadequate housing, financial pressures upon release, etc. compound these difficulties.
- There is a continued lack of specific, specialist service provision in the community to support families separated by the mother's imprisonment. There is a need for commitment at a local authority level to increasing specific service provision for families, adequately training social care professionals to understand the needs of women upon release and access to safe transitional accommodation prior to their children being returned to their care.

Housing remains a key issue, and women whose children are taken into care often do not have suitable accommodation for contact visits or overnight stays to re-establish themselves as competent and safe parents.[105]

Families described how after being released, women had to deal with the stigma of having spent time in prison, and the practical difficulties of adjusting to life outside.

An 18-year-old woman who died in prison was serving a two year sentence for robbery. She had been in prison on a prior occasion. Her mother described her daughter's experience leaving prison for the first time.

> "There was no assistance when she left the prison. If I hadn't had youth justice there would have just been me. All of her things were just put in a big see-through carrier bag and youth justice went and picked her up for me. I said 'how is she going to get home from Redditch?' They didn't seem to care. She would have had to get a train with a great big bag that's got HMP Brockhill written right across it. How degrading is that? What are they trying to do with these kids? They might as well just stamp it on their forehead and say walk around the street like that.
>
> She tried so desperately to get a job. She went for cleaning jobs, she said 'I'll do absolutely anything' and of course she got knock back after knock back. She went absolutely mad. She said 'you know I've

104. Interview with Christine Wood, 9 June 2006.
105. Correspondence with Suzanne Sibilin, Women In Prison, February 2008.

> been away and I've got every certificate possible.' She joined in everything that was expected of her. She said, 'I've really tried and nobody will just give me that chance…' so her self esteem was then going downhill again. So then she started to go on the drugs and commit crime. My daughter said to me, 'I am on a merry-go-round and I'm gonna go round and round and round I am never going to come off it'. All she could see was prison, drugs, crime.
>
> …I spoke on the telephone to my daughter the day before she died. She said 'I love you and when I get out I just want to come home and I want to get my life together and I just want people to give us a chance.' She come off the phone and then the next day she [died]."

Families also felt that re-entry into prison contributed to the women's deaths. Experts agree:

"Perhaps on the first sentence women are still hopeful that they can make things change once they get out, but coming back shows them that they haven't been able to make the change. It may make them feel like a failure."[106]

"Women who have been in there before have increased hopelessness, are very self-blaming and very distressed that they have done it again."[107]

The possibility that a woman will lose contact with her children increases each time she receives a custodial sentence, further adding to her distress upon re-entering prison.

2.5.2 Dependence on prison

While it is not uncommon for women to experience difficulties coping outside prison, at least two of the women who died had developed a dependence on prison and re-offended specifically to return to prison.

"Some women are so deeply damaged, prison provides them with the most stable environment they've ever had. This can lead to institutionalisation… for some women with limited coping mechanisms, prison can be a saviour."[108]

A 48-year-old woman hanged herself during her sixth term in prison,

> "After the first time, she committed most of her offences to get back to prison. She only felt safe when she was in prison... By her second time it had become her place of escape in a way, a place when she couldn't cope with something outside. She just did something to get back there.'"(Partner of a 48-year-old woman who died in prison)

Case study

A 30-year-old woman set fire to a house and then presented herself to police. Previously, the woman had been detained for two years in a secure hospital. Inadequate preparations had been made for her release back into the community. The woman wanted to be sent to prison as she could not cope with life outside institutions. A doctor recommended that she be detained under section 38 of the Mental Health Act. Instead, she was sentenced to prison for arson for three years where she died in the prison's psychiatric wing.

106. Interview with Cathy Stancer, 25 November 2005.
107. Interview with Kimmett Edgar and Juliet Lyon, 6 December 2005.
108. Interview with Harriet Wistrich, 25 November 2005.

2.6 Imprisoning mothers

"With women we are not just sentencing an individual, we are sentencing the whole family."[109]

"There is no disputing the fact that the separation of the mother from her children causes a great deal of distress to a woman. When a lot of these women leave prison they have perhaps lost their home, they have lost their job and sometimes their children have to go into care. Women entering a prison situation generally seem to take with them a greater mix of problems than many male prisoners do."[110]

The imprisonment of women has a disproportionate impact on children and families. A Home Office study into mothers in prison concluded,

"While women serve their sentence they also try to keep their families together with all the associated difficulties and strains. Fathers on the other hand will generally serve their sentence knowing their partners will keep things together, albeit with difficulty. The fundamental difference in this experience needs greater recognition by sentencers and the Prison Service."[111]

The Howard League for Penal Reform has argued that,

"If a court is considering custody, remand or sentence, the baby should be represented in court as a party to the decision as it affects him or her. Separation from the mother is a serious matter for any baby and its human rights should be represented."[112]

Some families believe that a contributing factor to a woman's death is the impact of her imprisonment on her children. They describe the sense of loss, guilt and frustration at being separated from children.

> "She felt she had let her family down and me and most of all her son, I think that's what did it in the end." (Mother of an 18-year-old woman who died in prison)

In this case the woman's son was being cared for by her mother while she was in prison. During this time Social Services attempted to remove the child from his grandmother's care.

> "When [my daughter] first went away I asked Social Services to get involved cause I didn't know what to do. Then Social Services turned it round on me and took me to court to try and have my grandson taken from me. For five or six years I've never had a partner. I don't go out. I don't drink … I was getting them here to help her and they turned it and they wanted to try to take her son

109. Lord Dholakia addressing the House of Lords: *House of Lords Hansard*, debates for 28 October 2004, column 1448.
110. Pauline Campbell giving oral evidence before the Home Affairs Select Committee on Prison Suicides and Overcrowding, House of Commons, 8 November 2005.
111. *Mothers in Prison*, 1997, p4.
112. Baroness Walmsley addressing the House of Lords: *House of Lords Hansard,* debates for 28 October 2004, column 1456.

> away from her. They wanted her son adopted not fostered out. They contacted me twice to ask me to take [her son] to a foster carer so that he could get to know them. I said no, I'm not.
>
> They tried to get an interim order to remove him within 24 hours and I had to go to court at 9 o'clock in the morning and it finished at 6 o'clock at night and if they had won that day they would have removed him, and I felt absolutely sick.
>
> I didn't realise the friends and schools support that I had behind me but it was hard going to try and prove to the court that I was a decent person and I wasn't all the things they were putting in that report.
>
> Bearing in mind [my daughter] was away when all this was going on and I was fighting for her son – so she felt even more down. They were tearing her apart."

The woman won her case. Her grandson has remained in her care since her daughter's death.

A 19-year-old woman was on remand for robbery when she died. The woman was imprisoned eleven days after giving birth. Initially she had been allowed to visit her baby in hospital. However, these visits were stopped. Her mother believes the recent birth contributed to the nervous breakdown the woman had in prison, which was a factor in her death:

> "Anybody in that courtroom should have been worried about this girl going to jail because this girl looked like an old woman. She was so frail she looked terrible… The judge said I would release her now if you could find a bail hostel and in one month they didn't do nothing. There was telephone calls and everything going on but nobody was getting her papers… they were biding time but it was costing her her life."

In general, when a woman goes into prison it is usually a battle for her to keep her children. If the children go into the care of Social Services it becomes almost impossible. Women in prison rarely know that they have a right to challenge these decisions or receive legal advice and representation.[113] In a number of cases women signed papers agreeing to the adoption of their children on the day they died, or in the days immediately prior. Conducting this research, INQUEST heard anecdotal evidence of women signing adoption papers or handing their children into state care while undergoing drug detoxification.

The following trends are also of serious concern:

- Each year nearly 18,000 children are separated from their mothers due to imprisonment.[114]
- A Social Exclusion Unit report found that 21% of women prisoners were living alone with dependent children at the time of their

113. Interview with Cathy Stancer, 25 November 2005.
114. *House of Lords Hansard*, debates for 28 October 2004, column 1471.

imprisonment.[115] Deaths of women in prison potentially leave children without their primary carer.

- In 8% of cases children were placed in local authority care as a result of their mother's imprisonment.[116] Given that one in four sentenced women prisoners spent time in local authority care as children,[117] and prisoners, in general, are thirteen times more likely than the general population to have spent time in care a children[118] there is the potential for generational problems of imprisonment to arise.

Childcare following a death in custody

Childcare arrangements following the death were similar to arrangements made when women went into prison.[119] Very few of the children went to live with their father and none appear to have stayed in the house they had lived in with their mother. Most went to live with maternal grandparents, were put in the care of the state or adopted either by relatives or strangers.

In some cases family members, friends or potential adoptive parents were only able to care for one child. Separation from siblings potentially created further disruption and trauma for children who had already lost their mother.

During the course of this research, INQUEST met some of the relatives caring for the children of women who have died in prison. The tireless commitment with very limited resources and support, and the love and care they showed these children was overwhelming.

- The son of an 18-year-old woman who died in prison lives with his maternal grandmother. She is the sole person responsible for the child's welfare, providing all financial and emotional support.
- The two children of a 19-year-old woman who died in prison are housed and cared for by their maternal grandmother. She looks after them in addition to her own two children, including a son with very serious physical disabilities requiring full time nursing care.

2.7 She hadn't been found guilty

> "When [my daughter] died in custody she was on remand. Legally innocent of any crime." (Mother of a 29-year-old woman who died in prison awaiting trial)

Between 1990 and 2007, 92% of women who died on remand had not been convicted at the time of their deaths. Families expressed

---

115. *Reducing Re-offending by Ex-prisoners*, 2002, p19.
116. *Counting the Cost: The social and financial consequences of women's imprisonment*, 1998, p17.
117. *Psychiatric Morbidity among Prisoners in England and Wales, op cit*, p27.
118. *Reducing re-offending by ex-prisoners, op cit,* 2002, p6.
119. Prior research found that when a mother went to prison, 75% of children were not cared by their fathers or their mother's spouse or partner. Carers tended to be grandmothers (27%) and other relatives or friends (29%). Eleven per cent of mothers in prison had one or more children in care, fostered or adopted: HM Chief Inspector of Prisons *Women in Prison: A thematic review by HM Chief Inspector of Prisons*, 1997, p12.

concern that women had been held in prison prior to being found guilty of any offence.

In other cases, women were remanded in prison while pre-sentence reports were being prepared. A 29-year-old woman was remanded in custody for three weeks for this purpose. She died less than two weeks after entering prison.

Women on remand are known to have significant legal, social and health care needs and are at high risk of suicide and self-harm. HM Chief Inspector of Prisons' review of suicide and self-harm in prison found the overall suicide rate in prison was higher for unsentenced than sentenced prisoners.[120] Given this risk, extreme caution should be exercised before remanding women to prison.

The Prison Reform Trust believes that many women on remand have problems which should be addressed in the community and are only exacerbated by removal from the community.[121] This is particularly relevant to young women:

"Young women on remand are a very difficult group to work with. It is very difficult to keep them in one place. The only way to deal with them is in the community. Every attempt should be made to divert them from prison."[122]

Organisations working around women's imprisonment and deaths in custody echo this concern. As a matter of priority the government, courts and prisons must work together to reduce the number of women remanded to prison.

2.8 The punishment didn't fit the crime

It was not uncommon for women to have been imprisoned for shoplifting or petty theft when they died. In these cases women usually had a long history of prior convictions but had previously avoided imprisonment. The theft was often to support a drug habit. Diversion at the earliest possible stage from the criminal justice system into appropriate drug rehabilitation may have prevented the imprisonment and the subsequent tragic loss of life, particularly given the increasingly understood risk of self-harm and suicide among women in prison with drug problems.

> "[My daughter] was a heroin addict. All she could think about was her next fix, thus ending up shoplifting to fund her habit. This is what made her a criminal in the eyes of the law. If [she] could have overcome her drug dependency, she would not have ended up in prison." (Mother of a 19-year-old woman who died in prison)

An 18-year-old woman died in prison. She was serving an 18-month sentence for stealing a mobile phone from a friend. She had a history of petty theft offences from age 12.

---

120. *Suicide is Everyone's Concern: A thematic review* by HM Chief Inspector of Prisons, 1999, p20.
121. *Lacking Conviction: The rise of the women's remand population, op cit,* p52.
122. Interview with Cathy Stancer, 25 November 2005.

> "[The first time] it was all over two mobile phones and a pound. The police said we'll drop the two mobile phones if you admit the pound and she got sentenced on the pound." (Mother of an 18-year-old woman who died in prison)

2.9 Could these deaths have been prevented?

"Simply continuing to lock up more and more women in the light of the information we have about the profile of so many women prisoners seems like avoiding the real issues, exacerbating the problems and leaving the Prison Service to carry out a role it is not properly equipped to do and was not intended to do."[123]

It is widely recognised that prison is ill-equipped to meet the needs of many of the women in its care. Following an inspection of HMP & YOI New Hall, HMIP commented that:

"New Hall, like other women's prisons we have recently inspected is holding women and girls who should not be there. They include those who are seriously mentally ill, as well as some women and girls with high levels of self-harm, linked to abuse, including substance abuse. Staff at New Hall were doing their best to provide a stable and safe environment; but were unable to do more to contain the level of need of some very damaged individuals."[124]

Some of the families, who felt that prison was an entirely inappropriate place to send the women, believed there was nothing prison staff could have done to prevent the death.

The brother of 41-year-old woman who was only in prison for four days before killing herself questioned the prison's capability to deal with someone as mentally ill as his sister. Giving evidence at the inquest into his sister's death, he was more critical of the lack of assistance provided by mental health services to his sister over the years. Despite these circumstances, the jury still found the prison's care of this woman was "less than adequate".

The sister of a 19-year-old woman with severe mental health needs praised the prison staff for the care they provided.

> "She shouldn't have been in prison full stop. I mean there's only so much the prison services can do. The prison staff were amazing when she was there but unfortunately they don't have the training."

However, the majority of families felt that even though the women should never have been imprisoned the poor care they received in prison heavily contributed to their deaths.[125]

> "It is important for the courts to stop imprisoning so many

123. Lord Rosser addressing the House of Lords: *House of Lords Hansard*, debates for 28 October 2004, column 1461.
124. *Report on an announced inspection of HMP/YOI New Hall 10-14 November 2003*, 2004, p5.
125. For further discussion see Part 3 of this report.

people needlessly, so that deaths in custody become a rare occurrence rather than the twice weekly shameful manifestation of institutionalised neglect." (Mother of an 18-year-old woman who died in prison)

2.9.1 The role of other agencies

"The use of punishment is spreading more and more into territory that belongs to others. It is territory that belongs to the health services and social services. It is not just bad policy that punishment should be used for health and welfare problems, clearly it doesn't work, [these women] *are all dead."*[125]

Many of the women who died had come into contact with Social Services and the National Health Service (NHS) prior to entering prison. Overwhelmingly, families found this interaction frustrating and ineffectual.

> "I think [the NHS] just gave up. From my perspective they see it as someone crying out for attention or something like that." (Sister of a 19-year-old woman who died in prison)

A 23-year-old woman who died in prison suffered from manic depression and was a prolific self-harmer who had made numerous suicide attempts and spent periods of time in psychiatric hospitals. Her family experienced great difficulty getting her appropriate help.

> "One minute they were diagnosing her with schizophrenia, the next with a personality disorder. They dragged their feet when it came to getting her into a psychiatric hospital. She had tried to make a fresh start at one point, even going so far as to change her name by deed poll. We tried to get her into a psychiatric hospital and funding had been secured but then the hospital wouldn't accept her as she was not suitable." (Mother of a 23-year old woman who died in prison)

A 20-year-old woman was serving a life sentence for murder when she died. Her mother described her daughter's experiences with mental health services and the courts:

> "Earlier in the year that my daughter committed the murder she had been in New Hall and she had been transferred to a psychiatric hospital for assessment in Liverpool because basically people wanted to figure out whether she was schizophrenic, [had a] personality disorder or both or something else.
>
> So she went back to court for a review and the hospital wanted to say 'we're done now, let's get her out' and her solicitor asked that they wait two weeks until some sort of care plan could be

126. Baroness Stern addressing the House of Lords: H*ouse of Lords Hansard*, debates for 28 October 2004, column 1453.

provided and the judge also asked for this, and they wouldn't do it.

So Mental Health Services wouldn't make a care plan because she had a personality disorder, and this is not classified as a mental health issue, but the probation services wouldn't make one either because she was mentally ill. So she was just out in the community.

What I didn't realise until she went into another unit to be assessed after she murdered someone was that I could have objected to that as the primary carer and said I want the care plan, but it's too late. You don't realise what you're entitled to ask for and while there were some people who were helpful, there were some that weren't because sometimes you would ring the hospitals up and they say it's all confidential. So you're getting nowhere really.

The youth team report, prepared for an earlier court appearance, didn't reflect the difficulties that my daughter had."

The mother of an 18-year-old woman who died in prison described her daughter's futile attempts to find help for her heroin addiction:

"She went all over for help. She went to see psychologists, she went to drugs teams. There is just not enough help and there's a long waiting list to see counsellors and that doesn't help cause it's what you actually do in the meantime.

She used to say to me, 'I am constantly telling my story to someone new. They're coming in knowing nothing about me, then making a judgement and they don't know the full history of it.' She'd just get settled with one person and then they'd move on and then somebody else would step.

We have a drugs team but again they come out, they talk to you for 15 minutes – and then go away. I don't see the logic in that. They see you for 15 minutes and then you have another week to wait and again they get promoted and another one steps in. There is no continuity.

You can't get a lot of help in Rugby. She even went to Coventry... but to get treatment in Coventry she had to go 'of no fixed abode' because they will only treat you if you actually live in Coventry, which again I think is wrong cause you've got some kids all crying out for help and they are trying to do something."

Not all experiences with other agencies were negative. This woman received invaluable assistance and support from the Youth Justice Team:

"The only help I ever saw [my daughter] get was with youth justice… She had reached 17 so youth justice shouldn't have

> been involved but when she first committed the crime she was just before 17 so they decided to stay on with her throughout which was a good thing…Without them I wouldn't have been able to go down there and go to the meetings and find out what was happening and put things in place."

Even in moments of crisis, families experienced difficulties trying to get help from Social Services, the NHS and other health services. A mother described how she was unable to obtain appropriate medical care for her daughter while she was on bail:

> "In that eight week period in the lead up to her trial… she only had two appointments with her consultant community psychiatrist. Only two appointments over a period of eight weeks which I did not think was enough.
>
> The first GP practice which I took her to, which is my GP practice, which is where [my daughter] used to be, they threw her out after two appointments. It was quite clear they didn't want her. They just heard the words heroin, manslaughter, prison, psychiatric components and … basically they threw her out of the practice.
>
> I got the distinct impression nobody really wanted to help her. They all thought that she was going to back to prison anyway, so nobody really made much effort."

An unsympathetic attitude by community health providers towards people with drug addictions is concerning given that Primary Care Trusts (PCTs) are increasingly becoming responsible for commissioning healthcare within prisons. To date, there has been no prison-specific training for PCT staff going to work in prisons.[127]

2.9.2 The role of the courts

Families recognised that the courts had the final say on whether a woman was sent to prison. They expressed frustration at the court's focus on the offence committed and their inability to take into account other relevant factors, including the known negative impact of imprisonment on women. Magistrates and judges rarely visit prisons, meaning they have not observed first hand where they are sending women and seeing the types of regimes and conditions in prison. This is particularly problematic in relation to women with severe mental and physical health problems.[128]

Family members strongly believe better understanding among judges and magistrates of the prison environment and its potential impact on the women appearing before them is crucial to preventing further deaths of women in prison.

---

127. *Annual Report of HM Chief Inspector of Prisons for England and Wales 2003-2004,* 2005, p26; Interview with Paul Fenning and Michael Loughlin, 25 May 2006.
128. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.

> "On the day of court she was due at Coventry drugs team and we told the court but he just wasn't interested. Her barrister said could we just delay sentence until I get reports in to show you how [she] was trying to get a job and help and look after her son but he wouldn't. He said no, I will sentence her today. The barrister was shocked that he didn't delay the sentencing until he got the report. I think we all were, cause [my daughter] had tried so hard when she come out of prison, really, really hard. I was angry at that because either way she would have been remanded. She wasn't going to go free but he wouldn't wait." (Mother of an 18-year-old woman who died in prison)

> "Judges and magistrates should have a better understanding, cause I don't think they do. They just put everyone in categories. They don't look at the person. It's the court system causing all these deaths because they are sending people to prison. I don't think they've got a heart and I know that sounds callous and cruel to say about them because they are human beings at the end of the day, but from where I am sitting they don't seem to have feelings at all. The one [judge] that worked with [my sister] towards the end was fantastic. He was trying to get her out of prison. He moved her to another court to see her because he wasn't in that court – he was really, really good but unfortunately there are other ones." (Sister of a 19-year-old woman who died in prison)

In oral evidence presented to the Home Affairs Committee on prison suicides and overcrowding INQUEST argued,

"We…need to make magistrates and the judiciary generally aware of the alternatives to prison that could better deal with the reasons why these women got into prison in the first place and their many complex needs."[129]

In recent years we have seen a significant increase in the female prison population. Individuals who previously would have received community penalties are being imprisoned and those who previously would have been sent to prison are being given longer sentences.[130] Courts are believed to be harsh on women whose offending is regarded as socially unacceptable e.g. women who commit violent offences and women who take drugs, particularly if they are mothers.[131]

Given these trends, the following findings of a Prison Reform Trust report on sentencing are very concerning:

- Crown Court judges, recorders, district judges and magistrates repeatedly stressed that they only use custody as a last resort as required by legislation.

---

129. Oral evidence of Deborah Coles given before the Home Affairs Select Committee on Prison Suicides and Overcrowding, House of Commons, 8 November 2005.
130. *The Decision to Imprison: Sentencing and the prison population,* 2003, p21.
131. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006. See also *Analysing Women's Imprisonment op cit* for a discussion on the criminal justice system's attitude to women.

- Given their insistence that they already use custody only as an absolute last resort, many sentencers were resistant to the idea that they should reduce their use of custody in order to reverse the rise in the prison population.
- Some magistrates commented that a lack of appropriate facilities for persons with mental health problems lead them to impose a prison sentence.

The Prison Reform Trust also found that sentencers are acutely aware that their sentencing decisions are not made in a vacuum, but in a highly pressured political and social context. Some felt pressure from politicians and the senior judiciary who send them conflicting messages – get tough on crime but do not send people to prison. They believed the public and media also sent this conflicting message in their appraisals of sentencing decisions.[132]

Sentencers believe that public attitudes to sentencing are largely based on media reporting of cases. These reports are often inaccurate or incomplete and usually conclude that courts are too lenient.[133] Sentencers believe that when people are presented with the full details of a particular case their sentencing preferences are not especially severe.

Likewise, the SmartJustice campaign has found that although harsh sentences supposedly reflect public opinion, the majority of the public believe that short term prison sentences have a negative impact on individuals.[134] SmartJustice's public opinion survey on women in prison found that 67% of respondents said prison was not likely to reduce offending. There was overwhelming support (86%) for community alternatives, for example centres where women are sent to address the causes of their crimes whilst also having to do compulsory work in the community.[135]

These findings suggest the need for better dialogue between sentencers and the public – sentencers need to understand that the public is not always in favour of punitive responses and the public needs to better understand how sentencing decisions are made. The Prison Reform Trust has found strong support among sentencers for public education programmes on sentencing, for example programmes such as Magistrates in the Community which organise public talks and hold court open days.[136] Visible, consistent political leadership that takes action to stop the growth in prison numbers and is vocal in advocating and promoting greater use of alternatives to custody is also required.

Conducting this research a number of recommendations relating to sentencing were made, including:

---

132. *The Decision to Imprison: Sentencing and the prison population, op cit,* p53.
133. *Ibid*.
134. Interview with Lucie Russell, 7 December 2005.
135. See the SmartJustice for Women website www.smartjustice.org/womenabout.
136. *The Decision to Imprison: Sentencing and the prison population, op cit,* p55.

- When handing down a prison sentence, sentencers should fill in a form stating why they felt alternatives to prison were not appropriate.[137]
- Further judicial training on women's offending .
- Sentencers should visit women's prisons.
- Sentencers should give consideration to the impact of a custodial sentence on a woman's children.

2.10 The role of the media

"When prison tries to do something that may help women in prison there is backlash from the Daily Mail. Its readers were in uproar when they heard £40 a day was being spent on acupuncture for women in prison as it helps with drug withdrawal."[138]

The media's portrayal of women who commit crimes does little to facilitate public support for prison alternatives or better facilities within prisons. The media often vilifies women who commit crimes, particularly if their actions are deemed unacceptable behaviour for women.

It is not uncommon for women who commit acts of violence or mothers stealing to support drug habits to make headlines and be described as 'evil'. Backgrounds of physical and sexual abuse or domestic violence are less likely to be mentioned unless the story is specifically on the vulnerability or 'crisis' of women in prison. Perhaps reference to these issues at an earlier stage would result in stronger support for more appropriate custody alternatives and ultimately fewer deaths in prison.

This unsympathetic media attitude can extend to the children of prisoners who are often presented as 'bad'. Given that seven percent of children in the UK will, at some point during their school years, have a parent in prison this stereotyping should be avoided, otherwise imprisonment may become generational for the increasing number of children with a parent in prison.[139] A consideration of the childcare responsibilities of a woman appearing before the courts should be mandatory in determining a suitable penalty.

2.11 Conclusion

For the women who died in prison, the road to imprisonment was neither straight nor obvious. Despite being inappropriate, ineffective and ultimately costing them their lives, prison was the chosen criminal justice response to these women and the problems they presented. Their cases illustrate that there were many missed opportunities for alternative and potentially life-saving decisions to have been made.

---

137. Interview with Cathy Stancer, 25 November 2005.
138. Interview with Natasha Vromen, 7 December 2005.
139. Interview with Lucy Gampell, 24 May 2006.

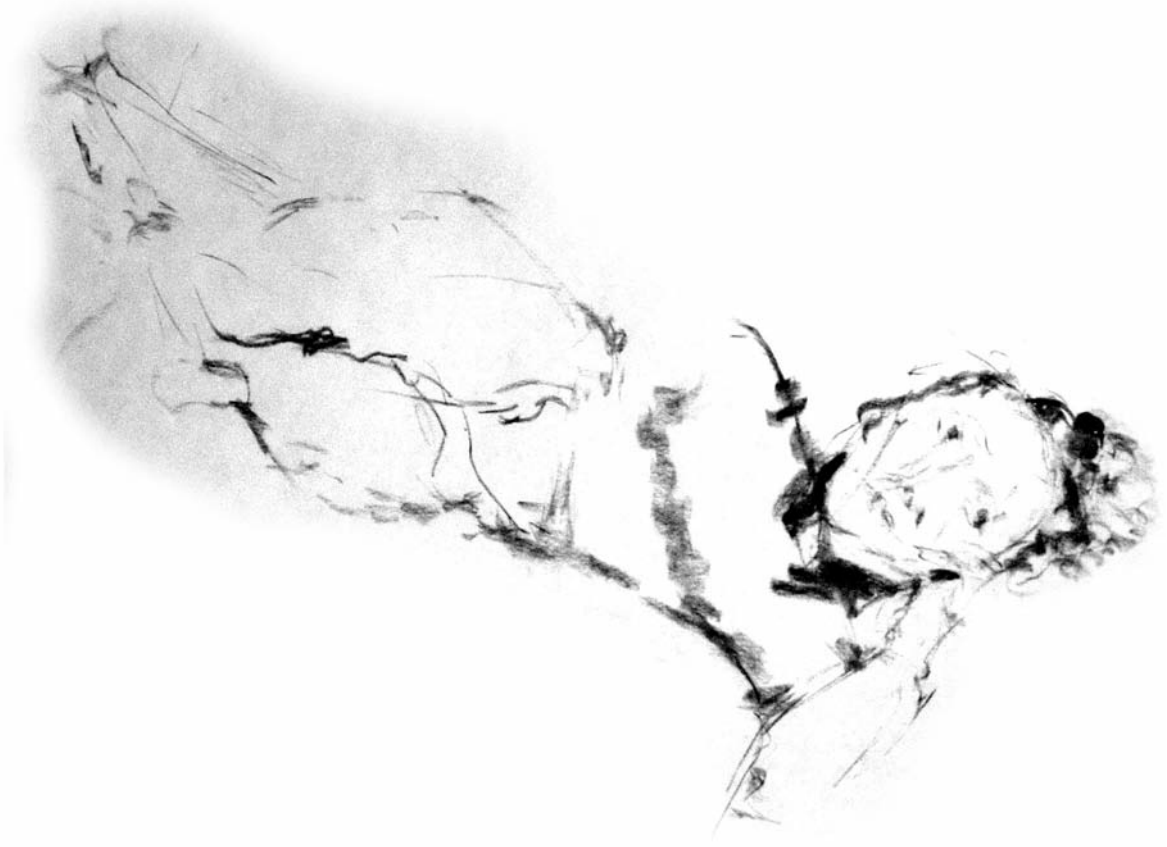
2.12 Recommendations and best practice

Issue	Description	Recommendation	Examples of best practice	Reference
Prison as a response to mental illness	Prison is being used as a dumping ground for women suffering from mental illness.	Better assessment of the suitability of prison for women appearing before the courts.		Section 2.2
The cycle of imprisonment	Prison often becomes part of a unbreakable cycle of offending, conviction and imprisonment.	Prioritise resettlement assistance for women following a period in prison.	**Clean Break** Founded in 1979 by two women prisoners at HMP Askham Grange, Clean Break is the only theatre company in the UK for women who are, or have been, in contact with the criminal justice system. Its aims include expanding the skills, education and employment opportunities for women prisoners, ex-prisoners and ex-offenders, producing high quality original theatre to provide a powerful and unique voice for these women and educating the public on issues surrounding women and crime. Every year more than 70 women take part in Clean Break's programme, based in north London. Many gain qualifications in the arts and progress to higher education, employment, work placements, further training or volunteering – all key factors in reducing the risk of re-offending. *"Clean Break is the only service of its kind available in the UK but its resources are stretched and it is unable to meet the needs of all the women who could benefit from its programmes. Women who are not released in the London area, for instance, are especially ill provided for."*[140]	Section 2.4

140. Baroness McIntosh of Hudnall addressing the House of Lords: *House of Lords Hansard*, debates for 28 October 2004, column 1456.

Issue	Description	Recommendation	Examples of best practice	Reference
Imprisoning mothers	The imprisonment of women has a disproportionate impact on children and families and is believed to be a factor contributing to deaths of women in prison.		• In the Netherlands, women with responsibility for children who receive a prison sentence are allowed to return home before starting their term of imprisonment. This provides them with time to make suitable arrangements for the care of their children during their absence. It allows mothers to say good-bye, avoiding an abrupt disappearance which can be very distressing for children.[141] • In Germany, women are housed under curfew with their children in units attached to prisons but located outside the gates.[142] • In Russia, mothers of children aged under 14, convicted of all but the most serious offences, are routinely given a suspended sentence until the child reaches the age of 14.[143]	Section 2.5
The role of courts	A lack of understanding amongst sentencers of the prison environment and its potential impact on the women that appear before them.	Sentencers should be required to make regular visits to women's prisons and facilities providing alternatives to prison.		Section 2.8.2
Public attitudes to sentencing	Public attitudes on sentences are often based on inaccurate or sensationalised media reports.		**SmartJustice for Women** SmartJustice is a five year campaign to reduce the overall prison population. It aims to increase confidence in alternatives to custody. It finds out what the public really thinks about the use of prison and feeds this to policy makers. The campaign uses the media and well-known personalities to spread its message. School visits are undertaken and information on custody alternatives is available on their website. A number of targeted campaigns are being run including SmartJustice for Women. This campaign aims to send out the message that locking up women does little to reduce their offending and promotes the use of alternatives to prison. Spokespersons for this campaign include Michelle Collins, actress and well-known character from the soap opera East Enders.	Section 2.9

141. *Ibid*, column 1468.
142. *Women and the Criminal Justice System A Report of the Fawcett Society's Commission on Women and Criminal Justice System, op cit*, p50.
143. *Ibid*.



Part 3: Dying inside

"Women will continue to die while prison is used inappropriately as a place to house those with mental health and drug problems. This does not negate the duty of care that prison owes to those in its custody. It continues to be very alarming that they fail in this duty."[144]

3.1 Introduction

Regardless of whether families believed the decisions to imprison the women were appropriate, they had serious concerns about the treatment and care provided to the women while they were in prison. In this part of the report we identify the failings in the care provided and how these failings contributed to the women's deaths. We consider systemic issues including: the management of the women's prison estate and the policies in place to deal with women identified as at risk of suicide and self-harm; drug withdrawal and detoxification; and family contact in prison. We also look at staffing issues, events immediately prior to the women's deaths, and the impact of the prison regime on the lives of the women who died.

3.2 Management of the women's prison estate

In 1999 the government announced that the women's prison estate would be managed separately from the men's estate. This was in response to the rapidly growing female prison population and the then HM Chief Inspector of Prisons Sir David Ramsbotham's report *Women in Prison: A Thematic Review.* The report had recommended that the women's prison system be managed as an entity by one director with responsibility and accountability for all that happens within the women's estate.

This arrangement lasted until November 2003 when the government announced the disbandment of the separate female prison estate. From 1 April 2004 the 17 women's prisons (and two women's wings attached to male prisons) were integrated, for management purposes, within their geographical areas.[145]

This move was justified on the basis that managing the prison population by geographical area would allow greater scope for addressing women's offending behaviour and resettlement needs. Under the new arrangement, the Women's Policy Group within the Prison Service Directorate of Operations provides support on gender-related issues to area managers.

Due to the small number of women's prisons, any gender-specific issues arising in women's prisons are easily sidelined as they do not affect the majority of prisons within any geographical area.[146] Managing prisons by geographical location also makes it difficult for knowledge to be shared across the women's estate, particularly in relation to deaths in custody. The move has been widely criticised.

---

144. *Funeral of Young Black Woman Found Dead in Holloway Prison*, 2000.
145. *Rehabilitation of Prisoners: First Report of Session 2004-05, Vol. 1*, 2005, p88.
146. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.

"It is regretted that the separate management of women's prisons has been moved back under the control of area managers, which means that the specific needs of women inevitably receive less attention and we know of inconsistencies in regime and management between prisons in different areas."[147]

3.3 Trigger events

In a number of cases, women died following a distressing event or incident. While suicide is multi-dimensional and usually the result of a number of factors, certain incidents appeared to trigger the women taking their own lives.

- A 28-year-old woman was pregnant while in prison. She was transferred to hospital due to complications with the pregnancy and subsequently lost the baby. She was immediately placed back in prison and hanged herself three days later.
- At least three women died following incidents relating to relationships in prison including break ups and being transferred to prisons away from their girlfriends.
- A 27-year-old woman died the day her bail application failed. Evidence was given at the inquest into her death that this can be a time when women are feeling low, overwhelmed and at risk of suicide.
- A number of women died shortly before sentencing.
- Harsh or unexpected sentences were particularly devastating when the woman involved was very young and her case had received media coverage. Families believe additional support should be offered following sentencing, failed appeals or bail applications.

Case study

A 22-year-old woman was charged with armed robbery. She had no prior convictions and denied her involvement in the crime. The woman thought she would receive a community sentence order or fine as this is what everyone kept telling her, including her solicitor, probation officer and prison staff. Instead she received a prison sentence of nine and a half years.

While on remand the woman repeatedly told her family and prison staff that should she receive a prison sentence, she would kill herself. During this time she was placed on suicide watch.

Evidence of her vulnerability was overwhelming during her arrest and trial. The woman's pre-sentence psychiatric report described her as "depressed … at risk of self-harm" and "vulnerable".

On the day of sentencing, the woman's solicitor told prison staff to keep an eye on her and the court escort service kept her on suicide watch.

Following sentencing the woman returned to prison where she was not put on suicide watch. Her family had difficulty contacting her or prison staff to discuss their concerns that she was suicidal. A nurse gave her anti-depressants and asked her if she would do anything to herself, to which she replied no. That night she spent four hours with a listener. The next morning she was dead, hanging in the closet in her cell. Records show that prison staff barely checked on her in the 24 hours she was in their care.

147. Baroness Linklater addressing the House of Lords: *House of Lords Hansard*, debates for 28 October 2004, column 1470.

3.3.1 Entering prison

Entering custody can be an event that triggers a woman taking her life. As discussed in section 1.4, the majority of women died in the early stages of custody. In their report on deaths in prison, the JCHR concluded that "a confluence of six factors… combine to place women prisoners at especial risk in the first few hours of being placed in custody". These can be summarised as follows:[148]

- Many women prisoners are mothers and coping with the trauma of separation from children. They often arrive at prison very late in the evening. Only then are they asked about childcare arrangements, adding to their anxiety.
- The design of prison can exacerbate risk of self-harm or suicide as it is difficult for prison officers to observe vulnerable women.
- Women's sentencing patterns (short, frequent sentences for minor offences) mean that their lives and families are disrupted without a realistic chance of addressing the cause of their behaviour.
- Women prisoners are vulnerable in any event – often having mental health or drug dependency problems and being the victims of physical and sexual abuse.

A Prison Reform Trust report on women on remand describes inadequate support in the early days of custody, poor drug treatment at a time of urgent need, extended periods of time locked in the prison cell, little purposeful activity and inability to maintain contact with families.[149] It also raises the importance of first night centres and designated support at this time. These factors have been identified as contributing to deaths, placing women on remand at considerably high risk of dying as the case studies in this report testify.

3.3.2 Transfers

"Transfers are a really strong example of the loss of autonomy experienced by women in prison. They are usually done on short notice. Women are often halfway through courses and have to leave. There appears to be no sensible management of transfers. The continual re-roling of women's estates into male prisons means that transfers will keep occurring."[150]

> "It was done in a total absolute mess. They couldn't have done it better if they wanted to ensure that she was going to kill herself!" (Partner of a 48-year-old woman who died)

Transfers were a trigger event in at least seven deaths. Inquest verdicts were often highly critical of the decision to transfer the woman and/or the management of the transfer. Families believe these transfers, between or within prison establishments, directly contributed to the women's deaths.

---

148. *Deaths in Custody: Third report of session 2004-2005 Vol.1, op cit,* p22.
149. *Lacking Conviction: The rise of the women's remand population, op cit*, pp19-20.
150. *Ibid*. See below for further discussion of the re-roling of women's prisons.

Case study

A decision was made to transfer a 48-year-old woman serving a life sentence from HMP Holloway to HMP Durham. This decision was made by Holloway's newly-appointed life sentence governor with little knowledge of the woman and no consultation with staff who knew the woman well.

The woman had developed a dependency on HMP Holloway where staff were able to manage her self-harming and suicidal behaviour. Prior moves within or between prison establishments were known to have caused the woman distress and resulted in an escalation in her self-harming behaviour.

The woman was transferred first to HMP Foston Hall and then to HMP Durham. Minimal preparation for the transfer was made. She was told she was going to Foston Hall only a few hours before she went and was never informed that she would be moving from there to HMP Durham. This did not allow for her concerns to be dealt with or the other prison to be informed about her need for extra care following a transfer.

Evidence given at the inquest into this woman's death showed poor communication between the various prison establishments. The governor at HMP Durham said he understood the woman's mental health and self-harming problems to be under control. He was also thought the woman knew where she was being transferred. The life sentence governor at Holloway said that she gave HMP Durham a 'warts and all' picture of the woman.

The woman spent five days in HMP Foston Hall in a highly distressed state. She refused to eat and drink and again began to self-harm. To reduce the potential for further distress, the governor of Foston Hall sent the woman to HMP Durham in a prison vehicle with escort instead of a cellular van. HMP Durham was not informed that the woman would be arriving like this. In consequence her reception was rushed.

The reception nurse was unaware the woman was on self-harm and suicide watch as she did not have access to the relevant documentation. As a result no level of supervision for this watch was set and no review was carried out. In fact, no one at HMP Durham looked at the woman's extensive file until after her death. She hanged herself after two days at this prison.
The jury at the inquest returned a verdict finding a serious failing in the prison system to satisfactorily complete planning and preparation for the woman's transfer from HMP Holloway to HMP Durham; a failure to provide adequate information to HMP Durham so that they could properly assess the woman's risk of self-harm; and a failure to assess the woman's risk of suicide and self-harm when she arrived at HMP Durham.

"Best practice would have been telling wherever she was going that she is going to probably need 24/7 care for a bit until you see how she is going to settle. She was almost certain to make a suicide attempt simply because she was being moved… There was no preparation. It comes down to good practice – good preparation…there should be a list of directives – 'has this been done?' – before the movement order is issued. They could do that without a lot of trouble because they have to issue the movement order anyway." (The woman's partner)

The negative impact of prison transfers led some families to question the necessity of moving women.

Case study

A 24-year-old woman was serving a four month sentence for theft at HMP Holloway. Approximately two weeks into her sentence, a doctor assessed her as being at serious suicide risk and suggested she be transferred to in patient healthcare. This never happened. Rather, on the same day she was assessed as fit to travel and moved to HMP Foston Hall as part of an overcrowding draft.

At Foston Hall she was moved to segregation where she was found with ligature marks around her neck and subsequently moved to an unfurnished room and put in protective clothing. She is recorded as having said she had "enough of being shipped around". Despite this, a few days later she was transferred again to HMP &YOI Styal where she died after six days.

The investigation into her death found that resettlement of the woman at Styal prison was poorly managed. At the inquest into her death, the jury returned a verdict critical of the transfer. It found that the lack of communication between staff within Styal and between other establishments had contributed to the woman's death.

Case study

A 20-year-old woman died after being transferred to HMP Durham. The woman was one of only six women being held in this establishment. The woman had a long history of self-harm, however her family noticed a further decline in her mental state following the transfer. Her mother believes a more appropriate transfer for her daughter would have been to a secure hospital.

More than 18 months prior to this woman's transfer, HMIP had strongly criticised HMP Durham for its poor facilities, inability to provide women with work or any purposeful activity and recommended its immediate closure.[151]

Overcrowding often results in transfers as prisons have to find places for new prisoners. The constant changing of women's prisons into male establishments also means transfers within the women's estate continue to occur. Frequent moves within or between establishments are distressing and destabilising for women, particularly when the woman has already been identified as volatile or vulnerable and the transfer occurs because the prison wing or establishment is unable to cope with her.[152] Any support networks or education and training established in the original prison are stopped when women are transferred to other prisons.

---

151. See Section 5.4 of this report for further discussion on the closure of Durham prison.
152. Interview with Kimmett Edgar and Juliet Lyon, 6 December 2005.

Between 1990 and 2007, seven women's prisons were re-roled – HMP & YOIs Brockhill and Bullwood Hall and HMPs Buckley Hall, Cookham Wood, Edmunds Hill, Highpoint and Risley. This required the transfer of women to other prisons. In these circumstances, it is crucial, and a matter of priority, that lessons be learned from past experiences. Transfers should only be carried out when absolutely necessary and conducted with greater care, planning and follow-up.

These re-roles are concerning for a number of other reasons:

- Greater capacity within women's prisons has been identified as a contributory factor in the reduction in deaths in 2005. Re-roles, unaccompanied by a reduction in the number of women being sent to prison, reintroduces the problem of overcrowding in the women's estate.[153]
- Brockhill was the only prison for women in the West Midlands – the second largest probation area in the country. Eighty per cent of women at Brockhill lived within 50 miles/80 km of the prison. Many were trying to maintain contact with families and dependent children.[154] Moving women to prisons further away makes this increasingly difficult. The consequence of this re-role was that women from the north west and Essex were sent to prisons even further away from their support networks, family and friends furthering the risk of suicide and self-harm amongst a group already recognised as highly vulnerable.
- A brand new purpose-built detoxification and healthcare centre was recently built at Brockhill.
- Women in these prisons may be engaged in counselling and rehabilitation programmes and re-roling leads to a curtailment of these programmes.

Problems also arise when prisons change their status. For example, when HMP Foston Hall took on an additional role as a local prison, it went from a prison with a relatively settled and stable population to one which had to manage a remand population. HMIP's report on its inspection of Foston Hall in May 2007 raised concerns that self harm procedures were not robust enough to deal with the levels of self harm and vulnerability among women on remand. The report commented on a high use of force, often to remove ligatures from women. Clearly the consequences of this change had not been thought through nor were the necessary safeguards put in place.

3.3.3 Establishments

Prisons vary due to location, management, culture, facilities and the nature and size of the prison population. For example, HMP Holloway has the difficult job of being the main local women's prison for

153. *Ibid*.
154. *Annual Report of HM Chief Inspector of Prisons for England and Wales 2004-2005*, 2006, p50.

London. Women frequently go in and out and the prison deals with some of the most severely mentally ill and substance abusive prisoners in the women's prison estate.[155]

HMCIP described local prisons as being "*at the sharp end of prisoner vulnerability*"[156] and expressed concerns that

"Detoxification, mental health problems and adjusting to the trauma of imprisonment mean many prisoners in local prisons need a form of intensive care in the early days – which few local prisons are resourced to provide."[157]

Inspections of local prisons continue to reveal endemic overcrowding, poor quality purposeful activity and inadequate time out of cells.[158]

Eight of the seventeen local women's prisons where deaths occurred between 1990-2007 still operate today. The others have had the women's section closed or have been re-roled as male prisons.[159]

In some cases, families believe the environment at a certain prison or the decision to send a woman to a particular establishment contributed to her death.

- A 20-year-old woman on remand for breach of a community rehabilitation order arrived at HMP Styal after being 'locked out' of HMP Brockhill because it was full. Her parents believe she had been settled at Brockhill, where she had spent time on remand, but was extremely anxious about being sent to Styal. She died after two days.
- During the investigation into the death of a 32-year-old woman in Durham prison, a fellow prisoner described how the woman's behaviour changed when she was moved from HMP Holloway to HMP Durham:

"She never used to cause trouble in Holloway. I think Durham is such a small place you are in each other's face all the time. You can't go nowhere. You can't lock yourself in your room because you are padded up with someone."[160]

This woman was one of four women to die at HMP Durham in a nine month period.[161]

---

155. Interview with Cathy Stancer, 25 November 2005.
156. *Annual Report of HM Chief Inspector of Prisons for England and Wales 2004-2005, op cit,* p14.
157. *Ibid.*
158. *Ibid.*
159. HMP Durham, HMP Edmunds Hill, HMP Highpoint, HMP Risley, HMP Bullwood Hall, HMP Brockhill, HMP Buckley Hall and HMP Cookham Wood are no longer part of the women's prison estate.
160. Comment made by fellow prisoner at HMP Durham during post-death investigations into this woman's death. Published in the PPO report into her death.
161. See Section 5.4 for further discussion on HMP Durham.

3.3.4 Extended periods of time in a cell

> "Her punishment was being locked up from society. You don't lock them in a cell. The day before she died she was in 23 hours out of the 24…when I questioned it, they said simply because there was not enough staff and I said that's not good enough. You can't do that to people and then expect them to get through a sentence perfectly sane, nobody to talk to, locked in a cell 23 hours out of 24 – that would drive me insane, let alone somebody that is coming off drugs." (Mother of an 18-year-old woman who died in prison)

"Permanently being behind your door and not having any human contact is very distressing." (Serving prisoner giving evidence at the inquest into the death of a 22-year-old woman)

In a number of cases women were locked in their cells up to 23 hours a day in the period immediately prior to their deaths. Families believe this extended period of time alone in a cell contributed to these deaths, particularly in cases where the woman was self-harming or withdrawing from drugs. In her 2003-2004 annual report, HMCIP noted that despite the recent suicides in HMP & YOI Styal, women on remand could spend 19 hours in their cells each weekday.[162]

Five of the six women who died in Styal between August 2002–August 2003 were women on Waite Wing.[163] The investigation into these deaths identified women on Waite Wing as more at risk of self-harm and suicide than those held elsewhere in the prison.[164]

Case study

A 24-year-old woman hanged herself over the August bank holiday weekend. She had been in prison only three days and there was no association over this period. The woman left a note indicating her inability to cope on the long weekend without time out of her cell on association.

The Prisons and Probation Ombudsman (PPO) report on Styal found that women on Waite Wing spend most of the time locked in their cells, where most meals were eaten and apart from in-cell television, there were few other ways of occupying time.[165] The report recommended that the governor establish a review with a remit to improve time out of cells and maximise access to structured activities on the wing.[166]

An inspection of Styal in 2005 revealed these improvements had taken place in all areas of the prison except Waite Wing, where "women could expect no more than five hours a day out of their cells,

---

162. *Annual Report of HM Chief Inspector of Prisons for England and Wales 2003-2004, op cit,* p52.
163. Waite Wing is where women on remand/unsentenced women are held in HMP & YOI Styal.
164. *The Styal Report - The death in custody of a woman and the series of deaths in HMP/YOI Styal August 2002–August 2003,* 2005, p40.
165. *The Styal Report - The death in custody of a woman and the series of deaths in HMP/YOI Styal August 2002–August 2003, op cit,* p41.
166. *Ibid*, p42.

with little opportunity for productive activity, outside the CALM centre, during that time."[167]

Overall, activities in prison remain fairly gendered. For example, embroidery is offered across the women's estate. At one prison, women had to have undertaken an eight week sewing course to be eligible for one of the five spaces available to learn hairdressing.[168]

Activities can also be very limited. HMIP's inspection of HMP & YOI New Hall in 2003 revealed an "inadequate" library with static stock, a limited education system and lack of access to the gymnasium – 93% of women said they had no access to the gym at all. Facilities to occupy the time of women when out of cells were described as "poor".[169] In 2004-05 there were four self-inflicted deaths at New Hall. An unannounced inspection of the prison in 2006 found improvements in the quality and quantity of purposeful activity at the prison, with improvements in education and physical education in particular.[170]

3.3.5 Bereavement

In a number of cases women who died had experienced the death of someone close to them. The death was often due to unnatural circumstances including suicide, murder or a drug overdose. It is not uncommon for women in prison to have experienced a number of losses and be deeply affected by these deaths.[171] Past research has found that bereavement may be a factor contributing to women in prison taking their lives.[172] A community-based study found that the suicide of a family member may increase an individual's long term risk of suicide.[173]

- A 22-year-old woman died in prison. Her father committed suicide when she was ten years old.
- Both parents of a 48-year-old woman who died in prison had committed suicide.
- A 20-year-old woman was receiving bereavement counselling in prison when she died. Her grandfather and girlfriend had both recently died.

A number of women in prison have been cared for by grandparents throughout their lives. Despite this, women are unable to attend the funeral of a grandparent as prisoners are only allowed

---

167. *Report on an unannounced full follow-up inspection of HMP/YOI Styal 26 October – 4 November 2005*, 2006, p7.
168. Interview with Cathy Stancer, 25 November 2005.
169. *Report on an announced inspection of HMP/YOI New Hall 10-14 November 2003, op cit,* pp16-17.
170. *Report on an unannounced short follow-up inspection of HMP/YOI New Hall 20-23 March 2006*, 2006, pp11-12.
171. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.
172. 'Learning from 'near misses': Interviews with women who survived an incident of severe self-harm in prison', *op cit*, p58 and 'Self-inflicted deaths of women in custody', *op cit*, p37.
173. Interview with Louisa Snow, HM Prison Service, 1 September 2005.

to attend the funerals of parents. This potentially denies these women an important part of the grieving process.[174]

Given that bereavement may be a contributing factor in a suicide, it is imperative that prisoners be provided with appropriate counselling and support following news of a death while in custody. The Thematic Review on Women in Prison found that,

"Women prisoners are often deeply rooted in their outside lives and a bereavement whilst in custody is profoundly shocking. It is essential that every establishment has some provision for bereavement counselling."[175]

Some of the women who died were in prison for murder. In cases where they killed an abusive partner, bereavement may be complicated by feelings of guilt.[176] Women may be arrested and imprisoned straight after their offence. Untrained prison staff have to deal with the post-tramatic shock these women can experience.

Bereavement counselling is very helpful when provided.[177] Unfortunately it is often provided on an ad hoc basis in women's prisons and is funding-dependent.

"It is clear that women like these would benefit from bereavement counselling. They often try to cope outside prison by resorting to alcohol or drugs. Often their offences can be linked to the deaths and are committed in a desperate attempt to draw attention to their confusion and unhappiness. Once in prison, sometimes in single cells, they have the time but not the personal resources to make sense of their lives and the losses they have experienced."[178]

Case study

A 29-year-old woman was charged with moving a dead body. She was very traumatised by the events leading to her arrest. She told prison staff that every time she closed her eyes, she was haunted by the face of the dead body and requested bereavement counselling. She hanged herself before her first session.

Case study

The mother of a 22-year-old woman was herself a serving prisoner when her daughter died in prison. The bereavement counselling she initially received stopped due to limited funding. Only after transferring to an open prison did her access to bereavement counselling resume. This counselling was provided by an outreach service concerned specifically with suicide-related bereavement.

3.3.6 The impact of other deaths in prison

Some of the women who died in prison witnessed or were involved in the events surrounding the death of other women in prison. It is unknown whether these women received bereavement counselling.

---

174. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.
175. *Women in Prison: A thematic review by HM Chief Inspectorate of Prisons, op cit*, p89.
176. Jennifer Woolfenden's report on her work at Holloway prison, in correspondence with INQUEST, 14 July 2004.
177. Interview with Cathy Stancer, 25 November 2005.
178. Jennifer Woolfenden's report on her work at Holloway prison, *op cit.*

Case study

A 23-year-old woman hanged herself in prison. Her cell was so tiny staff had to move her into the corridor to perform CPR. The woman vomited non-stop and resuscitation was unsuccessful. The prison investigation report into this woman's death found that moving her into the corridor added to the distress of staff and other women on the wing. There were mixed reports on the support received by prisoners and staff after the event.

Case study

A 39-year-old woman died following a drug overdose. Along with other prisoners she had stolen the drugs from the prison medication trolley. None of the other women died although they all became ill and were rushed to hospital.

Returning to prison, they received little or no counselling or support. The woman who shared a cell with the deceased said the officer walking her back to her cell asked her if she was OK and that was all.

Some of the other prisoners gave evidence at the inquest into the woman's death. Their treatment at the inquest was deeply concerning. The women gave evidence with little support. Despite being obviously emotional, they were not even provided with water or tissues. They had to answer very detailed questions which they found highly distressing. They were under the influence of the drug at the time of the death and could barely remember the events. One woman gave evidence for two hours and she was crying, distressed and extremely confused throughout.

Of greatest concern was the suggestion put to these women by Prison Service lawyers that they were responsible for the death of their friend.

After this harrowing experience most of the women were sent back to prison. Apart from the presence of prison escorts no one else was there to assist them. It is also unknown if the women had either been prepared for the inquest or given support afterwards.

- An 18-year-old woman who hanged herself in prison was in the cell opposite a woman who hanged herself a few months prior. She witnessed the body being carried away and gave evidence during the investigation into the death.
- A 35-year-old woman had been summonsed to give evidence at the inquest into the death of a woman who had died one year earlier. She was so distressed at this prospect she was excused from attendance at the inquest. When she later died in turn, another prisoner agreed to clean out her cell. This woman subsequently took her own life.

According to the Prison Service, additional support for other prisoners is put in place when a prisoner dies including case reviews of any women already identified at risk of suicide or self-harm at the time of the death. The Samaritans are brought in and counselling is provided.[179] Women who shared a cell with the deceased and women in the cells next to, above or below women who die are identified as 'at risk' and closely monitored.[180]

Some women also witnessed resuscitation attempts and other prisoners being cut down from ligatures. This may contribute to a further deterioration in the mental state of already vulnerable women.

179. Interview with Louisa Snow, HM Prison Service, 1 September 2005.
180. Evidence presented at the inquest into the death of a 22-year-old woman.

3.3.7 Cell sharing

Fewer deaths occurred when prisoners shared cells.[181] This is thought to be because women sharing cells can alert staff with concerns about each other and be a source of support and understanding.[182]

Although cell sharing can act as a protective measure against suicide, each share needs to be carefully and individually assessed.

Forced cell sharing due to overcrowding can place lives at risk. As the female prison population rises, 'doubling up' has become common practice. Single cells are often fitted with bunk beds to house two prisoners. This practice occurs across the prison estate and has lead to many young adults being held in conditions that are "cramped, unhygienic and unhealthy".[183]

In some cases, the decision to allow or deny a woman to share a cell is believed to have contributed to her death.

In no circumstances is support from another prisoner an appropriate substitute for professional care and monitoring of some of society's most vulnerable women. Given that some women have been imprisoned because they are deemed a threat to others in society, the suggestion that cell sharing can be used for this purpose is also ironic.

The investigation report into the death of a 39-year-old woman following an overdose of an anti-depressant found,

Case study

A 37-year-old woman was assessed as unsuitable to share a cell. Despite this, she was accidentally placed with another prisoner. When the mistake was realised she was moved to a single cell. This greatly distressed the woman due to the relationship she had formed with the other woman in her cell, and she was already highly distressed as she was experiencing severe drug withdrawal symptoms following a rapid detoxification programme.

At the inquest into her death a narrative verdict was returned stating that the decision to remove the woman from the double cell and place her in a single one should have been reconsidered and was a factor contributing to her death.

Case study

A few days prior to her death, a 32-year-old-woman (Prisoner A) was moved from a single to a double cell. She was given three cell sharing options. One was with a woman (Prisoner B) with whom she had a fight two weeks prior. The fight arose because Prisoner B was involved with Prisoner A's former girlfriend. It resulted in both women being disciplined. Prisoner A chose to cell share with Prisoner B. While cell sharing, they had another fight and Prisoner A was moved to special accommodation to calm down. She was then moved to a holding cell pending adjudication where she hanged herself.

An officer interviewed during the investigation into Prisoner A's death stated that the decision to put these two women together was like "putting fuel in the fire". Given the history of their relationship, it is difficult to see how a cell share for them was ever an option.

181. 15% of women died in shared cells compared to 68% in single cells. In 18% of cases cell type of the deceased women was unknown.
182. Interview with Louisa Snow, HM Prison Service, 1 September 2005.
183. *A Lost Generation: The experiences of young people in prison, op cit,* p9.

"It appears to be commonplace for a cellmate to be asked to call for assistance when a prisoner is unwell. Delegating vigilance to a cellmate raises difficult issues the Prison Service might wish to reflect on."

At the time of this death, the woman who died and the woman she was sharing a cell with were both detoxifying from long-term drug addictions and experiencing severe withdrawal symptoms.

There is also evidence of women learning to self-harm and tie ligatures from other prisoners, encouraging each other to self-harm and making suicide pacts. While this occurred among prisoners not sharing cells, it was more common amongst women who did.

Case study

Two women were moved into a cell together so that they could provide mutual support for each other. They had been on the prison's psychiatric wing together. Prisoner A was on an open F2052SH. She had a history of self-harm and suicide attempts. Prisoner B was depressed, volatile and extremely anxious. A decision was made not to place her on an open F2052SH partly because she was in a shared cell and could be watched by Prisoner A and staff.

The women made a suicide pact and on occasions tied ligatures together. Prisoner A (on the open F2052SH) assaulted Prisoner B, who was moved to a single cell where she hanged herself the next day.

3.3.8 Bullying

In some cases, families were aware of incidents of bullying by other prisoners and/or prison staff in the period prior to the woman's death and believed this contributed to the death.

In cases where families believed bullying between prisoners contributed to the death, it was usually physical and often very serious. Bullying between prisoners appears to occur for a number of reasons including: prison relationships breaking up;[184] access to drugs in prison; boredom; the punitive nature of the environment; and a desperate attempt to hold onto and assert some kind of power in such a disempowering environment.[185] In the course of conducting this research we were also told that it can also be a strategy employed by prison staff, however much it is denied, to divide the prisoners amongst themselves.[186]

Prisons have anti-bullying strategies and programmes in place. It can be difficult for women to avoid each other in prison and this underlines the importance of a prompt, effective response to threats or incidents of bullying.

---

184. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.
185. Interview with Natasha Vromen, 7 December 2005.
186. Comment provided by Professor Joe Sim, Professor of Criminology, School of Social Science, Liverpool, John Moores University; interview with the family of a 19-year-old woman who died in prison.

Case study

Arriving in prison a 22-year-old, Prisoner A, feared being bullied by another woman, Prisoner B, already in the induction unit over an incident outside prison. The prison investigated her concerns, which proved to be valid, and a decision was made to keep Prisoner A "behind her door" until Prisoner B finished her induction programme the next day.

This meant that shortly after arriving in prison, this young woman was locked in a cell, alone, for 24 hours. She left the cell briefly – to make a phone call, visit the prison doctor and get some hot water.

Prisoner A was a long term heroin user. Drugs and alcohol create an even greater risk of suicide and self-harm in the early stages of custody. She hanged herself, locked in the cell, less than 48 hours after arriving in prison.

Prisoner A's family questioned why the prison had responded to her fears of being bullied by locking her alone in a cell for an extended period of time. The family believes the most effective way of keeping Prisoner A safe would have been to take action against Prisoner B, who had admitted to staff that there would be trouble.

At the inquest the jury agreed. They found that a number of issues relating to Prisoner A's arrival and short stay at the prison affected her already fragile state of mind negatively including the decision to segregate her. Insufficient consideration was given to the potential risks to Prisoner A's safety from other prisoners and her own concerns were underestimated.

3.3.9 Racism in prison

While black women are under-represented in self-inflicted death rates among women in prison, as discussed in section 1.4 above, the black women who died in prison were often victims of racist bullying.

Case study

A 20-year-old woman of mixed race was moved from the prison psychiatric wing to the young offender wing, where she was repeatedly physically assaulted. The report into the woman's death concluded that her suicide was the tragic and unintentional consequence of a desperate attempt to be moved back to the psychiatric wing. Her family agreed with this conclusion.

The report into this woman's death stated that there was "some indication of a kind of race war taking place on the unit" and this particular incident was part of it. The report also found that women were frequently taunted and abused by other prisoners when moved from the psychiatric wing to other wings within the prison. This is a source of concern as it is preferable to house all prisoners on residential wings.

Case study

A 20-year-old black woman hanged herself on remand. While serving a previous 18-month sentence, the woman had made a complaint against a prison staff member for racially motivated abuse and assault. This complaint was never investigated. When she returned to prison she had further problems with this officer.

At the inquest into the woman's death, the jury returned an open verdict. The jury answered 'no' to the coroner's question on whether the Prison Service adequately investigated the woman's complaint of racially motivated abuse and assault. Following the verdict, the coroner announced that he would be writing to the Secretary of State to make recommendations under rule 43 relating to the following issues:

HMPs should ensure that there is an adequate system for investigating prisoners' complaints, especially where they touch upon the suitability of staff to have direct prisoner contact.

HMPs should ensure, as far as practicable, that all prison staff with direct prisoner contact are trained in suicide awareness.

HMPs should ensure that systems for the supervision of and accounting for prisoners on residential wings are both in place and properly used.

3.3.10 Foreign national women in prison

Self-inflicted death rates among foreign national women in prison are low. This is surprising given their exceptionally vulnerable position in prison – the majority of foreign national women in prison are serving very long sentences for drug importation despite being first-time offenders. Others are imprisoned for having illegal documentation. They are often single mothers with backgrounds of extreme poverty and exploitative and abusive relationships. These women face an isolation and loneliness that far outstrips their British counterparts[187] and are usually thousands of miles away from home and loved ones and exceptionally anxious about their children. Foreign national women in prison have an average of three children. Many of their children are killed, prostituted or driven to crime following their mother's imprisonment. Children may be thrown on to the street by landlords or their houses burnt down by drug lords, angry at the woman's arrest and failure to complete her mission. The women themselves may be at risk of being killed should they return to their countries because of the debt owed as a result of the drugs being seized.[188]

In prison, foreign national women experience a strange climate, language, food, culture and a generally hostile environment. They are often victims of racial bullying and racist treatment by other prisoners and prison staff.

187. Interview with Olga Heaven, 8 June 2006.
188. *Ibid.*

A number of explanations have been offered for the relatively low numbers of self-inflicted deaths among foreign national women. First, they receive support tailored to their specific needs from FPWP/Hibiscus, a charity supporting and campaigning for the rights of foreign national women in UK prisons. Second, they are less likely to display the characteristics putting women in prison at greater risk of death – they are often drug mules, but rarely drug users themselves, and are usually older than the general female prison population.[189] Third, foreign nationals are more likely to take part in the prison's education programmes, providing them with skills and opportunities they may not have in their own country. Prison can be a less hopeless situation for them.[190]

Despite the low rate of self-inflicted deaths, the vulnerability of foreign national women in prison is an issue of serious concern. In 2006, the Inspectorate of Prisons published *Foreign National Prisoners: A thematic review.*

The review identified foreign nationals in prison as a divergent group with a recognisable cluster of specific needs related to language, family links and immigration. These needs are interlinked and can result in isolation, depression and confusion. Family links were identified as particularly important for women prisoners. The review found that prison staff recognised these needs, yet did not realise their severity or have the resources to respond appropriately. The review recommended the introduction of a national policy for the management and support of foreign nationals in prison. The Prisons Inspectorate has been calling for the introduction of national standards for the treatment and conditions of foreign nationals since 2001. To date, the Prison Service has firmly rejected the need for specific policies for foreign nationals in prison.[191]

Racist bullying was an issue in the case of a 32-year-old black Caribbean woman who hanged herself in prison. At the time of her death she was one of fifteen Jamaican drug mules being held at a particular establishment. A number of the black Caribbean women interviewed during the investigation into her death described being bullied by white prisoners. Racism in women's prisons has been described as rife.[192]

3.3.11 Medication

Medication is part of the daily routine in prisons – it is used as part of drug detoxification and to address the range of physical and mental health needs of women in prison. Its use in women's prisons is so prolific, medicalisation is regarded as one of the ideological strands that defines women's imprisonment, today and historically.[193]

---

189. Interview with Natasha Vromen, 7 December 2005.
190. Interview with Cathy Stancer, 25 November 2005.
191. *Foreign National Prisoners: A thematic review*, 2006, p1.
192. Interview with Olga Heaven, 8 June 2006.
193. *Analysing Women's Imprisonment, op cit*, p2.

Many of the women who died in prison were prescribed (or on existing prescriptions for) medication. In some cases the administration of this medication was so negligent it was believed to be a factor contributing to the death.

Case study

A 37-year-old woman's anti-psychotic medication was withheld as punishment for at least two days in the four days prior to her death. The woman was believed to be storing the drug after one tablet was found in her bra. The woman had been a long term user of this medication. In prison she was withdrawing from long term heroin addiction. At the inquest into her death, evidence was given that withholding the drug added to the woman's already anxious and distressed state and should be the subject of disciplinary proceedings. The jury concluded that it was one of the contributing factors that led to her death.

The investigation report into the woman's death recommended that medication must never be withheld from prisoners without a valid medical reason. The incident was subject to a separate investigation, which concluded that the nurse involved made an independent decision to withhold the drug. Equally disturbing was the nurse's defence that withholding medication as punishment was common practice across the prison estate.

3.3.12 Healthcare

> "By the time you get to prison you are mentally and physically exhausted. You've been homeless, sleeping on people's floors, working as a prostitute. You are going down and then end up in prison." (Mother of 22-year-old woman who died in prison and also a serving prisoner)

Many women enter prison with acute mental and physical healthcare needs and yet no coherent or holistic policy is in place to manage their sentences.[194] The issue of women's medical treatment has been a long standing concern going back to the nineteenth century.[195] The use in prison of medication, isolation, surveillance and discipline has had major implications on women's mental and physical health.

In their report on the imprisonment of women and girls in Northern Ireland, Dr Scraton and Dr Moore refer to the research conducted by Margaret Malloch on the treatment of women who use drugs in prison. Malloch found that the emphasis on control and security led to the boundaries between care and punishment of these women becoming blurred:

"The need to monitor the condition of an individual withdrawing from drugs… leads to observation under secure (often strip) conditions… the overall effect is highly punitive. It is a denial of any clinical responsibility for the physical and psychological well being of the person 'in care'".[196]

---

194. *Women, Crime and Poverty,* 1988.
195. *Medical Power In Prisons*, 1991
196. Quoted in *The Hurt Inside: The imprisonment of women and girls in Northern Ireland, op cit*, p33.

While prison managers describe healthcare as being "at the heart of the care provided to women in prison",[197] prisons are not hospitals and have difficulties meeting these needs. In fact, the focus on security and discipline can seriously compromise the healthcare provided to women.[198] In some cases, families believe the provision of inadequate healthcare contributed to the women's deaths.

> "I am devastated by [my daughter's] death. She begged for medical help. I trusted the prison to look after her. I can't understand how she was able to die like this." (Mother of a 20-year-old woman who died after being sent to prison for medical help)

Case study

A 27-year-old woman took 30-40 tablets at one time. Other prisoners were aware of this and informed staff.

The officer informed concluded that the overdose was not serious as the woman told her she was fine. However, she did inform the prison doctor. On his rounds the doctor saw two other women first. His justification was that this was not the first time this woman had overdosed and if she was genuinely suicidal nursing staff should have decided to place her in hospital. He believed responsibility for suicidal women resides with nursing staff. The woman was hanging in her cell by the time the doctor came to see her.

The report into this woman's death concluded that the doctor's behaviour was "breathtakingly bad" and that "if it is indeed the nurses who have responsibility for suicidal patients, with no responsibility residing with medical staff, this is truly appalling and should be exposed as a public scandal."

In some cases the recording of vital medical information was very poor. This is a serious concern given the serious mental and physical health needs of these women.

Historically prison healthcare has been organised outside the NHS. However, there were ongoing concerns that healthcare was not being provided equitably across the prison estate.[199] Since April 2003 responsibility for commissioning prison healthcare has been transferring to NHS Primary Care Trusts (PCTs) and delivered in partnership with the Prison Service to provide prisoners with access to the same quality and range of healthcare services as the general public.[200]

This is yet to be accompanied by changes in the attitudes of prison healthcare staff towards prisoners,

Case study

At the inquest into the death of a 22-year-old woman a prison doctor said that information on this woman's file relating to her medical screening, clinical information and detoxification was so lacking he was unable to provide an opinion on the level of care needed.

197. Evidence given at the inquest into the death of a 39-year-old woman.
198. For further discussion, see section 3.7 on disciplining 'difficult' women.
199. *The Future Organisation of Prison Healthcare*, 1999.
200. *Transfer of prison health to the NHS – update March 2003*, 2003.

which has been described by some as disrespectful.[201] Other experts describe the frustration experienced by prison healthcare staff as they attempt to provide medical care in an environment that prioritises punishment.[202]

Under the new system, there is a lack of independence of clinical reviews conducted by the NHS following a death in prison. Effectively PCTs are in the position of investigating themselves resulting in potential conflicts of interest which may jeopardise the quality and thoroughness of their reviews in ascertaining the true circumstances leading to a custodial death.

3.3.13 Mental healthcare

> "Prisoners should be given regular appraisals of their mental state and well-being by fully qualified psychiatric staff, not trainees who should only be present to observe unless under the guidance and supervision of fully qualified staff. Appropriate action should be taken as required. Any decisions taken which could materially affect a prisoner's situation should be fully documented and accountable for future reference." (Father of a 35-year-old woman who died in prison)

> "For part of the time, or actually it was only a few days, [my daughter] was put onto the Reeman Wing, but it does not exist any longer. It was, I think, a 10 bedded psychiatric unit… not run by a psychiatrist, just staffed by nurses, where I think there was a more relaxed regime. She was only there for a few days and it was not because she did not need to be there, it was because they only had ten spaces, so out of hundreds of women in the prison they could only ever take the ten worst cases. Prison staff used to say to her you should be on Reeman Wing, but it was impossible because it was all full up." (Mother of an 18-year-old woman who died in prison)

Families were also concerned that the level of mental healthcare provided in prison was grossly inadequate and contributed to the deterioration in the women's mental state and subsequent death.

Given the extent of mental health problems among the female prison population, it is a serious concern that in some prisons women have limited access to psychiatrists or psychologists, whether working in the prison or brought in from outside agencies.[203]

The 2005 inspection of HMP &YOI Styal found there were no psychologists in the prison.[204] This is a particular problem for women serving life sentences. Without the input of psychologists they are

---

201. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.
202. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.
203. *Annual Report of HM Chief Inspector of Prisons for England and Wales 2004-2005, op cit,* p29.
204. *Report on an unannounced full follow-up inspection of HMP/YOI Styal 26 October – 4 November 2005, op cit*, p82.

Case study

A 25-year-old woman suffering with mental illness returned to prison following a licence recall. She had been in the same prison approximately four months earlier where she had been responding well to medication and treatment by the prison psychiatrist. Returning to prison, there was no psychiatrist and a new GP.

The GP did not access the woman's old medical file which would have outlined her prior treatment and did not listen to the woman when she told him about the medication she had previously been prescribed.

The woman began experiencing a severe deterioration in her mental state. She heard voices and made a number of suicide attempts. She was taken to hospital after she badly cut her wrists with a razor blade. The hospital said she needed to see a psychiatrist when she returned to prison. This never occurred. At the prison she continued to be treated by the GP, the mental health team and, on one occasion, a hospital duty psychiatrist. She made repeated unsuccessful requests for further psychiatric care. At the time, the prison had no regular psychiatrist despite sustained efforts by the prison and PCT to obtain one. The woman hanged herself after four weeks in prison. At the inquest into her death the jury return a verdict of "suicide while balance of mind disturbed."

often unable to reach the targets necessary to move onto the next stage of their sentence.[205]

Access to female doctors should be more widespread throughout the women's prison estate. Many of the women in prison have experienced physical or sexual abuse in the past and do not feel comfortable with a male GP.[206]

3.3.14 Counselling in prison

Providing counselling in prison is problematic for a number of reasons. First, most women are in prison for short periods of time. This means they may be released mid-way though counselling, leaving them vulnerable especially if there is no support plan for them outside. For women on remand, continuity of counselling is almost impossible.[207]

Second, prison is not a safe place. Following counselling sessions, which may be emotional and exposing, women have to go back to life on a prison wing which can be harsh and unsafe. They also have to return to prison cells where they are expected to deal with these feelings alone.

Third, the nature of prison means confidentiality cannot be guaranteed. An organisation working with women in prison has been told of counsellors being made to reveal information discussed by women during counselling sessions. It can also be difficult for women

---

205. *Ibid*, p20.
206. *The Styal Report – The death in custody of a woman and the series of deaths in HMP/YOI Styal August 2002 – August 2003, op cit*, p43.
207. Jennifer Woolfenden's report on her work at Holloway prison, *op cit.*

to approach counsellors confidentially. For example, one prison brings in local community counsellors only on referrals made by senior prison officers.

Fourth, relationships are often central to women's lives and problems. Counselling in prison does not involve other partners or family members. This makes it difficult for women to put into practice much of what they have learned in prison.

While these are not reasons why counselling in prison cannot work, they are factors that need to be taken into account when determining how counselling can be provided most effectively for women in prison.

It has been suggested that it may be better for independent agencies to go into prisons to advocate for and advise women as caseworkers rather than counsellors. This would allow for contact to continue post-release, providing women with support when they are back in the community.[208]

3.4 Staffing issues

Families acknowledge that the often disruptive and destructive behaviour of the women who died would have made it hard, at times, for prison staff to respond effectively.

Prison staff regularly deal with women at risk of killing themselves. They are routinely issued with ligature knives and describe how some women try to kill themselves up to ten times a day and others walk around with ligatures loose around their necks.[209] Evidence was presented to the Joint Committee on Human Rights that staff at HMP Holloway were having to cut down several women from ligatures almost every night.[210] Even against this background, staff attitudes and actions in cases where women have died remain problematic and of great concern.

> "My impression at the start was that they weren't coping and they just had to let it go over their heads. The three words stuck in my mind were incompetence, inefficiency, and complacency." (Mother of an 18-year-old woman who died in prison)

3.4.1 Prison officer attitudes

> "There are all sorts of things [you could do to prevent women from dying in prison]. To even have to think about it gives me mixed feelings, a mixture of anger and distress. Because they are such obvious straight forward things that you shouldn't have to teach another human being, like treat people with respect, don't shout at them, don't swear at them. Quote, "night sanitation system grossly inadequate with women on occasions reduced to

208. Interview with Cathy Stancer, 25 November 2005.
209. 'Some try to kill themselves ten times a day', 2004.
210. *Deaths in Custody: Third report of session 2004-2005 Vol.1, op cit,* p7.

> using plastic bags and rubbish bins" end of quote. I know this off by heart because I am so sickened and disgusted with what is going on… I mean, my cat gets a litter tray if he is locked in at night. I am being very facetious now, but I would like to say, please treat women prisoners with as much respect as you would treat your cat or your dog." (Mother of an 18-year-old woman who died in prison)

During this project, INQUEST met prison officers who are committed to their work and care about the welfare of the women in their trust. However, like prisoners, prison officers are not a homogenous group and INQUEST also came across evidence to the contrary. In some cases, prison officers' attitudes towards the women in their care were so poor families believe they contributed to the women's deaths. This was also reflected by the conduct of prison staff at some inquests attended. Prison staff rarely acknowledged the presence of the family or offered their condolences, and others would sit reading in court while the inquest was going on.

In some cases, allegations were made of abuse by prison staff or inappropriate relationships between staff and prisoners. The potential for abusive or inappropriate relationships is enormous given the power imbalance in the prison environment and the vulnerability of women in prison, many of whom have been victims of abuse all their lives. These relationships are highly unacceptable. When serious allegations are raised they must be addressed as a matter of priority. Failure to do so has been identified as a factor contributing to a number of deaths.

- At the inquest into the death of a 20-year-old woman the jury returned an open verdict. An officer in charge of the woman who died had been the subject of a prior complaint by the woman of racially-motivated abuse and assault. The complaint was never properly investigated. The jury described the complaint investigation as "inadequate."
- A 19-year-old woman was remanded in prison where she died. At the inquest into the woman's death, the jury returned a highly critical narrative verdict. They found that a number of factors contributed to her death. Among the most significant was the decision to transfer her to a wing where she was subject to severe bullying. This transfer was made not in the best interests of the woman, rather due to her knowledge of an inappropriate relationship between a prison officer and fellow prisoner.

A disturbing allegation arose in the investigation report into the death of a highly volatile and vulnerable 20-year-old woman. When the woman informed a prison officer that she was going to kill herself the officer told her to "do it quietly". She was found hanging a few hours later.

> "It's the way they talk to them. The first time [my daughter] was in, just before she was getting released, they said 'oh you'll be back in here again – you all are – you are all a waste of space'...

> I'm not saying all prison officers are the same, but [my daughter] told me there was quite a lot of prison officers who really goad the girls. They were really horrible. They've called them dirty dogs, they've called them drug addicts, nobody wants to know you, you'll never be any good, you'll be in and out of prison all your life… [My daughter] was quite a tough person in the respect that things would just go off her shoulders and she would ignore it but I think when you are locked up and you are hearing day after day after day that you're useless, you're going to be back, there is no hope for you, you are just a drug addict, nobody wants to be with you, eventually you just think that's true and that's what you are... All you get off the prison officers is they're not here to be molly-coddled. We are not talking about molly-coddling children. We are talking about getting these kids back on the straight and narrow so they don't want to feel like dying." (Mother of an 18-year-old woman who died)

Negative attitudes are reflected in the notes made by staff in prisoner observation books and medical notes – attempts at self-harm and suicide were frequently described as "manipulative" and "demanding".[211]

It is common practice for prison officers to refer to women in prison as girls regardless of age. This culture of infantilising women does nothing to assist them in taking responsibility for their actions – a crucial step in breaking self-destructive cycles. The practice would be relatively easy to stop, and would represent a significant attitudinal shift.

The mother of a 29-year-old woman who hanged herself has maintained contact with the prison since her daughter's death. In correspondence with INQUEST she wrote,

> "In truth the most important change I witnessed was the change in beliefs and behaviour of the staff. Their whole attitude to prisoners and their families is now more realistic and more compassionate. Styal prison is now aspiring to become a beacon for other prisons nationwide…[and] presently has strong and enlightened leadership. The governor has in my personal experience been prepared to acknowledge that previously Styal's duty of care was seriously flawed and lives were lost. Now with himself and committed senior officers at the helm of an entirely fresh approach which recognises the need to treat each inmate as an individual with individual needs and this can be reconciled with maintaining discipline. The women prisoners are now more purposefully occupied and valued."

A study into women's deaths in prison found that staff at establishments with the highest suicide rates considered attempted

---

211. Observation book notes referred to in the PPO investigation report into the death of a 27-year-old woman in prison.

suicides and threat of suicide as attention-seeking and manipulative.[212] At prisons with the lowest suicide rates, staff considered this behaviour as a cry for help and an expression of deep distress and provided appropriate support.

3.4.2 The role of the governor

"As the governor it all stops with you. You carry the lives of these women on your shoulders, yet your purpose is not to look after them in a way that will protect them. There is no other institution like it."[213]

Families often singled out the prison governor as the person ultimately responsible for the women's welfare. They believed that a committed and caring governor could affect the woman's experiences in prison. They also felt that governors should, as far as it is reasonable, be accountable for the behaviour of the officers in the prison.

Families often had frustrated dealings with governors. Consistency of contact was difficult as governors were often moved to other prisons at short notice. Families complained of governors not following up concerns they had raised with them, some of which were directly related to the woman taking her life. For example, failing to follow through on a promise to provide a woman with much needed psychiatric care. Families described how the women in prison had similar experiences dealing with prison governors.

The role of a prison governor is unique. Experts agree that a good governor can have a positive impact on a prison and the welfare of the women held there.[214] However, relying on governors to produce radical change within prisons may be unrealistic. Governors can be individuals who have worked through the ranks. Their attitudes are unlikely to be vastly different from other prison staff.[215]

There are very few women governors or women in senior management within the Prison Service. More women in these positions may provide a greater focus on the specific needs of women prisoners. This is not to suggest that an individual of any gender can solve systemic and institutional problems within women's prisons. However, diversity in leadership may mean greater diversity in the responses to the issues that arise there.

3.4.3 Staff shortages

Women's prisons frequently operate with inadequate levels of staff.

- The investigation into the death of a 20-year-old woman revealed that the wing where the woman was held had only three staff to deal with 50-60 volatile young women.

---

212. *An Evaluation of the Safer Locals Programme: A summary of the main findings,* 2005, p11.
213. Interview with Kimmett Edgar and Juliet Lyon, 6 December 2005.
214. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.
215. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.

- A 39-year-old woman died on a remand wing where there were meant to be four nurses on duty. Working on this wing was demanding for nurses due to the high number of women withdrawing from drugs. On the night she died there were only two nurses on the wing due to staff shortages,.

Staff shortages predominately occur due to a strong culture of staff sickness.

Evidence was given at the inquest into the death of a 39-year-old woman that high levels of staff illness can partially be attributed to the nature of the work. Dealing with self-harm and suicide attempts on a daily basis is extremely difficult. A vicious cycle arose whereby the more understaffed a wing was the more stress staff were operating under and the more time off they needed.

Families felt that staff shortages were a factor contributing to the women's deaths for the following reasons:

Staff had less time to get to know or foster relationships with prisoners

With no established relationship, prisoners were less likely to confide in officers if they were having problems. This meant prison staff were unable to provide women with additional support when needed. It also meant they missed subtle, yet significant, changes in the women's behaviour. This was worst on remand wings where women spend relatively short periods of time. Prison officers giving evidence at inquests frequently raised this issue.

In the investigation report into the death of a 25-year-old woman, an officer described the first week of a woman's imprisonment,

"Women are off the wing a lot on induction, interviews, talks etc, so it takes a week or so to really get a name to a face, to get to know them."

Yet it is in the early stages of custody that women are at greatest risk of taking their lives.

Lack of consistency in monitoring women at risk of suicide and self-harm

Under the old system for monitoring women at risk of suicide and self-harm, it was common for periodic case reviews to be carried out by a number of different members of staff. Again, this meant subtle but significant changes in the behaviour of women already identified at risk of suicide were missed. Providing consistency in the monitoring of women at risk of suicide and self-harm continues to be a problem under the new ACCT plan.[216]

216. For further discussion, see section 3.6 below,

Women are forced to spend longer periods of time locked in their cells alone

Case study

A 25-year-old woman hanged herself after being locked in her cell all day due to staff shortages. Since entering prison the woman was withdrawing from drugs and had made two prior suicide attempts.

Greater reliance on agency healthcare staff

Most agency staff were as familiar with the prison and its policies and procedures as permanent staff. However, in a few cases agency healthcare staff had little or no experience or training for working in prison.

Investigations into at least three women's deaths focused on the negligent actions of individual agency staff. This highlights the tragic consequences of ill-equipped staff working with vulnerable women in prison. It also allows the Prison Service to evade responsibility for women ultimately in their care.

3.4.4 Lack of appropriate training and knowledge

"The paradox is that the more training we get, the more we understand how we haven't got the training we need to be doing the work we are doing."[217]

The majority of women who died had severe mental health and substance abuse problems. Families were concerned that prison staff did not always have the knowledge, training or experience to deal with these issues. Nor did they believe it was possible to train prison staff to provide this specialised care given their purpose – maintaining discipline and order in the prison environment. Apart from ensuring staff are properly trained in emergency procedures so they can respond to women who have attempted suicide, families believed that at best, prison staff could be provided with training that promotes empathy towards women in prison and raises awareness of the issues they face in and outside prison – including self-harm and suicide.

- The investigation report into the death of a 20-year-old woman concluded that many of the staff had not received any training in suicide awareness and that overall the training of staff in suicide awareness at the prison was very poor.
- Evidence was given at the inquest into the death of a 29-year-old woman that the nurse responsible for the woman's reception healthcare assessment had not received training in suicide and self-harm prevention strategies for over two years.

The establishment of the Safer Custody Group (SCG) and the

217. Lord Judd recalling a conversation he had with a prison officer: *House of Lords Hansard*, debates for 28 October 2004, column 1469.

information circulated to prisons through its publication *Safer Custody News* makes it increasingly difficult for staff to excuse poor practice as lack of knowledge or training. However, despite the shocking high rates of suicide and self-harm and the heightened awareness of the need for knowledge and training, suicide prevention training is no longer mandatory for prison staff.

Lack of funding has also seen training stopped in other areas. For example, there is no longer training available for Family Liaison Officers (FLOs) in prisons. Given that family concerns are often the greatest source of distress and anxiety for women in prison this is unfortunate – the support and actions of FLOs may prove invaluable and life-saving.

Some families and experts supported bringing into prison relevantly trained and specialised outside agencies to deal with women who self-harm in prison.

> "It needs people who are very, very trained in [self-harming] not just anyone who's chucked in…I think it would help even just getting people who self-harm, that have been through similar things themselves, to actually get trained… and them to go in and talk to these people cause they would understand it and then the plus side would be…to actually give that person a lot more confidence and show that they can get their life back in order." (Sister of a 19 year-old woman who died)

3.4.5 Poor implementation of policies and procedures

> "In the 24 hours when [my daughter] was in their care, dying and died I put it all down to neglect. Neglect and negligence on the part of the prison full stop… the delay before they took emergency action in calling an ambulance, the profound ignorance on the part of staff who did not seem to understand that it was an emergency, and poor communication within the prison." (Mother of an 18-year-old woman who died in prison)

Too many investigation reports and inquest verdicts concluded that failure to implement good practice or follow policies or procedures contributed to the woman's death.

- Following the death of a 23-year-old woman in prison the jury returned a verdict of suicide contributed to by neglect. The jury identified a "gross failure" by the prison service to provide medical attention to the woman.
- A suicide verdict was returned following the death of a 45-year-old woman in prison. The jury commented on the prison's failure to adopt the correct procedures in relation to the woman's open F2052SH.
- A 22-year-old woman died in prison. The jury returned a narrative verdict identifying a number of factors that contributed to the woman's death including the failure of prison staff to follow published prison guidance on suicide and self-harm.

Disturbing evidence was given at the inquest of a 29-year-old woman that at some women's prisons there exists a culture of staff 'doing it their own way' irrespective of policy. This was often the result of continual changes to policy, with minimal explanation or related training, leaving staff unsure about which policies to follow. It also exposes the lack of effective management oversight.

Families were concerned about a lax and subsequently fatal approach to following prison policies and procedures, including:

Staff tampering with cell bells

Staff manipulated cell bell equipment to stay in the off or muted position.[218] There was also evidence of severely delayed responses to cell bells.

Case study

A 23-year-old woman rang her cell bell at about 5pm to request a listener. She received no response. Other women tried to get staff attention on her behalf. Approximately one hour later another prisoner saw the woman hanging and was ringing her cell bell for over 40 minutes trying to get help. The post mortem report found the woman "had been dead for a number of hours in one position before subsequently being moved."

Poor communication between staff

Communication between prison staff is critical to ensuring the safety and wellbeing of women in prison. Healthcare and discipline staff may be aware of different needs of the women and must communicate these to each other. Shift work and a high use of agency staff means that diligent recording of information may be the only way of passing on life-saving information. Deaths have occurred where there has been an over-emphasis on the two distinct areas of discipline and health without sufficient cross communication.[219]

> "Information was not clearly exchanged between different people when it should have been. It seemed to me that they had not relayed critical medical and psychiatric information to discipline staff so clearly there are problems of communication within the prison or people would be in receipt of information, but then they wouldn't necessarily act on it." (Mother of an 18-year-old woman who died in prison)

Case study

A 29-year-old woman was highly distressed and was thought to have attempted suicide in the cells at the magistrates' court. A court probation officer telephoned the prison where she was to be sent on remand to warn them that she was at high risk of suicide. He spoke to both the prison probation service and prison reception. He also sent a fax to prison reception.

None of the telephone calls were logged and the fax was nowhere to be found. A warning was also written on the escort form accompanying the woman to prison.

Despite this, the woman was assessed by reception staff as not needing suicide/self-harm monitoring.

She hanged herself two weeks later. (continued over...)

---

218. Cell bells are used by prisoners to call staff to their cells.
219. *Report on the deaths of Katherine Woods and Tracy Logan 1996/7, op cit*, p3.

It is deeply concerning that in these circumstances the opinion of the probation officer was not more seriously followed up or relied upon. The jury unanimously found a number of factors contributed to this woman's death including the failure to put her on suicide/self-harm watch,

"Six opportunities arose, in [this woman's] first 24 hours at New Hall prison, when a F2052SH could have been opened. Had vital information about Probation Services reached New Hall reception, and had procedures for reception been clear and fully understood, with appropriate training, the Form 2052SH would have been opened."

Given the overwhelming healthcare needs of women prisoners, a lack of communication between medical and disciplinary staff is particularly concerning. Women failed to receive the appropriate healthcare and often had their health-related issues treated as disciplinary problems.[220]

Case study

A 29-year-old woman was suffering with severe drug withdrawal symptoms. She was hearing voices and acting abusively towards staff and other prisoners. Following a suicide attempt she was placed on a F2052SH which was later closed with no input from healthcare staff.

The day before she died the woman was placed on basic regime due to her unpredictable behaviour. She was assessed as 'high risk' for cell sharing and placed alone in a cell with a bunk bed. Later in the day a F2052SH was opened by another officer.

On the morning of her death a senior officer expressed concerns to the prison's mental healthcare unit about the woman's mood swings and bouts of aggression. They agreed to see her but could not do so that morning as she was in segregation, pending adjudication, for an incident relating to her abusive behaviour.

In segregation, the woman was seen by a doctor and nurse. Her F2052SH had not accompanied her to this unit so neither was aware that she was identified as at risk of suicide and self-harm. In post-death investigations, both said that they would have acted differently if they had known. Specifically, the doctor said that he would have tried to stop the woman being placed alone in a cell with a bunk bed.

Despite the prior suicide attempt and being on a F2052SH, the woman was deemed fit for adjudication and cellular confinement. She lost her earnings and canteen privileges for seven days, and three days of association. Following adjudication, the woman was returned to the segregation cell where she hanged herself from the top bunk using a ligature made of strips of towel.

At the inquest into this woman's death, the jury returned a highly critical verdict. They found that a number of factors contributed to the woman's death including:

- **Inadequate assessment with respect to the woman's individual situation and needs upon admission to the prison.**
- **Serious concerns over the management of the F2052SH system with a lack of communication between staff and departments. No reference was made to the previous F2052SH. The decision to leave the woman on an open F2052SH isolated in a cell with a bunk bed was totally inappropriate.**
- **A total lack of awareness and staff training in the management of persons at risk of self-harm and suicide.**

220. For further discussion see the section X.X below on disciplining 'difficult' women.

Communication between prison staff is often in written form. Failure to accurately and comprehensively record incidents in prisoner observation books or use other appropriate forms of record keeping means that staff are often unaware of incidents which alone may appear trivial but together create a picture of a woman in great distress.

Case study

Shortly after arriving at prison, a 22-year-old woman was placed in a cell alone in response to her fears of being bullied. The decision to segregate this woman was not recorded in the observation book. The prison chaplain informed prison officers that the woman was distressed and tearful yet this also was not recorded in the observation book. The woman hanged herself less than 48 hours after arriving in prison.

Poor levels of higher supervision

At least four women died in locations and circumstances where higher levels of supervision were expected including segregation, healthcare and induction units and safer cells.

Case study

A 23-year-old woman was arrested with a large knife wound to her thigh and taken to hospital for treatment where she tried to kill herself. The officer escorting the woman to prison knew of this attempt and recommended a "watchful eye be kept over her". Although she told prison staff she would kill herself if she was left alone, she was put into a single cell where she hanged herself 24 hours later.

Case study

A 34-year-old woman was held in police custody for two days where she made repeated attempts to take her life. She was placed under constant supervision and a form advising anyone who had contact with her that she was under serious suicide risk (POL1) was opened. A psychiatrist assessed her as suffering paranoid depression and suggested that the hospital wing of a prison would be the most appropriate place for her. Supervision to this point was exemplary.

Upon arrival at prison her POL1 form was either ignored or not read properly. Despite being on an open F2052SH, the woman was left in a pre-search room alone. No-one observed her on CCTV or through the two way mirror. Staff, busy with other prisoners, did not notice that the woman was missing for half an hour. She was found on the floor of the toilet in the holding room having choked herself to death with tissue – an exact repeat of her earlier attempt to take her life.

3.4.6 Use of listeners

"There can be a caring culture between women in prison which should be used positively." (Joan Meredith, in correspondence with INQUEST)

Women in prison have a huge capacity to understand and support each other. The listener scheme, supported by the Samaritans, taps into this by training prisoners to provide support for other prisoners. There is evidence of lives being saved by listener intervention.[221]

However it is also questionable how appropriate it is to rely upon listeners in cases where women are extremely suicidal, depressed or have severe mental health needs. In some of these cases, professional support is more appropriate and potentially life-saving. The distress of women in prison can often be lowered if they can speak to someone with the power to deal with their concerns or provide information.[222] Listeners can play a very valuable role in supporting women in prison, though they cannot be seen as a substitute for professional support.

Case study

A 22-year-old woman told prison staff that she would kill herself if she received a prison sentence. Despite receiving a harsh and unexpected sentence, the woman was not placed on a F2052SH or provided with additional care and support. Staff were aware of her distress and intentions.

The night she was sentenced she spoke to a listener for four hours, repeating her intention to kill herself. The listener was unaware she was able to pass this information on to prison staff. The next morning the woman was found hanging in her cell. The listener remains deeply distressed and feels responsible for the woman's death.

3.5 Management of life-threatening situations

"Most people do not appreciate how quickly they lose consciousness and control when they hang themselves. It is a common misconception that it will take time or that you will be able to stop it."[223]

As discussed, 87% of self-inflicted deaths in women's prisons are hangings.[224] The speed with which this act becomes fatal stresses the need for rapid intervention by prison staff – if it is not already too late. In one case, staff needed assistance gaining access to the cell where a woman was hanging, wasting critical time.

In other life-threatening situations inexcusable and ultimately fatal delays occurred.

An 18-year-old woman died following an overdose. She informed staff of her intentions but delayed responses contributed to this act becoming fatal. Her mother described the delays:

> "There was a delay before they called the ambulance. An argument took place between a nurse and prison officer about whose job it was to call the ambulance, however the ambulance did eventually get called, during which time [my daughter] was

221. *Safer Custody News,* 2002, p1.
222. Interview with Olga Heaven, 8 June 2006.
223. Doctor giving evidence at inquest into death of a 41-year-old woman who hanged herself in prison
224. See section 1.4 of this report.

> becoming critically ill and she was dying. Now that delay, we will never get to know how long it was because they were all saying different things. That's why the statement is that there was "a delay of between 20 and 40 minutes." Then the ambulance got to the prison, but it was held up at the gate for eight minutes because they couldn't get in. So that by the time they got to [my daughter] she had lapsed into unconsciousness. Of course back when she told them she had taken the tablets, she was alive, breathing and talking wasn't she?"

An investigation report described the resuscitation attempt of a 27-year-old woman found hanging as "disordered, chaotic and ineffectual." Resuscitation with a defibrillator needs to begin as soon as possible. However, the prison did not have a defibrillator and only called an ambulance 25 minutes after the woman had been cut down. The investigation also found that the prison doctor present had out of date resuscitation knowledge and was unable to lead the situation.

Case study

A 39-year-old woman died after taking a lethal overdose of the anti-depressant dothiepin. The woman was one of five prisoners who stole the bottle of dothiepin during the evening administration of medication.

The women consumed the dothiepin in the shower area, where the empty bottle was later found and passed to staff who took no action, except to place the bottle in a waste-bin. It was a huge and possibly fatal error of judgment by staff not to question how the bottle got there or why it was empty.

An issue raised at the inquest into this woman's death was whether speedier or earlier intervention may have saved her life. The woman had continuous fits in the hours after taking the drug. The nurse on duty checked on her but chose not to call the doctor after the first fit.

The investigation into the death of this woman concluded that this was a high risk decision, even though it was a difficult decision as patients withdrawing from drugs are prone to having fits.

At the inquest into her death, a member of the Medical Toxicology Unit advised that, "Speedier treatment, that is immediately after, may have influenced the outcome in that it will almost always be the case that earlier treatment is better."

Crucial to the delayed response was that staff did not realise that the woman had taken the overdose. Prison staff and prisoners both gave evidence at the inquest that had there been a better relationship between staff and prisoners, prisoners may have passed on this information earlier.

In some cases, staff responses were so delayed, prisoners had to deal with distressing, life-threatening situations alone.

- A 33-year-old woman died of an accidental drug overdose. Unable to wake her, the other woman in her cell called prison staff. They failed to respond and other prisoners assisted the woman. During the post-death investigation, one of the prisoners reported that she saw the dead woman when she was blue, had a distorted face and blood coming out of her mouth. She described it as "a terrible sight, something I will never forget."
- During the investigation into the death of a 27-year-old woman who hanged herself, prisoners described how they regularly had to deal with the woman's prolific self-harming as officers very rarely came to assist her.

3.6 Managing women at risk of suicide

"Present systems for identifying and monitoring those considered to be at risk are only as good as the way they are used and managers in women's prisons need to give far more emphasis to ensuring all staff use the suicide prevention system properly."[224]

Managing women at risk of suicide is difficult due to the complex relationship between self-harm and suicide.[225] Suicide is often the response to an event or series of events. Self-harming can be a coping mechanism that prevents people from killing themselves. Yet acts of self-harm can put women at risk of dying, for example tying ligatures.[226] Given this relationship, it is understandable for prisons to manage self-harm and suicide under the same system, but it is also understandable why this approach fails to deal effectively with two differently-motivated problems.

The Assessment, Care in Custody and Teamwork (ACCT) plan is used to identify and manage women prisoners at risk of suicide and self-harm. This system is discussed in detail below in section 3.6.3 Prior to the introduction of ACCT, the F2052SH system was used for this purpose. Most of the women who died were monitored under this prior system which involved the use of a 'Self-Harm At-Risk' Form (F2052SH). In some cases, prisoners were under constant observation.

3.6.1 Failure to identify women 'at risk'

Compared to men, a greater proportion of women were identified as at risk of suicide at the time of their death.[227] In at least one-third of cases, women were on open F2052SHs when they died.[228] This may be

224. *Women in Prison: A thematic review by HM Chief Inspectorate of Prisons, op cit,* p89.
225. For a detailed explanation of this relationship see *Suicide and self-harm prevention Repetitive self-harm among women and girls in prison,* 2001.
226. Interview with Louisa Snow, HM Prison Service, 1 September 2005.
227. *Ibid.*
228. In 23% of cases it is unknown if women were on open F2052SHs when they died so this figure could be significantly higher.

because women present better recognised risk factors than men.[229] Some families could not understand the failure to identify where a woman was at risk of suicide.

Case study

A 20-year-old woman died after 12 days in prison. She had served a prior sentence in the same establishment where she had been placed on an open F2052SH. Outside prison she also attempted suicide.

Her mother believes that her problems would have been visible at the prison reception. She had extensive cuts to her arms and was withdrawing from heroin. She was assessed as low risk on reception and not put on an open F2052SH. This was never changed despite attempting suicide 12 days prior to her death.

At the inquest, the jury returned a verdict highly critical of the prison's arrangements for processing, sharing and accessing information about past self-harm incidents and the lack of monitoring of this woman. Her mother agreed that the failure to recognise her as a suicide risk was unacceptable:

"She wasn't a new girl going in…. so it's not like they didn't know her and know her history. They knew she was suicidal…They reckon they had monitored her and thought she didn't warrant a suicide risk. I said you can't tell me that somebody tries to take their life 12 days before that and 12 days after that they're going to be fine, that's just impossible. She's got a history of years of problems with drugs and self esteem and so there is no way in 12 days she's going to be okay. She might have come across okay but that's what depressed people do. They don't tell you … you have to read between the lines because when she sent letters I could, perhaps because I'm her parent, but they're in a job where they are supposed to spot the signs and be more qualified than even I am."

As knowledge of the factors placing women at risk of suicide increases, failure to identify certain women as 'at risk' becomes more inexcusable. For example, a young woman on remand was not on an open F2052SH at the time of her death despite displaying well known risk factors. She was withdrawing from heroin, had made two suicide attempts outside prison and while inside prison told officers that she intended to kill herself.

In conducting this research INQUEST heard a number of explanations for women not being on an open F2052SH at the time of their deaths, including:

The majority of women in prison display characteristics that put them at risk of suicide

"Tossing a coin or doing something that gives a 50/50 result would be a more accurate way of predicting who will commit suicide. If there are 60 women on a wing and you have to predict the one who would

229. Interview with Louisa Snow, HM Prison Service, 1 September 2005.

take their life it would be impossible as at least 50 would display the characteristics of being at risk of suicide. Particularly when self-harm is seen as an indicator as being at risk of suicide."[230]

Officers often gave evidence at inquests that if too many women in the prison are on open F2052SHs the system is meaningless and unmanageable due to the high levels of staff and supervision required to manage the system.

- In the investigation report into the death of a 48-year-old woman on an open F2052SH, prison staff stated they felt overwhelmed by the number of prisoners on open F2052SHs, some requiring extremely high levels of care due to their prolific self-harming.
- The investigation report into the death of a 20-year-old woman found that women can and do carry out self-harm and mutilation with absolutely no intention of killing themselves. This happens on such a regular basis at HMP Holloway that it is believed that if F2052SH procedures were used in every case of self-harm the system would be swamped and the whole process would be devalued due to the sheer volume of the documentation required.

Women indicated to staff that they were not suicidal

Prisoner responses to questions about suicidal intent should be treated with caution. Evidence was given at a number of inquests that prisoners with the strongest intention to commit suicide often deny these intentions to avoid being put under closer observation and do not inform staff of their feelings.

Staff attempt to address this problem by asking prisoners a variety of questions. For example, in addition to asking women if they are feeling suicidal they may ask them if they are expecting visitors and how they feel about their sentence. Even then identifying suicidal intention can be difficult.

Case study

On the day a 22-year-old woman hanged herself, her mother helped her to write a letter to her husband. In it she was making detailed plans for the future. The letter seemed positive.

At the inquest into the woman's death fellow prisoners gave evidence that she appeared upbeat on the day of her death. A few hours before her death, she was dancing to music in her cell and excited about the possibility of moving to HMP Durham depending on the outcome of her appeal.

The woman had expressed suicidal intentions outside prison, saying she could not cope with prison. However, she did not appear at risk of suicide or self-harm on reception or during her time on the drug detoxification wing. The investigation report concluded that the woman intended to take her life before going into prison.

230. Interview with Kimmett Edgar and Juliet Lyon, 6 December 2005.

3.6.2 Poor management of the F2052SH system

Caring for women at risk of suicide and self-harm is an enormous challenge for the Prison Service, which has to do its best to prevent these women from killing themselves while ensuring their basic human rights are not comprised.

Women often hanged themselves using clothing, bedding, towels or curtains provided to give them privacy in their cell when using the toilet or shower. Routinely depriving women of these basic necessities would infringe a number of their rights, including the right not to be subject to inhuman or degrading treatment.[231]

Despite acknowledging this difficulty, the care provided to women on open F2052SHs has been repeatedly criticised in post-death investigations. In some cases juries have concluded that the poor quality care provided to women on open F2052SHs contributed to their deaths.

Families share these concerns and provided numerous examples of how poorly managed the system was:

Poor record keeping

Paperwork relating to the woman's open F2052SH was often lacking in detail and incomplete. Significant acts of self-harm were not recorded. There was also confusion between healthcare staff and prison officers about who was responsible for making open F2052SH entries.

- A 48-year-old woman reported her act of self-harm to a nurse. The nurse made an entry in the woman's medical record but not on her F2052SH as she believed a prison officer would complete this form.

- During the post-death investigation of a 22-year-old woman the PPO looked at a 10% sample of the open F2052SHs in the prison at the time of her death to see if they complied with standards. Based on this sample, the PPO concluded that medical notes were less than adequate.

When a person dies in prison, the SCG provide notification of the death. The notification form records whether a woman is on suicide and self-harm watch at the time of her death.

Given the high level of observation expected of women on open F2052SHs, it is concerning that in 20% of cases the SCG notification states it is 'unknown' whether the woman was on an open F2052SH at time of death. Of equal concern were cases where the woman on an open F2052SH at the time of her death is recorded as not having been on an open F2052SH when she died.

231. Article 3 European Convention on Human Rights 1950.

Inadequate observations

Observations of women being monitored under the F2052SH system were often infrequent and/or at predictable intervals, meaning women knew how much time they had until the next observation. In some cases observations were not carried out at all. The quality of observations was also questionable.

- Evidence was given at the inquest into the death of a 37-year-old woman on an open F2052SH at the time of her death that there was no attempt to engage or communicate with her. She was simply observed at predictable intervals i.e. on the hour.

- A 23-year-old woman was found dead one hour and fifteen minutes after her last observation. She was meant to be observed every 30 minutes.

Leaving women with the means to kill themselves

Women are supposed to have all the possible means of killing themselves removed from them when they are placed on suicide watch. A number of women hanged themselves using shoe laces from trainers or cords from clothing that staff had failed to remove. Other suicidal women were placed in cells with ligature points which they used to hang themselves. While someone who is determined to die will always find a means to do so, failing to remove these items was a breach of prison policy.

In other cases, a woman on suicide watch had access to bleach which she swallowed, and another woman at risk of suicide was given an entire box of medication to self-administer. Unsurprisingly, she took all of the pills at once.

Lack of comprehensive staff input

The F2052SH system required a multidisciplinary approach. In reality, case reviews were frequently undertaken by individual officers without vital input from others, including prison healthcare staff.

Case study

A 20-year-old woman had been on an open F2052SH while on remand. She was sentenced to life in prison and transferred to an establishment where she was extremely isolated and left in her cell for extended periods of time. Her levels of self-harming increased and she become severely depressed. Despite this, her observation level was reduced and her F2022SH review noted that she felt anxious about what would happen at night with less observation. The woman died a few days later – during the night.

In some cases, staff displayed a profound lack of understanding of self-harming and suicidal behaviour.

Case study

A 22-year-old woman died after being remanded in custody for ten days. In court she was noted as being very depressed and suicidal. On arrival at prison she was placed on an open F2052SH.

The following day, a locum medical doctor at the healthcare centre assessed her as "not suicidal or thinking of self-harm…was reacting to failure to get bail. Compos mentis. I feel she is manipulative." He referred the woman back to a residential unit without completing the discharge section of the F2052SH form which details the post-discharge support plan.

At the inquest into her death, the coroner made a rule 43 recommendation questioning the use of locum doctors in cases involving very vulnerable women, especially when they have no working knowledge of F2052SH procedures, which the coroner described as the vital tool in identifying prisoners who are vulnerable and at risk of self-harm and suicide.

Poorly conducted case reviews

In the majority of cases the overall management of the F2052SH system has been criticised and described as "insufficient" and "inadequate." This is evidence of a systemic failure to look after women at risk of suicide and self-harm.

Case study

At the first prison where a 24-year-old woman was held, no review of her open F2052SH was ever conducted, nor was a support plan in place.

At the second prison, where she died, a review was held outside the door of her cell in case she became aggressive. The review co-ordinator was unaware the woman was withdrawing from poly-drug use. Despite her volatility, and having tied a ligature earlier in the day, a decision was made to reduce the level of observation of this woman. Over the next three days she was noted as acting strangely and as being unusually quiet. She died the following day.

At the inquest into her death the jury returned a highly critical verdict. It identified a number of factors that contributed to the woman's death including:

- **Perceptions of the cause of the woman's behaviour were inappropriate leading to inadequate treatment and levels of supervision.**
- **Insufficient and inadequate management of the F2052SH system.**
- **Low levels of staff, combined with a lack of appropriate training in relation to the prevention of suicide and self harm.**

Case study

A 27-year-old woman was placed on an open F2052SH on three separate occasions. One was never closed, one was lost for three days, leaving staff unaware the woman was on an open F2052SH, and one was closed without following proper procedures – there was no review by an officer or input from medical or nursing staff.

On another occasion the woman committed three separate acts of self-harm yet no F2052SH was opened. Instead she was punished for blade possession, which only added to her distress.

The poor management of this woman's open F2052SH was exacerbated by continually transferring her between and within prison establishments.

She killed herself in the prison segregation unit.

The report into the death of another woman, also on an open F2052SH at the same establishment 18 months later stated that there had been a failure to learn lessons from prior deaths about managing women on the F2052SH system.

- At the inquest into death of a 29-year-old woman the narrative verdict returned stated that the management of the woman's open F2052SH contributed to her death. The management was described as:

"...extremely concerning with a lack of communication between staff and departments. No reference was made to the previous F2052SH. The decision to leave the woman, whilst on an open F2052SH, isolated in a cell with a bunk bed, was totally inappropriate."

3.6.3 The Assessment, Care in Custody and Teamwork Plan

The Prison Service has responded to problems with the F2052SH system by replacing it with the ACCT Plan. This system was in place in all prisons by April 2007. Some experts believe the ACCT Plan is a huge improvement on the F2052SH system for the following reasons:

- It has a greater emphasis on teamwork and is a move away from suicide prevention through observation.
- A multi-disciplinary approach is adopted – a number of prison departments including education, healthcare and resettlement have input into the management of the woman's care.
- The woman is consulted. She is brought on board to discuss her needs and management plan.[232]

However, HMCIP has found that in practice (and this is supported by evidence at inquests into more recent deaths) the ACCT Plan can operate less effectively than its predecessor for the following reasons:

- ACCT Plan reviews and care plans are adopting a less multi-disciplinary approach. They are being performed by one person, usually a senior officer, with no input from other relevant staff including probation staff and prison psychologists.
- Key workers, if appointed at all, are usually senior officers. There is a failure to draw upon other disciplines within the prison for this role e.g. healthcare staff.
- ACCT Plan reviews lack consistency. One prisoner's review may be carried out by someone different every time.
- The actions arising out of care plans are often inappropriate. For example, a 17-year-old woman on the ACCT Plan was feeling suicidal and wished to contact her mother. She was told to write a letter to her mother, rather than being allowed to call her.[233]

---

232. Interview with Kimmett Edgar and Juliet Lyon, 6 December 2005.
233. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.

3.7 Disciplining 'difficult' women

> "In prison you get put in segregation if you self-harm. So in a way I feel quite sorry for them because it is like being punished for your pain and hurt. It's a shame the prisons see it like that because all [self-harming] is, is dealing with pain, and people punishing themselves." (Sister of a 19-year-old woman who died in prison)

> "By removing privileges like association, which was the time when she could call her mother, they put her in more danger because she really needed support. She was really struggling in prison." (Mother of a 19-year-old woman who died in prison)

Women were often seen as 'difficult' when displaying symptoms of mental illness or drug withdrawal and so were disciplined for their actions. Of particular concern was the disciplining of women for self-harming behaviour by, for example, placing them on basic regime or in segregation units or punishment cells when they self-harmed. This occurs because prison staff do not always understand self-harming and see it as manipulative, attention-seeking behaviour.[234]

The significance of the environment in which women are held was underlined in the Corston Report and by HMIP reports on individual establishments which note that those prisons providing most activity for women saw significantly less self-harm.

Women at their most vulnerable and depressed have been placed in the most dehumanising and punitive environment bereft of the appropriate professional support needed at the most critical time. Inevitably, this situation arises because discipline, security and punishment remain central to the operation of prisons. It is difficult to believe that in many other environments force and punishment would be used as the primary means to stop attempts at suicide and self-harm.

Case study

A woman with a long history of self-harm was subject to three days of cellular confinement while on suicide watch. She received this punishment for tying ligatures and attempting to set her dressing gown on fire.

Women's prisons face the challenge of responding to the overwhelming mental and physical healthcare needs of prisoners while imposing the discipline regime. Managing these conflicting interests often results in one woman being monitored and supported under the F2052SH system at the same time as she is subject to the full rigours of the prison's discipline system. The use of segregation and/or control and restraint often only increases the woman's distress, self-harming and suicide attempts, thus creating a life-threatening cycle where discipline is inevitably prioritised.

Lack of resources is also an issue. At HMP & YOI Styal extremely vulnerable and seriously mentally ill women are held in the care,

234. Interview with Cathy Stancer, 25 November 2005; interview with Harriet Wistrich, 25 November 2005.

support and reintegration (the renamed segregation) unit where they self-harm, alongside women in segregation for disciplinary reasons. In this environment self-harming has been normalised. Again, this highlights the disjuncture between what prisons provide and what many of the women held in them need.[235]

Case study

A 20-year-old woman died in prison after spending 153 of her 166 days in custody on an open F2052SH. She was a persistent self-harmer with a severe personality disorder.

In prison she assaulted staff, had 12 adjudications, 73 days added to her sentence for poor behaviour and was restrained physically six times. Her behaviour was so disruptive that on occasion she was moved to the punishment/segregation cell to give a break to both her and the prison staff on the wing where she was being held. The woman died while housed in a safer cell. This multipurpose cell was used for punishment and segregation and to provide a safe environment for at risk prisoners. There are no ligature points on the windows and the furniture is made of cardboard.

The woman hanged herself by attaching a ligature made of a shoe lace to a twin socket in her cell. She was in possession of trainers with shoe laces despite being on an open F2052SH.

The investigation report found that this cell did not meet accepted standards for a safer cell as taps were not ligature proof and there were twin sockets for electricty and TV. It also concluded that the woman's self-harm and failure to conform with prison rules led to a conflict between the need to treat her with care and support on the one hand and discipline her on the other. There was no evidence that a risk assessment was ever carried out to determine the potential danger from the mix of self-harm and disruptive behaviour.

The alarming increase in deaths between 1999-2004, and in particular the deaths of six women in a 12 month period at HMP &YOI Styal, has left the women's prison estate desperate to prevent further suicides. The use of force to prevent women self-harming and attempting suicide has increased and is a practice of great concern.[236]

3.8 Family contact in prison

"When Brockhill was a men's prison the visitor's room was always heaving. Now that it's a woman's prison it only gets about five visits a day."[237]

Some women have little or no contact with their families while in prison. The small number of women's prisons and therefore the huge distances from friends and families contribute to their sense of isolation. There is no research on whether women who die in prison are more or less likely to have visits from family and friends. In 2003

235. *Report on an unannounced full follow-up inspection of HMP/YOI Styal 26 October – 4 November 2005, op cit,* p7.
236. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.
237. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.

the National Confidential Inquiry found that over 40% of people who killed themselves in prison had no visits. This figure may be high because self-inflicted deaths are more likely to occur in the early period of custody when visits have not yet been arranged.[238] Prison visits must be organised and it can take some time for a prisoner and their family to understand how to organise them. This figure relates to women and men, yet the experiences of family contact in prison for these groups are vastly different.

When men are in prison, female partners usually continue to look after children and are more likely to take them to visit their father in prison. In approximately 80% of cases where women had a partner prior to entering prison, the relationship broke down due to her imprisonment.[239] Very few women in prison have partners bringing their children to see them. If a close relative is looking after the child the woman is more likely to receive visits from her children.[240] This separation and lack of contact with children is very difficult for women in prison, particularly as many were the primary care givers outside.

Support from family and friends outside can be vital to the welfare of prisoners. Although constantly surrounded by people, prison is repeatedly described as an isolating experience.[241] In the many cases where women in prison have no external support it is even more important that the Prison Service provide them with appropriate care and support.

Family contact does not always have a positive impact on women's experience in prison. Women may get very anxious about visits, especially with partners and may have complex feelings towards the people in their lives, e.g. anger and guilt.[242] Some women do not want their children visiting them in prison. This is partially due to the quality of the visits. In some establishments prisoners are not allowed to get up from their chairs during visits. This leaves them unable to interact with young children running around the visiting room and playing with toys, often located in one corner of the visitor's room. Given that family members have been searched prior to entering prison, it is questionable whether this security measure is necessary.

A number of non-governmental and voluntary organisations work to facilitate family visits to prison and improve their quality for both the visitors and prisoners. For example Kids VIP run storytelling workshops and provide books for children visiting prisons; in 2004 and 2006 Action for Prisoners' Families (APF) ran a Family Friendly Prison Challenge, encouraging prisons to run events that improve contact

238. It is unknown how many prisoners did not have visits and did not kill themselves. This research was referred to by Louisa Snow, HM Prison Service, interviewed 1 September 2005.
239. Interview with Lucy Gampell, 24 May 2006.
240. *Ibid*.
241. Interview with Christine Wood, 9 June 2006.
242. Interview with Cathy Stancer, 25 November 2005.

between prisoners and their families; the Prison Advice & Care Trust (PACT) runs child-friendly centres outside prison, providing services and support for visiting children and families of prisoners. They also run children's services inside prison visit halls.

According to APF, the Prison Service is increasingly sensitive to the issue of family contact in women's prisons.[243] However, there remains concern at the lack of management of family relations in the women's prison estate. The welfare of children is the biggest concern for mothers in prison.[244] Support for women coping with separation from their children is inadequate. In general, there is no structured support for family issues. Rather this support is provided on an ad hoc basis and is usually based on a prison officer taking an interest in an individual case or issue.[245] Best practice would be having qualified family support workers in all women's prisons.

In 2004 over half of all women in prison were held more than 50 miles/80 km from their home town or committal court address.[246] Families described the difficulties they had organising prison visits due to travel distance and prison visiting rules. This often led to minimal contact with women, which some families believe was a factor contributing to the women's deaths.

> "[The prison] is about an hour and a half drive from here… I'm a single parent and I've got no transport, I don't drive. I did get a little bit of help cause I had Social Services involved and Youth Justice and now and again they would put on transport, but I mean they couldn't do it every week... she needed it. I wrote to her constantly and she wrote to me, but she needed to have family support constantly because that's the one thing that kept her going." (Mother of an 18-year-old woman who died in prison)

In the case of an 18-year-old woman who died in prison the quality of family visits decreased dramatically when she was moved from a secure children's home to prison:

"When I took [her son] down she couldn't interact with him or hold him. I mean she can cuddle him but he was just under two years old, bearing in mind he is running around this place. I had to keep jumping up and chase after him. There was very little toys for him to play with… just two or three broken ones. So of course he was bored. She was getting upset obviously, because in [a secure children's home] it was different. It was a living room. And although you got staff there they are not constantly watching you. You are in a sitting room and the door is locked so you couldn't escape or anything. There was a settee there and toys. I could even take a few toys in for [her son]. I used to take his dinner in and [my daughter] used to feed him herself

---

243. Interview with Lucy Gampell, 24 May 2006.
244 Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.
245. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.
246. *House of Commons Hansard*, written answers for 7 September 2004, column 965W.

so she was interacting with her son and changing his nappies…So it's a better environment for her to interact with her son. When she went into prison it was nothing like that."

Transferring women between prison establishments at short notice made visiting increasingly difficult. It was not uncommon for the new prison to be much further from the women's family and friends, making visiting difficult, if not impossible.

> "I'd book a visit to go to Birmingham, which wasn't on my doorstep, to find she'd been moved to Manchester. It was unacceptable; I was the only visitor she was getting." (Ex-partner of a 46-year-old woman who died in prison)

This woman was moved from a prison near her ex-partner to one 400 miles/650km away. Her ex-partner remained her sole support in prison. She described how impossible it was visiting the new prison,

> "I went to visit her once but it was very expensive. £100 on the ticket alone and it meant taking three days off work. I wasn't eligible for assistance as I was working so I had to pay for accommodation. One of our visits was cut short by 45 minutes while I was waiting for clearance."

Telephone contact is very important for women in prison. In theory, it provides a quicker, less expensive and more regular way for them to maintain contact with family members. It is often the only way they can maintain contact with children and be updated on concerns relating to their school and health. In reality, it is expensive to make telephone calls from women's prisons and the time allowed for calls is limited. In some prisons there are two phones for one hundred women.[247] Queues are long and women often miss out. In most women's prisons incoming calls will not reach prisoners, if they are allowed at all. Making phone contact with family easier for women in prison would not be difficult and could greatly reduce levels of stress and anxiety amongst the female prison population.[248]

3.8.1 Communication between families and the prison

> "[My daughter] phoned me desperate… and when she phoned I phoned the governor thinking I was helping her, only in fact I may have made matters worse for her because all [the governor] did was make her lose association which stopped her from making phone calls to me." (Mother of a 19-year-old woman who died in prison)

Many of the families involved in this project contacted the prison to discuss issues of concern relating to their relative's imprisonment, particularly when the woman involved was very young.

---

247. Interview with Christine Wood, 9 June 2006.
248. Interview with Lucy Gampell, 24 May 2006.

In general, it is not easy for families to access the prison unless the prison has a FLO. Even then, the quality of this access will often depend on the level of confidence and eloquence with which the family member can express their concerns.[249]

Families were often frustrated by the lack of communication they had with the prison, the nature of their communication or the impact of this communication on the women in prison. Better communication may have resulted in more effective management of situations.

> "There was no correspondence between the prison and me although I was going down for meetings with Youth Justice because I wanted to be involved with everything, and I wanted to let [my daughter] know I was supporting her every step of the way and getting any help that possibly we could get.
>
> The prison hadn't even bothered telling me [that she had tried to commit suicide 12 days before she successfully killed herself]. I felt let down there because I wasn't aware and let down that they don't think about families. When these kids go away they need their family support more than ever… [My daughter] used to say to me there are some girls in here from so far away they never get to see their families apart from an odd letter. It was only for the fact that I was involved in Youth Justice that I was able to get help and go down. Some of these girls haven't got that…But I really feel like the prison should have been in contact with me and we should have been working together… At [a secure adolescent unit] the staff kept in contact with me, if they had problems they used to ring me and say [your daughter's] on a downer and we feel if you come in, see if you can chat with her and find out what's wrong." (Mother of an 18-year-old woman who died in prison)

Case study

A woman died in prison one month after her 18th birthday. She had been remanded in prison when she was seventeen. Her mother was concerned that the prison had not informed her that her daughter's behaviour was causing them concern in the days before she died.

Following her death, the woman's family met prison management, the prison's suicide awareness support unit member, the local MP and a local councillor.

At this meeting valuable practical suggestions were made about managing women under the age of eighteen in prison, including the provision of better information about visits for families, involving families in local support networks for prisoners and encouraging families to provide sustained support to women throughout their time in custody.

---

249. *Ibid.*

3.8.2 Identified as 'at risk'

It was not uncommon for families or others outside the prison to have informed the prison authorities that they believed that the woman was at imminent risk of killing herself.

One percent of calls made by families of prisoners to the Prisoners' Families Helpline were about fears that the prisoner was suicidal or self-harming. The helpline coordinator passes on these concerns to the Safer Custody Group. As a result of these calls prisoners may be placed on suicide and self-harm watch.[250]

In some cases, this potentially life-saving information was not acted upon. Other families experienced difficulties relaying their concerns to the prison. Prison Service instructions require prisons to have an arrangement for receiving, recording and passing on this information to relevant people within the establishment. However, this Prison Service Order is not prescriptive and practice varies between prisons.

> "[Telling the prison that I was worried about her] didn't get me anywhere but I did try very hard. I did it in three ways. I wrote to the prison on a number of occasions during that six month remand period in 2002 expressing my very serious concerns about [my daughter's] deteriorating state of health and I pointed out that she had made attempts to end her life and self-harm and really would they please do something about it. I always kept copies of my letters. I always insisted on getting replies from them, which I did but they were a little bit like politician replies, words, words, words, but didn't ever really amount to anything. A number of those letters were actually produced at [my daughter's] inquest. It was very clear evidence that I had alerted the prison in writing…[to] exactly what was wrong. Can't you put [my daughter] in some kind of therapeutic community?
>
> There were occasions where I telephoned them and there were occasions when I spoke to them in person at the prison. Well, again the same sort of response. There would be some sort of response, because they can't say nothing, but it would be as if they were trying to reassure me, but I wasn't being reassured. It would be something like "oh we will go and check on her", "we will see if everything

Case study

A 21-year-old woman with a young child and a long term heroin addiction was in prison for the first time.

Her brother wanted to get a message to the prison expressing his concerns that his sister would not cope in prison and may attempt to kill herself. He was a prisoner at the time, and was not allowed to make an inter-prison call.

A prison officer agreed to make the call for him. Despite being assured a careful watch would be kept on his sister, she was left alone in her cell all night with no support or assistance and was found dead in the morning.

In subsequent correspondence with INQUEST the brother said his sister's death could have been avoided had she had access to a buddy until she was mentally stronger, or if she had been placed on suicide watch and given adequate advice and treatment to cope with her drug withdrawal.

250. The Prisoners' Families Helpline is run by Action for Prisoner's Families. Information received during interview with Lucy Gampell, 24 May 2006.

is alright", "leave it to us and we will make a note in the log book" and "I'll pass this on to the Wing staff when they come up", but nothing actually ever got done." (Mother of an 18-year-old woman who died in prison)

Case study

A 33-year-old woman was due to be sentenced on a Monday. Her lawyer was concerned about her welfare and sent a fax outlining his concerns to the prison. At a meeting on the previous Friday the woman had told her lawyer that she was not going to court on Monday – she would be in hospital.

The lawyer's fax arrived at the prison at 15:20 on Friday afternoon and was placed in the relevant pigeon hole on Monday morning. The woman had hanged herself on the Sunday night.

3.9 Drug withdrawal and detoxification in prison

3.9.1 The scale of the problem

Prisons take into their care a large population of long term poly-drug users. Outside prison their lifestyle is usually chaotic. They arrive into prison with drug and alcohol dependencies, poor physical health and often in a very emotional and volatile state. These women have a high morbidity rate in the community. Many have made a number of unsuccessful drug rehabilitation attempts and broken community service orders before being imprisoned.[251] Historically the treatment of drug users in prison was inadequate, arbitrary, and in some cases deadly.

Today, a system is in place across the women's estate that allows for drug detoxification and drug maintenance. Prisons increasingly offer longer detoxification programmes based on individual needs. The catalyst for change in the management of drug problems among women in prison was the six deaths that took place at HMP & YOI Styal within a 12 month period between August 2002-August 2003. All six of the women who died had a history of poly-drug use.[252]

Improvements in the management of drug problems in women's prisons are only part of the solution and clearly require adequate resources and properly trained staff. The real focus should be addressing women's drug problems in the community.

It is unacceptable that today the easiest way to get drug treatment is in prison.[253] It creates a danger that sentencers will send women to prison so that they can access these services as there is so little available outside.

Drug rehabilitation facilities outside prison need to be more accessible to women. For example, access should not require women

---

251. Interview with Jan Palmer, HM Prison Service, 1 September 2005.
252. See Section 5.4.2 for further discussion of the series of deaths at HMP & YOI Styal.
253. Interview with Lucie Russell, 7 December 2005.

to have a fixed address and some residential rehabilitation facilities should be able to accommodate children. This may prevent anxiety-provoking separation and may also provide children of mothers using drugs with much needed support.

Getting a woman into community drug rehabilitation requires co-ordination and funding. Emphasis should be placed on creating this infrastructure as it remains a cost-effective option.[254] The average cost of a three month period in a residential drug rehabilitation centre is £5,000. The average annual cost of imprisoning an individual in 2002-2003 was £36,268 or approximately £9,000 over a three month period.[255]

Most of the deaths in this research occurred prior to the introduction of adequate drug detoxification and maintenance programmes in women's prisons. It is worth identifying how families believe poor management of drug withdrawal and/or detoxification contributed to the women's deaths. This may assist in further change and prevent further deaths.

3.9.2 Drug withdrawal

Women with substance addictions will experience withdrawal symptoms at some stage of their imprisonment, including post-detoxification. Approximately 20% of women enter prison using drugs for which there is no available detoxification.[256] For these women withdrawal symptoms will be even more severe and involve serious physical distress and emotional disturbance.

Expert evidence given at inquests was that drug withdrawal places a woman at increased risk of a self-inflicted death. Doctors familiar with women in prison experiencing drug withdrawal described them as impulsive, abusive, threatening, having low stress tolerance levels and disturbed outbursts interspersed with periods of desperation when they express ideas and commit acts of attempted suicide and self-harm. Their sudden mood changes and unpredictable behaviour means women prisoners experiencing drug withdrawal often give no warning of suicidal intent prior to taking their lives.[257]

There is also a danger in pathologising women who may be reacting in a rational and real way to drug withdrawal, the symptoms of which may be exacerbated by the prison environment. Ideally drug withdrawal would be undertaken in an environment sensitive to the women's physical and psychological needs.

The distress experienced while withdrawing is exacerbated by severe and painful physical symptoms, including diarrhoea, vomiting,

---

254. Interview with Natasha Vromen, 7 December 2005.
255. *Using Women*, 2005, p12.
256. Evidence given at inquest into death of 39-year-old woman. There is currently no recognised detoxification regime for crack cocaine or stimulant withdrawal; interview with Jan Palmer, HM Prison Service, 1 September 2005.
257. *Ibid*; Interview with Louisa Snow, HM Prison Service, 1 September 2005.

Case study

The death of a 29-year-old woman on remand captures the volatility of a woman withdrawing from long term poly-drug use in the first weeks in prison.

The woman threatened to assault another prisoner or wreck her cell when a promised move to another prison wing did not occur. She experienced hearing voices and hallucinations and was noted as being highly abusive to prison medical staff. The woman tried to hang herself a number of times. At one stage she was moved to a strip cell. She hanged herself after 25 days in prison.

> insomnia, fitting, shaking, sweating and/or loss of appetite. Of greatest concern were cases where the management of these symptoms was so poor it contributed to the woman's death. Too often, as the attitudes expressed earlier reveal, symptoms of drug withdrawal are treated as a discipline problem, thereby exposing the women to greater risk and damage. This observation is supported by Margaret Malloch's research into the treatment of drug users where she noted that "medical care and treatment or its absence is framed in the context of punishment".[258]

Case study

A 30-year-old woman was rushed to hospital during the first week of her four month sentence. A long term heroin addict, the woman had been vomiting non-stop and suffering from diarrhoea and abdominal discomfort since entering prison. Her weight dropped to 88lbs/40kg and she complained to family members that she was getting minimal support to assist her in coming off the drugs. There was also an unjustifiable delay transferring the woman to a hospital for expert treatment, where she died two weeks later. The woman was classified as having died a 'non self-inflicted death'.

At the inquest into the woman's death, an open verdict was returned. The woman's family took the case to the European Court of Human Rights where it was found that her treatment by the prison authorities contravened the prohibition against inhuman and degrading treatment contained in article 3 of the ECHR and was also a breach of article 13, the right to an effective remedy.[259] The UK government was ordered to pay the family substantial damages.

Case study

A 23-year-old woman was suffering severe symptoms of withdrawal from long term poly-drug use, including continual shaking and diarrhoea. She told a fellow prisoner that if she didn't get more help with her drug withdrawal she would hang herself. She requested to see a nurse who immediately referred her to a doctor due to her symptoms and low mood. The doctor gave her anti-depressants and only basic painkillers for her symptoms. He believed she was not displaying "objective" withdrawal symptoms as her eyes were not dilating. The doctor's opinion was that drug users often exaggerate their symptoms to get more medication. The woman hanged herself the following day. Again, this example is illustrative of the view of prisoners as being manipulative.

---

258. Quoted in *The Hurt Inside: The imprisonment of women and girls in Northern Ireland, op cit,* p33.
259. *McGlinchey v UK* (2003) 37 EHRR 41.

3.9.3 Drug Detoxification

The relationship between drug detoxification and women dying in prison is not a straightforward one of cause and effect. Women often go on drug detoxification when they first enter prison, a time when they are already recognised as being at greater risk of a self-inflicted death.

Approximately 60-70% of women entering prison require drug detoxification.[260] A well-implemented, well-controlled drug detoxification is not life-threatening. To the contrary, it can alleviate most of the physical effects of drug withdrawal especially those which are protracted. Many women come back to prison to detoxify. Even if this is not a conscious decision, it is often life-saving.[261] As discussed, today prison is the easiest place to get access to treatment for drug misuse, further stressing the importance of effective detoxification in women's prisons and the urgent need to improve access to detoxification in the community.

In the past, drug detoxification programmes in prison have been so inappropriately designed and poorly implemented that families, inquest juries and experts believe they have contributed to women's deaths. Some of the reoccurring problems, which have since been addressed, have included:

- The provision of largely ineffective drugs for women with long term and severe drug problems. For a period of time, dihydrocodeine in the form of DF118 tablets was the standard detoxification provided for women entering prison with heroin addictions. Dihydrocodeine only slightly alleviates drug withdrawal symptoms.
- The failure to provide methadone to women who were receiving the drug on prescription outside prison.
- Rapid detoxification for long term drug use. Following the deaths at HMP & YOI Styal, heroin detoxification has increased from a standard 11 days to 21 days.

Case study

A 21-year-old woman arrived at prison in the evening. Despite being a long term heroin addict, there was no doctor on reception to prescribe her any medication. She was placed on the detoxification wing, where there was no nurse on duty. The woman died within 24 hours of arriving in prison.

At the inquest into her death the jury concluded that failure to provide a doctor or nurse was negligent and part of a system of care in place that was inadequate to prevent the woman's death.

260. Evidence given at inquest into death of 39-year-old woman.
261. Interview with Jan Palmer, HM Prison Service, 1 September 2005.

Case study

At the inquest into the death of a 22-year-old woman, a jury found that when she arrived at prison insufficient action was taken to establish an accurate picture of her recent drug intake or commence an immediate and effective drug programme of detoxification. She died prior to the commencement of any detoxification.

The jury specifically noted the prison's failure to contact the drug agency responsible for the woman's methadone administration outside prison. It is common for prisons to obtain this information from outside agencies.

Two weeks prior to her death, the then Director General of the Prison Service had visited the prison and noted complaints by nurses on the healthcare unit that the standard of detoxification being offered to women was very poor. They described the delay in providing drug detoxification as life-threatening.

Case study

A 24-year-old poly-drug using woman hanged herself after three days in prison. Following her death, her family expressed concerns that prison staff needed to be more proactive in their initial assessment and ongoing monitoring of prisoners who are drug users. A prison doctor saw her for ten minutes the morning after she arrived and assessed her as being fine. That evening an officer looked at her through the flap of her cell door, but did not speak to her, and made the same assessment.

In the investigation into her death, a number of prisoners commented on the woman's extreme distress during the three days.

At the inquest into her death, the governor and head of healthcare gave evidence that they expected newly-admitted prisoners with serious drug addictions to come forward where they experienced feelings of vulnerability, withdrawal and distress. Given the state of women entering prison with serious drug problems, it is questionable if this expectation is realistic.

3.9.4 Post-detoxification period

> "No sooner did the physical symptoms [of withdrawal] start to subside then her mental state began to deteriorate. The factors causing that would have been several. Firstly, being incarcerated in that hell hole. Secondly, the side effects due to abrupt withdrawal of two powerful drugs and thirdly her generally deteriorating… physical and mental state." (Mother of an 18-year-old woman who died in prison)

"Only when the drugs are taken out of a woman's system can we understand why she takes them. At this stage counselling is important. Detoxification without routine and support won't work."[263]

263. Interview with Natasha Vromen, 7 December 2005.

Most women in prison with a history of drug use have done so as a coping mechanism and often to suppress memories of painful life experiences including abuse. Once they have gone through detoxification they have to confront both the underlying reasons for and consequences of their drug use. Post-detoxification is regarded as the biggest 'at risk' period, yet there is a severe lack of support provided during this time.[264]

Post-detoxification a woman may wake up to the fact that she has not seen her children for years and has a very strong desire to re-engage. When women are told, as is often the case, that this is not in the child's best interest they can become very distressed, and feel that if they cannot see their children they will die.[265]

The Prison Service recognises how vulnerable women can be post-detoxification. Policy across the women's estate is that during drug detoxification, or in the four weeks post-detoxification, no woman should be placed in cellular confinement.

At the inquest into the death of a 37-year-old woman, evidence was given that while no one specific factor can be directly linked to a woman dying in prison, cellular confinement is a common factor in the deaths that have occurred in the withdrawal or post-detoxification period, regardless of the purpose of the confinement.[266] This woman was placed in cellular confinement during her four week post-detoxification period, highlighting that life-saving policies are only as effective as the staff implementing them.

Case study

A 22-year-old woman with a serious heroin and crack cocaine dependency died shortly after her nine day drug detoxification. In the period following detoxification she was not checked on by prison medical staff.

3.9.5 The introduction of methadone maintenance

Providing effective drug detoxification in prison is difficult for a number of reasons, including:

- The ideal detoxification area should be quiet and restful. Alternative therapies and distractions should be available.[267]
- Women, especially those on remand, may be in prison for an insufficient time to undergo effective drug detoxification.
- Women using drugs as a coping mechanism will continue to misuse them until the reasons for their substance abuse are addressed. It is questionable whether prison provides the right environment for women to address these issues.
- Effective detoxification regimes require adequate and sustained funding, resources and staffing.

In response to these difficulties, methadone maintenance

264. *Ibid*; Interview the Paul Fenning and Michael Loughlin, 25 May 2006.
265. Interview with Jan Palmer, HM Prison Service, 1 September 2005.
266. Evidence given at the inquest into the death of a 37-year-old woman.
267. Evidence given at the inquest into the death of a 39-year-old woman.

programmes are increasingly available across the women's prison estate.[268] There is a future plan to introduce benzodiazepine maintenance for women on shorter sentences. Having fits is a major problem associated with benzodiazepine withdrawal and has been a factor in women's deaths in the past.

While it is too early to assess the long term impact of drug maintenance in reducing women's deaths in prisons, in 2005-2006 there was a significant reduction in the number of self-inflicted deaths among women with drug problems.

Case study: HMP & YOI Styal

Methadone maintenance was introduced in HMP & YOI Styal in September 2003. At the inquest into the sixth death that occurred at Styal between August 2002-August 2003 evidence was given that once methadone maintenance was introduced the whole temperature of the remand wing at the prison reduced and positive changes were noted. Women appeared to be calmer and in less physical and emotional pain.[269]

In 2001 the management of Styal had pushed for the introduction of methadone maintenance. However, they were unable to provide the infrastructure needed to administer methadone or secure funding for capital healthcare spending.

In 2001 the coroner who was later involved in the inquests of the six women who died in Styal between August 2002-August 2003 was conducting an inquest into an earlier death in Styal. Following this inquest, the coroner wrote a rule 43 letter firmly backing the then governor's requests for detoxification facilities.

Likewise, HMCIP's report on Styal in February 2002 identified the "profound and damaging effects" of the lack of proper detoxification and recommended immediate improvements to the detoxification regime.[270] This finally occurred in 2003. The investigation report into the six deaths in Styal states, "after the [sixth death], it was decided to delay no longer in introducing a methadone detoxification programme."

It is deeply concerning that despite these earlier recommendations, six lives had to be lost before a proper drug detoxification regime was introduced in Styal. Had a mechanism existed to penalise gross negligence and systemic failures in the form of a corporate manslaughter offence, then arguably some of these deaths could have been avoided.[271]

---

268. Since 2003 methadone maintenance programmes have been introduced gradually in women's prisons; evidence given at the inquest into the death of a 37-year-old woman.

269. Evidence given by prison governor at the inquest into the death of a 39-year-old woman.

270. *Report on a full announced inspection of HMP & YOI Styal 4-8 February 2002,* 2002, p3 and p65.

271. See section 5.5 of this report for further discussion of corporate manslaughter and deaths in custody.

3.10 A catalogue of errors

"The tragedy which occurred is that these factors came together to create the dark, desperate sense of isolation and hopelessness that drives a person to contemplate, and then to commit, suicide."[272]

Based on twenty-five years casework experience, INQUEST has found that,

"many of the cases, and obviously we are working with the families of people who have died, do raise very important systemic and individual failings and what we would call inhuman and degrading treatment."[273]

Often there were numerous failures in the treatment and care provided to the women who died. Investigation reports and inquest verdicts often echoed families' concerns that prison had failed the women on every level.

Case study

A 27-year-old woman hanged herself after two and a half months in prison. During this time she was depressed, regularly self-harmed, took two drug overdoses and was continually moved between establishments.

Six days before her death she had an individual consultation with a psychotherapist which appeared to have helped her. Despite this, plans were in place to transfer her to another prison.

The investigation report into her death concluded that she did not intend to commit suicide. Rather, her actions were a desperate act to avoid this move. She had already been moved twice and was very distressed at the prospect of a further transfer. It jeopardised a planned visit from her son and meant separation from a woman with whom she having a relationship with in the prison.

A medical report concluded that her ".. death was entirely preventable… it was due to a catalogue of poor communications, superficial and meaningless assessments of her condition and straightforward neglect."

Case study

A 35-year-old woman hanged herself while serving a life sentence. She had been placed on suicide watch on numerous prior occasions.

In the days before her death she was described as very down, withdrawn and was having trouble eating and sleeping. Despite this, observations of the woman were reduced on the day she died.

---

272. The committee in *R v Her Majesty's Coroner for the County of West Yorkshire (appellant) ex parte Sacker* (FC) 11 March 2004, House of Lords. Issues arising at the inquest into the death of a 22-year-old woman became the subject of this Court of Appeal case.

273. Deborah Coles, co-director of INQUEST, speaking at the Meeting of the All Party Parliamentary Penal Affairs Group, "Deaths in Prison and their Prevention", 25 January 2005.

The jury explicitly criticised the failings of the prison in their verdict and made comments relating not only the death of this woman, but also the care of vulnerable prisoners in prisons throughout England and Wales.

The jury found that the panel who reviewed the woman's F2052SH on the morning of her death made crucial decisions about her care with insufficient information. They did not have information from medical records, previous F2052SH reports, recent evaluations or relevant written medical correspondence.

They also found that the decision to reduce levels of observation from intermittent to half-hourly contributed to the woman's death for the following reasons:
- **More frequent and irregular inspections would have reduced her opportunity to kill herself.**
- **An intermittent watch signifies a higher state of concern and would motivate a higher level of care from staff in general and a reduced level of care would give more confidence to the prisoner to attempt suicide.**

Finally, the jury outlined nine steps that should have been taken to prevent the woman's death, including the provision of an appropriate and accessible counselling service and a method of promptly expediting the recommendations of previous investigations and reports.
Her father described the verdict as "a scathing catalogue listing 16 points relating to the failings of the prison service in its duty of care."

A 20-year-old woman serving a nine month sentence for assault and affray hanged herself after two months in prison.

The woman's family was concerned about the lack of care provided to her by the Prison Service. Their concerns, outlined as follows, raise wider issues about the treatment of women with mental illness in prison:
- The prison did not obtain full medical records or an understanding of the woman's recent medical history. As far as they were aware she only had one previous overdose attempt, aged 15. However psychiatric evidence showed very troubled behaviour in the period prior to her imprisonment.
- There were failures in communication between medical staff and prison officers.
- Staff absenteeism meant that the woman was dealt with by a number of people in the days leading up to her death. There was no consistency in the care provided and no one really got to know her. Her personal officer had few dealings with her and was absent during most of the time she spent on the young women's wing.
- Bullying of women moving from the psychiatric or medical wings to regular wings was addressed ineffectively.
- Staff were not well versed in self-harm and suicide awareness procedures. They were aware the woman was suicidal but did not place her on a F2052SH.

At the inquest into her death, the jury heard evidence of serious concerns about the quality of suicide prevention policies in place at the prison and the failure of the prison to implement

recommendations from previous deaths. Despite this, the coroner did not allow the family's legal representative to raise these deaths or the prior investigation recommendations at the hearing. The coroner also did not allow the jury to incorporate neglect in their verdict. The jury returned an open verdict.

3.11 Conclusion

This part of our report has identified serious systemic and individual failings in the care provided to the women who died while in prison. The women's cases demonstrate how these failings contributed to their deaths and show that their deaths were not inevitable. On the contrary, much more could have been done in prison on both a systemic and individual level to keep these women alive.

3.12 Recommendations and best practice

Issue	Description	Recommendation	Examples of best practice
Management of the women's prison estate	Since 2005, women and men's prisons estates have been managed together, according to geographical location.	Return to separate management of the women's prison estate	
Trigger events	Women frequently died following a distressing event or incident.	Prison staff should be aware of dates of personal importance to the women in their care and provide additional support. For example anniversaries or children's birthdays. Staff guidelines should be formulated on how to deal with trigger events e.g. incidents of death in custody, deaths in prisoner's families, loss of custody of children.	In HMP Holloway additional support is put in place on certain days recognised as more difficult for women. For example, on Mothers Day women are unlocked for longer.

Issue	Description	Recommendation	Examples of best practice
Extended periods of time in cells	Women were locked in their cells for extended periods of time in the period immediately prior to their death.	Provide women in prison with purposeful daily activity and distraction.	Open prisons: Best practice due to their permeability. Independent agencies can come into them and women can go out and work in the community. Closed prisons: HMP Downview has imaginative, creative programmes in place. The women are allowed to go into the community to college and to work.
Bereavement	Women who died had often experienced the death of someone close to them.	Bereavement counselling should be more readily available across the women's prison estate.	
Care/ adoption issues	Women whose children go into care or are adopted while they are in prison	The impact of the loss of their children must be recognised and support made available.	
The impact of other deaths in prison	Some of the women who died in prison had witnessed or were involved in the events surrounding the death of another woman in prison.	Support and bereavement counsellors should be available for prisoners and staff following the death of a woman in prison, with special attention being given to women who were involved in or witnessed the death or saw the dead body. When prisoners give evidence at inquests they should be prepared for the experience, have a support person attend the inquest with them and be offered support and counselling where necessary afterwards.	

Issue	Description	Recommendation	Examples of best practice
Prison officers' attitudes to suicide attempts	Staff attitudes and responses to suicide attempts may contribute to the rate of suicide and self-harm in women's prisons.	As a matter of priority, prison staff should be trained on how to respond to suicide attempts and threats.	
Use of listeners	Trained prisoners provide support to other women in prison.	Listeners must never be used as a substitute for proper monitoring and support.	In cases where foreign national women are threatening to kill themselves, prisons allow FPWP/Hibiscus to intervene. This may involve caseworkers going to talk to the woman or informing the Border and Immigration Agency that the woman is at risk of suicide and her deportation orders should be completed as soon as possible. In Canada women prisoners are used to support other prisoners to stop them self-harming. This effective programme runs in prisons where women live in small houses. In this environment they have a degree of autonomy over their daily lives, for example they cook for themselves.[274]
Use of counsellors	Too many women in prison are medicated rather than being offered counselling.	Specialist agencies independent of the Prison Service should provide properly-trained counselling and support for women in prison.	

274. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.

Issue	Description	Recommendation	Examples of best practice
Disciplining 'difficult' women	Women in prison are often disciplined for self-harming or displaying symptoms of mental illness or drug withdrawal.	The introduction of appropriate responses to women's self-harming, including staff training and guidelines on self-harming.	The sister of a prolific self-harmer who died in prison described the environment that assisted in stopping her own prolific self-harming behaviour. She entered a caring, therapeutic environment that offered group therapy, distractions and placed an emphasis on personal responsibility.
Family contact in prison	Family support can be vital to the welfare of women in prison and should be easily accessible.		HMP Askham Grange has phones on the landings which allow women to receive incoming calls. A roster is placed next to the phone and women know when they will be receiving calls.

Part 4: The experiences of the bereaved

4.1 Introduction

In this part of the report we discuss the difficulties families can experience in seeking answers and establishing the truth about what happened to women who died while in the care of the state. We focus on how families negotiate complex and intrusive legal processes with limited financial resources. We examine the impact that institutional defensiveness and indifference can have on a family's ability to participate in the investigation and inquest process.

4.2 Treatment of the bereaved

> "The prison's philosophy is to treat all inmates with humanity. Should this not apply to the families as well?" (Mother of a 24-year-old-woman who died in prison)

Bereaved next-of-kin need to be:

1. **Treated with respect and sensitivity.**
2. **Kept fully informed.**
3. **Enabled to make informed choices.**
4. **Central to the procedures and investigations that follow a death in custody.**[275]

Families' experiences with the Prison Service varied greatly following a death. Some prisons went into shutdown mode, creating the perception that their main aim was to avoid blame. This defensive damage limitation exercise is inappropriate and unproductive, particularly if there is a desire to prevent further deaths. In some cases this shutdown manifested in the prison failing to offer the family condolences for their loss.

Prison Service protocols have changed and now recognise the need for better practice in the treatment of families following a death in custody.[276] However, there is still no uniformity of approach despite the important impact this has on the family's ability to engage with the subsequent investigation and inquest. Some prisons will pay all of the family's expenses in attending the inquest. Other prisons will agree to the standard fee of £1,000 towards funeral expenses and be difficult in making the payment. This bureaucracy causes additional stress to families at a very difficult time.[277]

In the past it was difficult to get the Prison Service to pay for funeral expenses. Since 2005 this has been the norm, although it is still not enshrined in Prison Service policy.[278]

> "[Our solicitor] thought we should have possibly received a letter of condolence from the prison but we didn't….What I did

275. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit*, p21.
276. Interview with Fiona Borrill, 8 December 2005.
277. *Ibid.*
278. *Ibid.*

receive is a two line letter saying this is the money that [your daughter] had in the prison and a cheque. It wasn't even a generated letter, somebody had sat and actually done that. They could have just added their sympathies to it." (Mother of a 20-year-old woman who died in prison)

"There was no 'sorry this ever happened' or 'we need to address this' or 'are there any questions you would like ask us'. Nothing at all from the prison side like that." (Mother of an 18-year-old woman who died in prison)

Case study

A 22-year-old woman died in prison. At the time her mother was a serving prisoner at the same prison. None of the prison officers or anyone in the Prison Service offered the mother their condolences. This is particularly disturbing as the mother was housed in prison so would have had limited avenues of other support.

The sister of a 39-year-old woman who died went to the prison to retrieve her belongings. She described her experience as follows:

"It takes about an hour to travel to the prison. I called to the main gate and was asked if they could help me. I told them that I was [the woman's] next of kin and I had come up to collect her belongings. I was told to wait and someone would be over to see me. I thought that I may have been taken into a little room to make things more discreet but this wasn't done. I was left approximately 20 minutes. I was taken into the locker area and asked to sign for [the woman's] belongings. I was given her possessions. I wasn't even offered a cup of tea and nor were my brother or sister. I was actually physically ill at the gate. I then travelled back [home]…

[The prison governor] contacted me on the morning of Monday 18 August. She told me that she had some money to pay to me and asked if I would like to come up and collect it. I told her I had no intention of coming back up, particularly in light of the way I had been treated when I had been up there. The following day I received flowers by way of an apology… I was also told that the prison was holding a memorial service which was actually taking place as [the governor] was with me. I do not recall anyone telling me about this prior to her calling to see me.[279]

Following the inquest into this woman's death, the coroner commented that her family had not been welcomed at the prison and wrote a letter to the prisons minister drawing attention to this issue.

4.2.1 Access to independent information and support

INQUEST's report *Unlocking the Truth* found a lack of information and support for families at all stages following a death in custody. The absence of independent advice and support immediately following the death prevents families from making informed choices about if and

279. *The Styal Report – The death in custody of a woman and the series of deaths in HMP/YOI Styal August 2002 – August 2003, op cit*, pp54-55.

how they participate in the post-death investigation and inquest process. Inquests into deaths in detention are particularly complex. Without access to specialist legal advice meaningful participation in the inquest process is hindered. Those who have immediate contact with the family after the death can have a crucial role in ensuring families seek advice from lawyers with adequate qualifications and experience.

A number of agencies (the coroner service, the voluntary sector, the prison and the investigation bodies) could be expected to provide information and support to bereaved families, but at present the process is disjointed and confusing.

In the absence of a comprehensive statutory service, INQUEST continues to provide a generic information service to any family bereaved in circumstances requiring an inquest, and a unique casework service to families bereaved after deaths in custody. It publishes *Inquests – An Information Pack for Families, Friends and Advisors*[280] which explains the whole process and where to find emotional and practical support. Its relevance is demonstrated by the number of requests for the information pack made to INQUEST. The pack was launched in August 2004 and by the end of 2007 had been downloaded from the website over 25,000 times. An increasing number of coroners are requesting copies to give to families. INQUEST's pack is the only such comprehensive guide available and everyone who needs it should have access to it. However, it is not satisfactory for the voluntary sector to have to seek charitable funds to produce information that should be provided by the coroner service.

In the long term, the service provided by INQUEST should be complementary to a properly resourced and comprehensive support service provided by the coroner service. It should ensure that families receive all the basic support and information they require.[281]

4.3 Funding the bereaved family's legal representation

"It still remains the case that unlimited public funding is available for experienced, good quality lawyers to represent the police, Prison Service and other bodies, while those representing families have to make lengthy and time-consuming representations to the Legal Services Commission for the little funding they receive."[282]

Post-death, the family becomes the woman's representative. Defined as "properly interested persons", they have the right to ask questions

280. INQUEST 2004, free for bereaved families and also available from www.inquest.org.uk

281. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit*, p37.

282. *INQUEST's Submission to the Constitutional Affairs Committee into Reform of the Coroner's System and Death Certification in England and Wales, op cit,* p10.

at the inquest.[283] Under both domestic and European law it has been established that the participation of next-of-kin in post-death investigations is an essential ingredient in compliance with article 2 of the ECHR, the right to life.[284]

Many families cannot actively participate in post-death investigations as they are unable to afford legal representation for the inquest and related preparation. The lack of funding available for bereaved families is a matter of serious concern.

Currently, there is an anomalous situation where the state has automatic and unlimited access to tax payer funding for legal representation at an inquest involving a death in custody, while the bereaved family experience great difficulty accessing any limited public funds for this purpose.[285] At the inquest into any death in prison Treasury Solicitors and Counsel will represent the Prison Service. Individual officers may also be represented through their trade union, the Prison Officers' Association, and doctors and nurses through their union or professional organisation.

For families, it is an uphill battle to secure funding. The process is highly intrusive as families are asked detailed questions about their individual income and assets. These details are asked of a wide range of, and often distant, family members which can cause considerable stress to family members and difficulties for solicitors as they have to persuade relatives to provide this information. Even when funding is granted, it is often only partial and requires a contribution from families that can run into thousands of pounds. Sometimes families have decided not to participate in the inquest because this process is too distressing.[286]

The father of a 35-year-old woman who died described his experiences trying to secure legal funding:

> "It was bad enough to be in the situation where our daughter had taken her own life. Then to add insult to injury, during a time of deepest personal grief, we had to demean ourselves and practically beg for means-tested financial help, by laying open for scrutiny all our personal circumstances. This opposition to our efforts nearly made me give up, and only my solicitor, through INQUEST, persuaded me to go on.
>
> My solicitor later informed me that the first application was refused, and then she appealed. It went to very high office in government before being finally approved. Even with that, we have been warned that we may have to contribute. Moreover, we are pensioners on limited means!

---

283. Rule 20 of the Coroners Rules 1984.
284. *Deaths in Custody: Third report of session 2004-2005 Vol.1, op cit,* p88.
285. INQUEST briefing to the Corston Review of women with particular vulnerabilities in the criminal justice system, 2006.
286. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit*, p95.

> We think that in cases such as this, legal representation should be freely available without having to go through this stressfully complicated and uncertain procedure.
>
> It is a very unfair situation, when the state has unlimited legal funding and the bereaved family can usually not even afford legal representation. Deaths in custody should have public funding without question, unaffected by the financial circumstances of the bereaved family."

Post-death investigations should be accessible to families following a death in custody. At the very least, families should have equal access to funding for legal preparation and representation for the inquest. Funding should be non means-tested and financial eligibility tests should be removed when article 2 of the ECHR is engaged. INQUEST's recommendation for public funding in these circumstances has received unconditional support from Baroness Corston in her review of women in the criminal justice system[286] – a review prompted by the disquiet arising from evidence which came out of inquests into deaths of women where the families were adequately represented. Disgracefully, this recommendation was rejected by the government in their response to the Corston Report[287] and we question whether or not this is in breach of the ECHR in terms of the families' ability to participate fully in the article 2 inquiry.

4.4 Family involvement in post-death investigations

Families provide a unique perspective on the events surrounding a death in custody. They had involvement with the woman prior to her entering prison, and their interactions with the woman while she was in prison may be highly valuable when creating strategies to prevent further deaths in custody.

Families often felt ignored throughout the investigation process. This is unacceptable given the impact of the death on their lives and their right to know what happened to their relative.

Basic information which could alleviate stress is often not passed on to families. For example, the sister of a 42-year-old woman who died in prison described how the prison failed to inform her that her sister's funeral expenses would be paid.

Families appearing as properly interested persons at inquests often received copies of investigation reports after other parties and very close to the inquest date.

- The family of a 27-year-old woman who died in 1998 received the investigation report into the death the day before the inquest.
- The family of a 37-year-old woman who died in January 2004 had to chase up the investigation report into their daughter's death as it

286. *The Corston Report: A review of women with particular vulnerabilities in the criminal justice system*, 2007, p34.
287. *The Government's Response to the Report by Baroness Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice System*, 2007, p13.

seemed to be very overdue. The inquest was scheduled for January 2005 and they did not receive a copy of the report until December 2004. The family felt this did not give them adequate time to consult a lawyer. Subsequently, the inquest was moved to June 2005.

INQUEST raised this issue in their evidence to the JCHR who concluded that it potentially breached article 2 of the ECHR:

"For disclosure to the family to support real and effective participation in the inquiry, as required by article 2, it must be thorough, prompt and affordable. We recommend that the fullest disclosure should be made to the family well in advance of the inquest."[288]

At inquests, there is often rarely a private room for the family to go to debrief or talk to their legal representatives. While this is usually due to space constraints at the coroners courts, in some cases a room specifically for this purpose is provided for Prison Service representatives. The family of a 27-year-old woman who died in prison found this particularly disturbing as the waiting area was shared with a number of prison officers. Another family complained about prison staff sitting in the courtroom reading newspapers while evidence was being heard.

Once an investigation is completed there should be a mandatory responsibility to keep families informed of any action taken in relation to recommendations during the investigation and inquest process. In cases where families have maintained contact with the prison following the investigation their experience of the investigation process has been much more positive. Some describe seeing a real commitment to preventing further deaths and in some cases have been able to make suggestions for change themselves. However, this rarely occurs and if it does it is usually at the initiative of the bereaved family. This follow-up is very important as families' needs after a death in custody are twofold – to speedily find out as much as possible about how and why their relative died; and to help prevent other deaths.

4.5 Bereavement counselling for families

> "Where do I go? A woman I know, her son had hanged himself. He wasn't in custody. He had been a drug user and he killed himself. The bereavement group for families she joined was mainly when children died of leukaemia and things like that. There was no where you could particularly go because they have taken their own life or because they have been in prison as well… It's stopped me going to a lot of the self-help groups because I don't want to have to discuss all this with people." (Mother of a 20-year-old woman who died in prison)

Families often had difficulty receiving appropriate bereavement counselling following the death. Some were also caring for the woman's children, which often meant helping the children grieve.

288. *Deaths in Custody: Third report of session 2004-2005 Vol.1, op cit,* p87.

None of the families had been provided with relevant help and support, nor had the children received any counselling.[289]

4.6 Support from others with similar experiences

Families often found comfort when they realised they were not alone in their experience.

In June 2006, INQUEST organised a meeting for some of the families involved in this research. The intention of the meeting was to discuss the project and bring families together. Many described how much they had benefited from being with others who had been through a similar experience.

Some bereaved families are unable or unwilling to access support from others in similar circumstances. In these cases input from statutory agencies is essential. INQUEST's research has highlighted the limited understanding of government and related agencies of the specific and ongoing needs of families bereaved after deaths in custody:

"Appropriate ongoing support must be available and follow-up communication about action being taken where the death has occurred in an institution must be provided. Family Liaison Officers, Family Support Workers, counsellors, psychologists and social workers should be trained to understand the investigation and inquest systems and the complex responses of people bereaved by a death in custody."[290]

4.7 Conclusion

Bereaved families can provide a unique perspective on women's deaths in prison due to the length and nature of their relationship with the women who died and their involvement with her outside the prison environment. In many cases this involved contact with other state agencies. Their contribution to post-death investigations is potentially highly valuable if further deaths in similar circumstances are to be prevented. The investigation and inquest process that follows a death in prison must facilitate the maximum involvement of the family in terms of access to information and resources. This should include non means-tested public funding for preparation and representation; access to independent advice and support; and full and timely disclosure of all relevant documents.

---

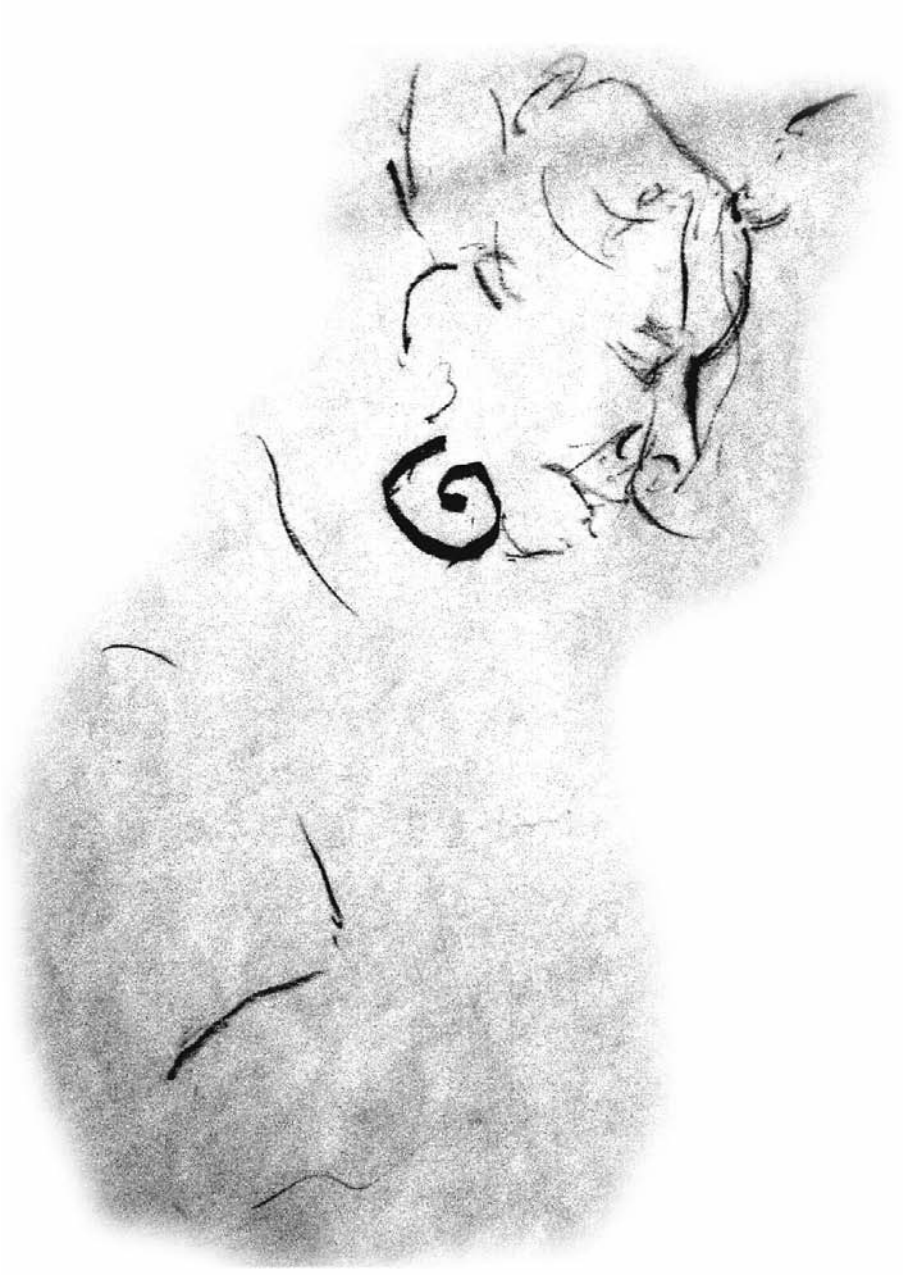
289. For further discussion of this issue see *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit*, p118.

290. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit*, p121.

4.8 Recommendations and best practice

Issue	Description	Recommendation	Best practice
Funding for the bereaved	Many families could not actively participate in post-death investigations as they were unable to afford legal representation for the inquest and related preparation. Even where limited public funds were received there was no money available for travel and subsistence. Families often have to make long journeys to attend an inquest.	Automatic provision of good quality, publicly funded legal representation for bereaved families appearing at inquests concerning deaths involving the state and its obligations under article 2 of the ECHR. Baroness Corston recommended in her recent report that "public funding must be provided for bereaved families for proper legal representation at timely inquests relating to deaths in state custody that engage the state's obligations under article 2… funding should not be means tested and any financial eligibility test should be removed when article 2 is engaged."[291]	Following a death at HMP Durham, the prison agreed to pay for all of the family's expenses during the inquest, which included travel, subsistence, accommodation, childcare provision and loss of earnings.
Bereavement counselling for families following a death in custody.	Families often have difficulty receiving appropriate bereavement counselling following a death.	Improved access to counselling for families, in particular for the children of women who die in prison.	

291. *The Corston Report: A review of women with particular vulnerabilities in the criminal justice system, op cit*, p5.



Part 5: After a death – implementing change following a death in custody

5.1 Introduction

In this part of the report we focus on the investigations into deaths of women in prison. We consider why opportunities to learn from previous deaths are not being maximised and examine issues such as delays in post-death investigations, inquest verdicts and rule 43 reports. We also consider post-death investigations when there have been a series of deaths at one prison.

5.2 Failure to take action to prevent deaths

"The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."[292]

"In law, as well as in humanity, prison staff and the Prison Service, acting on behalf of the state, have a duty to protect life and to apply lessons from adverse incidents."[293]

"At inquests you see the same officers doing the same mistakes."[294]

Further deaths can be both devastating and demoralising for families who have already lost relatives, especially when they have dealt with their loss by hoping that changes will have been made as a result of their experiences.[295]

> "I hope the Prison Service and Health Service will make changes so that other women in [my daughter's] position receive the help that they need and other parents can be spared the heartache which my family has suffered." (Mother of a 24-year-old woman who died in November 2003. Since her daughter's death, a further 31 women have died.)

> "I hope that what I, and others, have been through will lead to things improving. I wouldn't wish this on anyone." (Father of a 35-year-old woman who died at HMP Durham. He was incredibly distressed to hear of two further deaths at the prison.)

An investigation and inquest takes place after every death in prison.[296] With appropriate advice, support and resources families can

---

292. *R v. Secretary of State for the Home Department ex parte Amin* [2003] UKHL 51 para 31.
293. *The Styal Report – The death in custody of a woman and the series of deaths in HMP/YOI* Styal August 2002 – August 2003, *op cit*, p60.
294. Interview with Harriet Wistrich, 25 November 2005.
295. Interview with Fiona Borrill, 8 December 2005.
296. The Coroner's Act 1998 states when someone dies a "violent or unnatural death" or a "sudden death of which the cause is unknown" or when there is a death in prison, the death has to be reported to the coroner and there has to be an inquest into the death.

be actively involved in these processes, which provide opportunities to learn lessons and potentially act as preventative tools for further deaths. Subsequent deaths, in similar if not identical circumstances suggest these opportunities are not being maximised.

"INQUEST has been frustrated by the failure to learn the lessons from deaths occurring in different custodial settings and the lack of joined up learning between agencies. In our view this failure has resulted in more deaths occurring because this serious human rights issue has not been approached in a holistic way. Many of the issues arising from deaths in custody need to be fed into the wider agenda for social inclusion of government, local authorities and the voluntary sector. Many of the deaths which occur are part of a pattern which impact on policies on combating racism, drug and alcohol use, homelessness, mental health, crime prevention and policing. There has been a failure to address thematic issues that surround deaths in custody."[297]

There are four major flaws in the current system for dealing with deaths in prison which contribute to the failure to learn from previous deaths:

- **Lack of joined up thinking** – With no centralised databases for collating investigations and inquest findings or recommendations, there is a huge missed opportunity to learn from the experience of others and implement life-saving changes across the women's prison estate.
- **Lack of accountability** – Neither state nor corporate bodies, nor the individuals working within them, are ever held fully accountable for their actions following a death in prison. The lack of mechanisms for enforcing recommendations made at any stage of the process – from death through investigation, to inquest and beyond, means there is little incentive to implement change. There has never been a successful prosecution of any individual or institution for homicide following a death in prison, even when a verdict of unlawful killing has been returned.
- **Delays** – The current system is impeded by unnecessary delays at every stage. These delays exacerbate the grieving process for families and dilute criticism, allowing the prison service to say that procedures and policies have changed, which makes the quest for the truth an exhausting and frustrating process.
- **Culture** – Investigations into deaths in prison and legal advocacy on behalf of the state have been perceived by many observers as attempts to explain away the deaths. As Scraton and Chadwick reported, "speaking ill of the dead" was a process of categorisation suggesting that the "inadequate … or … mentally ill" contributed to their own death either by their pathological condition or personal choice. This is done in order to deflect attention away from the

297. Deborah Coles, co-director of INQUEST, addressing *Deaths in Custody: Lessons to be learned*, a Centre for Crime and Justice Studies (CCJS) conference, 29-30 November 2005.

political and social context of these deaths – the prison environment, treatment by custodians, and sentencing policies.[298]

5.3 Post-death investigations

The police conduct an initial investigation into every death in prison on behalf of the coroner to assess whether there were any suspicious circumstances.[299] Prior to April 2004 the Prison Service investigated deaths in custody internally. These investigations were often extremely poor and limited in scope. In April 2004 the responsibility for investigating deaths in prison passed to the PPO.

Once the PPO is informed of the death by the Prison Service their investigation begins. It involves visiting the prison where the death occurred, contacting the family, writing and circulating a draft and then a final report. The PPO sets the terms of reference for each investigation, which will vary according to the circumstances of the death.

PPO investigations assist the UK in meeting its obligation under article 2 of the ECHR that the deaths of individuals involving the state must be officially and effectively investigated.[300]

Since the PPO took responsibility for investigating deaths in prison the investigation process itself has not changed. Under both systems information is gathered and presented in an investigation report which also makes recommendations.

Case study

A 23-year-old woman died after five days on remand. During this time her drug withdrawal was poorly managed and prison staff failed to notice her distressed and suicidal state.

The investigation report into her death was extremely uncritical and narrow in its approach. It made no recommendations directly relating to the circumstances of her death and there was a failure to interview everyone involved. The report stated that "during the course of this investigation we found no outstanding issues from the reports into the last three deaths in custody at HMP & YOI Eastwood Park. It is important to note that we did not scrutinise areas not relevant to this incident."

In contrast, the investigation into the death of a 22-year-old woman took place shortly after the changes to the investigation system were introduced. It addressed and made recommendations on issues wider than just her death. The prison developed an action plan based on these recommendations and most, if not all, of the recommendations were actioned. The coroner at the inquest into her death commended the PPO investigation for its thoroughness.

To date there has been no clear policy on the minimum standards of investigation. While PPO investigations are more thorough and will often examine a wider range of issues than the previous investigations carried out by the Prison Service, the investigations remain too dependent on the

298. *In The Arms of The Law,* 1987, p223.
299. For further information on the investigation and inquest process see *Inquests – An information pack for friends, families and advisors, op cit.*, 2004.
300. *R v Middleton v West Somerset Coroner* [2004] 2 WLR 800. See below for further discussion of this obligation.

individual conducting them. This is the case in terms of breadth, exploration of wider policy issues and thorough interviewing of key witnesses. It is often the involvement of the bereaved family and their lawyer that has ensured a broader and more comprehensive investigation.

Despite these improvements, families and experts continue to express concern that the failure to implement investigation recommendations has cost lives. Equally concerning is the repetition of recommendations across investigations into a number of individual deaths. For example, several investigations recommended that ligature points be removed from cells and that better equipment for resuscitation should be made available, yet in some cases these suggestions were not implemented in time to prevent further deaths.

Case study

A 35-year-old woman recognised as increasingly depressed by prison staff was housed in a single cell with obvious ligature points. She used a hook on the back of the cell toilet door to hang herself. Recommendations had been made in previous inquests and investigations that cells needed to be made safer, which included the removal of ligature points. Only following this woman's death were hooks removed from doors.

Case study

A 35-year-old woman (Prisoner A) hanged herself from the curtain rail in her cell. The investigation report into her death recommended that curtain rails be removed from all cells in the prison. Instead only the rail in Prisoner A's cell was removed.

Ten months later a 20-year-old woman (Prisoner B) hanged herself from the curtain rail in her cell at the same prison. The investigation into her death found that the prior recommendation to remove curtain rails from all cells had not been properly implemented.

There is also no mechanism in place to learn from deaths across the women's estate. A further three woman hanged themselves from curtain rails at other prisons.

The investigations into some of the deaths examined as part of this research took place prior to April 2004. However, families and experts still have concerns that investigations are not always as effective as they could be. We outline some concerns below as they can help to inform best practice in any investigation system:

- Investigations vary greatly in quality and quantity. The quality of an investigation will often depend upon the level of input from lawyers and INQUEST. In cases where families contacted INQUEST, and legal representation for the inquest and its preparation was organised, investigation reports tend to be more thorough. Ultimately the quality of the report will depend on the approach of the investigator.

A solicitor involved in the inquest of a 37-year-old woman who died at HMP New Hall suggested to the investigator that they interview a senior official at Prison Service Headquarters about broader issues arising from the series of deaths that had taken place at

HMP New Hall. Initially the investigator advised the solicitor to contact the Prison Service herself, but the final investigation report showed that he had interviewed staff at Prison Service and expanded its scope.[300]

Interviewing techniques appear to depend on which investigator is allocated. Some interviews are very thorough while others are summarised and no transcripts are provided.[301] In other cases key witnesses had not been interviewed at all until the family's solicitor had intervened.

- Extensive and unnecessary delays in publishing investigation reports mean that life-saving changes have not been introduced as soon as possible following a death. For example, the investigation report into the death of a 37-year-old woman was only available 18 months after she died.
- If investigations look at the death in isolation it means that ongoing systemic failings are easily ignored, especially wider questions about policy and practice in relation to women and custody.
- Delay in the completion of investigation reports can be due to lack of staff and resources. This can result in delay in interviewing crucial witnesses, particularly other prisoners who may have been transferred or released.

Case study

The death of a 20-year-old woman was investigated by the PPO. However, there were considerable problems with the enquiry. The senior investigator went on long-term sick leave and the investigation ceased. Despite numerous representations by the family and their representative, which included a formal complaint to the Ombudsman, the investigation was not restarted for several months. The delay meant that crucial witnesses were not interviewed until a year after the death. When the draft of the report was produced it became clear a number of key interviews had not been taped and only notes of interviews were provided, making it impossible to establish whether relevant questions had been put to witnesses.

It became apparent during the course of the inquest that key documents highlighting the known risk of suicide posed by the woman had either been suppressed or simply not been disclosed by the Prison Service and the PPO.

Case study

A 22-year-old woman hanged herself after two days in prison. Arriving at prison she was fearful of being bullied by other prisoners in relation to events outside prison. The investigation into her death focused on the gravity of this threat and the prison's response to her concerns.

CCTV footage captured a prisoner kicking her cell door in the moments before she died. The PPO expressed concerns about the actions on the tape. When the coroner went to the prison to collect the tape it had disappeared and it was never recovered. The prison governor described the disappearance of the tape as "an administrative error". At the inquest the coroner stated, "this is not the first time in this court video footage has disappeared… it is a terrible state of affairs."

300. *Ibid.*
301. *Ibid.*

5.4 Investigating a series of deaths

"When people say that a series of deaths in a prison does not have connecting factors, they miss the obvious connecting factor, the prison itself and the way in which the possibility of suicide has 'gone into the walls'".[302]

Some deaths were one of a series occurring at a prison within a relatively short period of time:

5.4.1 HMP Durham

In January 2004 HMCIP carried out an unannounced inspection of HMP Durham. At that time the female centre was a high security establishment that housed approximately 120 women in one wing (F wing). The inspection took place at the end of an 18 month period in which five women housed on the wing had taken their own lives, between August 2002 and November 2003. Prior to this, there had been no deaths at the prison for 12 years. The spate of deaths coincided with a massive 150% increase in the female prison population at the prison which raised concerns about the impact of overcrowding.[303] These deaths were never examined as a series but investigated in isolation.

The Inspectorate found the unit to be claustrophobic and inward looking "*scarcely likely to enhance the mental state of women who are feeling depressed and anxious*"[304] and not supporting the mental health needs of the women there. They found it to be an unsuitable place to hold women serving long sentences and recommended they be moved to alternative locations.

"We do not believe that the environment, or the regime that can be made available within [HMP Durham], are appropriate to hold long-sentenced women who need both support and sufficient purposeful activity. The women in Durham can and should be accommodated in other women's prisons, with better facilities and closer to home, with appropriate security restrictions for those few women who need this."[305]

The Inspectorate recommended that the unit should be closed and all the women moved to other prisons. Four months after the publication of the 2004 report, a 45-year-old woman died in HMP Durham. HMIP's recommendation was accepted and the majority of the 120 women were transferred to other prisons. However six women continued to be held in Durham and in November 2004 they were transferred to I Wing, previously a unit of eight cells designed for the most high-risk male prisoners. This was only ever meant to be a

---

302. *The Styal Report - The death in custody of a woman and the series of deaths in HMP/YOI Styal August 2002 – August 2003*, *op cit*, p45.
303. *Beverly Fowler Inquest Verdict Returned*, 2003.
304. *Report on an unannounced inspection of HMP Durham 5-9 January 2004, 2004,* p3.
305. *Ibid*., pp4-5.

transitional environment before their move to Low Newton could be arranged.

A report from the Women's Policy Team of the Prison Service who visited the unit in March 2005 concluded that "*distress levels were very high among the women and there was a real risk of suicide unless significant changes were made quickly*".[306]

In June 2005 HMCIP carried out a further inspection of I Wing and their report gave a stark warning about the increased risk of suicide and noted "*the Prison Service itself was well aware that the situation was having a seriously damaging effect on the few remaining prisoners.*"[307] The report noted that the remaining six women accounted for nearly one third of all 700 self-harm incidents among the prison's total population.

They found that of the recommendations of the previous report made in the section on prevention of self-harm and suicide, one was no longer applicable and the other seven had not been implemented. These included recommendations about learning from action plans of previous deaths, learning from serious incidents of self-harm and improving the quality of the reviews and management checks.

The wing was described by both prisoners and staff as a tense, claustrophobic and oppressive environment in which each group felt they had been abandoned by management. The inspection report concluded that "*urgent action is needed to ensure that women prisoners are no longer held in such isolating and alienating conditions*".[308]

Despite the very serious concerns expressed by the Women's Policy Team, a 20-year-old woman who had been moved there on 30 March 2005 hanged herself on I Wing on 21 August. There was no suicide prevention strategy in place at the time of her death as the prison was meant to be closing. The PPO report into her death concluded that "*…the placement of a young woman with an unstable mental condition in to such a situation should have been avoided*".[309] Following her death, all women were finally transferred from the establishment and the women's section of the prison was closed. Today, HMP Durham only operates as a men's prison.

At the inquest held in November 2007 into the young woman's death, the jury heard that not one significant change was made in response to either inspection report. All prison staff conceded that I Wing suffered from a lack of management at both a local and national level for much of its existence and was an inappropriate environment for mentally vulnerable young women. It also emerged that the Inspectorate had raised special concern about this woman's death with the Director General of the Prison Service and no action had been taken.

---

306. *Report on an unannounced follow-up inspection of HMP Durham (Women's Unit) 7 – 8 June 2005, 2005*, p5.
307. *Ibid.*
308. *Ibid.*, p6.
309. PPO Fatal incident investigation report into the death of a 20-year-old woman in HMP Durham, September 2006.

The jury returned a condemnatory narrative verdict, which stated that she died an accidental death. Their concerns included the following:

- Conditions on the wing were unsuitable for the woman, including inadequate healthcare provision.
- There was insufficient guidance and organisational input through the management system.
- There was insufficient representation from staff on I Wing and healthcare professionals at health and risk management meetings.
- The management and implementation of F2052SH case reviews was inadequate and support plans unclear for staff to follow.
- There was a delayed reaction to the urgent recommendations from various bodies to close I Wing.
- The woman was not provided with appropriate care on the night of her death or nights leading up to her death. Signs of emotional distress were overlooked.

The coroner declined to make any rule 43 recommendations in her case as the wing had closed and the women transferred.

Implementation of the Inspectorate's recommendation from the January 2004 inspection could have prevented the desperate plight and ultimate deaths of two more women. No-one was ever brought to account for this failure.

In December 2005 the jury at an inquest into the death in 2003 of a 35-year-old woman at HMP Durham returned the following highly critical verdict:

- *"The F2052SH review panel sitting on the morning of* [this woman's] *death had insufficient information before it to make an informed decision about her care, particularly: access to relevant information contained in medical records; all previous FS2052SH reports for the prisoner concerned; access to all recent relevant written correspondence including details of all recent evaluations, documented or otherwise*

- *The decision to reduce the levels of observations from intermittent to half hourly had contributed to* [this woman's] *death as: more frequent and irregular inspections would have reduced the opportunity for her to kill herself; an intermittent watch signifies a higher state of concern and would motivate a higher level of care from staff in general; a reduced level of care would give more confidence to the prisoner of success*

- *The Prison Service did not take adequate steps to prevent her death and the jury held that the following further steps should have been taken:*

i) a more robust 2052 review procedure should have been in place as standard practice;

ii) a reinforced staffing establishment should have been in place to cope with local situations and conditions reported in feedback from prison staff;

iii) a method of promptly expediting the recommendations of previous investigations and reports;

iv) the provision of an appropriate counselling service easily accessible to prisoners;

v) a review of the training requirements for all prison staff in connection with the specialist care required for vulnerable/at risk female prisoners;

vi) actions to make ordinary cells safer;

vii) actions to ensure the best emergency procedures were available at all times and fully understood by staff;

viii) communications within the service should have been strengthened;

ix) an investigation in to the structure and mechanisms of the entire prison review process."

The coroner did not make any rule 43 recommendations, specifically because it was believed that women would no longer be held at this prison.

Examining the five deaths in 2002-2003 promptly as a series could have resulted in looking at both the individual circumstances of the deaths and the broader thematic issues. This may have ensured earlier closure of the prison. Instead two more lives were lost before this took place.

5.4.2 HMP & YOI Styal

Six women died in HMP &YOI Styal in the 12 months between August 2002 and August 2003.

Following the last of these deaths and the ensuing public and parliamentary disquiet, the PPO announced it would conduct an investigation into the sixth death and the series of deaths in the previous 12 months. This was the first time an independent body had been called in to conduct an immediate investigation into a death in a British prison and the first to examine a series of deaths.

While the examination of the deaths as a series was valuable, the remit of the investigation was extremely narrow. Following discussion with families, INQUEST issued the following statement when the investigation was announced,

"This belated response to the serious disquiet about the series of deaths of women in HMP Styal is a missed opportunity. What is needed is a wide-ranging independent public inquiry that examines all of the recent deaths, any institutional and systemic failings and most importantly involves bereaved families and women prisoners themselves. We are concerned that the proposed inquiry with its limited time frame and narrow remit cannot possibly establish what is going wrong and ensure that lessons are learnt."

The PPO investigation report was completed and given to the Home Office in 2003, yet only published two years later in November 2005. It failed to reflect any of the evidence that arose from the inquests into the six deaths between 2003 and 2005, including highly critical jury verdicts. INQUEST made this statement when the report was finally released:

"The government response to the publication of the Ombudsman report fails to address why it was that the Prison Service did not respond to well documented concerns about the situation at Styal until the sixth death had occurred and why it failed to implement a recommendation made by HM Chief Inspector of Prisons following an inspection of Styal prison in February 2002, "that, as a matter of urgency, a proper detoxification regime should be put in place". Had this taken place deaths may well have been prevented... Since the deaths at Styal another 30 women have died in prisons around the country. We reiterate the point we made when the Ombudsman investigation was announced that what is needed is a wide ranging inquiry in public that examines issues outside of the scope of inquests including allocation, sentencing and treatment and care of vulnerable women and ensures the meaningful participation of bereaved families".[310]

The PPO investigation identified systemic problems at Styal and recommendations were made. It identified a number of common factors across the six deaths including:

- The six women had been poly-drug users. Five were poly-drug users at the time of admission to Styal. The sixth had been drug free at the time of her admission. Ironically, she died of a drug overdose.
- Three women were placed on the standard eleven day dihydrocodeine detoxification, described in the report as "inadequate".[311]
- Five women had mental health problems, self-harmed and/or had made prior suicide attempts.
- Five of the women were located on Waite Wing. The sixth would have been housed there but was held in segregation for her own safety at the time of her death.[312]
- All of the women died within their first month of custody – two died within less than 24 hours of entering the prison.[313]
- Failure in communication between medical and non-medical staff was an issue in all of the deaths.[314]

INQUEST has highlighted how repeated warnings were made to the authorities about the problems faced at Styal in the years prior to the six deaths, but were never acted upon.

---

310. *Prison Ombudsman finally releases report into HMP Styal two years after completion*, 2005.
311. *The Styal Report - The death in custody of a woman and the series of deaths in HMP/YOI Styal August 2002 – August 2003, op cit*, p37.
312. *Ibid*, p40.
313. *Ibid*, p38.
314. *Ibid*, p39.

In 2001 the Cheshire coroner Nicholas Rheinberg conducted an inquest into one of the deaths in Styal and wrote a rule 43 letter backing the then governor's requests for detoxification facilities at Styal. This did not happen.

In February 2002, HMIP had inspected Styal and recommended that "a specialised drug detoxification unit is a necessity at Styal and should be set up as soon as possible."[315] Funding for improved drug services was not made available until after the sixth death in 2003. In the most damming of statements, HMIP said, "*only after the sixth death in mid 2003 was a methadone prescribing regime put in place to manage heroin withdrawal properly, and that regime was set up in great haste, within a matter of days*."[316]

At the inquests into the six deaths, the then governor gave evidence about her unsuccessful bids to secure funding for a dedicated detoxification unit as well as acute problems with staff sickness, recruitment, and shortages. No action was taken in response to these identified problems.

Following the deaths, problems continued to be highlighted and ignored. In January 2004 a full unannounced inspection of Styal took place and another critical report was published by HMIP, expressing concern at the impoverished regime in place at the prison. Women commonly spent over 19 hours a day in their cells. Residential staff were often dispirited and distant, feeling that their role had been reduced to little more than medical orderlies in a regime dominated by the dispensing of methadone.

A follow-up inspection took place in May 2006. In this inspection report HMCIP stated that although the prison was a safer and better place it was still unable to meet the needs of women sent there. She argued that while the recommendations made in this follow-up inspection report raise issues for the prison's managers, "*they pose even greater questions for those responsible for resourcing the prison, and ensuring there is a coherent and consistent strategy for managing and supporting women prisoners, now that the women's prison estate had been disbanded.*"[317] The inspection found an over-use of force and life-threatening practices such as segregation for women at risk of suicide.

Within days of the release of this inspection report, a 42-year-old woman died at Styal. Her death was the first at the prison since the six deaths in 2002 – 2003. Like the 18-year-old woman who died in 2003, she died in the segregation unit.

---

315. *Report on a full announced inspection of HMP/YOI Styal 4-8 February 2002, op cit,* p147.

316. *Report on a full-unannounced inspection of HMP/YOI Styal 19-23 January 2004, op cit,* p7.

317. *Report on an unannounced full follow-up inspection of HMP/YOI Styal 26 October – 4 November 2005, op cit*, pp6-7. In 1999 the Government changed the management of the women's prison estate so that it would be managed separately from the men's estate. This arrangement lasted until 2003 when the disbandment of the separate women's prison estate took place. See section 3.2 above for details of the changes to the women's prison estate.

In response to the publication of the PPO report and the parliamentary and public disquiet arising from the death, the government announced that it would undertake a review of vulnerable women in the criminal justice system. Baroness Jean Corston was responsible for this review, which reported its findings and recommendations in March 2007.[318] Had a public inquiry been set up as INQUEST had advocated in August 2003, life-saving changes might have been introduced and prevented the deaths of at least some of the 32 women who have since died in prison in all too similar circumstances. This raises questions as shown previously in relation to the deaths at HMP Durham about the constant official denial of culpability in these cases.

5.5 A case of corporate manslaughter?

"[This woman] *died as a direct result of the failure of Prison Service officials and ministers to act on the clear warnings that there was a real risk of suicide unless action was taken. Their complacency and inaction is a clear case of corporate manslaughter for which the Prison Service should be brought to account. Punishing women with severe mental problems by incarcerating them in such alienating conditions was cruel, inhuman and degrading treatment. Already this year seven women have taken their own lives in prison. The government's response to the Corston Review is characterised by delaying tactics: more reviews and no resources when the evidence is abundantly clear that without urgent action more women will die."*[319]

Too many of the cases INQUEST has worked on expose a failure of Prison Service management to act on warnings of risks to the health and safety of prisoners.

The UK parliament finally passed the Corporate Manslaughter and Corporate Homicide Act in 2007. Under this Act, companies and organisations including prisons can be prosecuted when their gross failures at senior management level result in a death. The six deaths in HMP Styal within a twelve month period and the deaths in Durham prison expose a blatant failing of the Prison Service to act on clear warnings about negligent practices and systemic failings and the failure of the prison to fulfil its duty of care, and are arguably a clear example of corporate manslaughter.

The initial draft Corporate Manslaughter and Homicide Bill 2006 exempted the Prison Service from prosecution for deaths in prison, with the government relying on the effectiveness of existing mechanisms for the investigation of deaths as being sufficient.

Organisations concerned with protecting human rights, including INQUEST, Liberty, the Prison Reform Trust and JUSTICE, made

---

318. For discussion of Baroness Corston's report and its recommendations see Appendix B of this report.

319. *Jury condemns Prison Service management following death of mentally ill woman in HMP Durham*, 2007.

submissions to the Home Affairs and Work and Pensions Select Committees calling for this immunity to be removed.[320] INQUEST's submission stated:

"There is a pattern of institutionalised reluctance to approach deaths in custody as potential homicides even where there have been systemic failings and gross negligence has occurred… A corporate manslaughter offence for deaths in custody would not only plug a vital gap in the law but could have a deterrent effect in preventing deaths in the future. It could also have a key role in maintaining public confidence in public bodies. Excluding deaths in custody from the Bill would have the opposite effect and would give the impression that those working for the state are above the law".[321]

The Home Affairs and Work and Pensions Select Committees concluded that there was no principled justification for excluding deaths in prisons from prosecution under the Bill and recommended that Prison Service immunity be removed.

Extensive parliamentary debate around this issue followed. Lord Ramsbotham led the campaign to remove the exemption relating to deaths in prison. In response to the argument that current existing mechanisms are sufficient for investigating deaths – in particular public inquiries and public scrutiny – Baroness Stern argued that there remain "gross inadequacies" with those systems – for example coroner's inquests:

"Several years can pass between a death and the inquest into it. Coroners' recommendations on the lessons learnt from deaths in custody are taken up only randomly by the body to whom the recommendation is made because there is no formal system for ensuring that they are taken up. INQUEST, for example, reminds us that an inquest held in 2001 into the death of a woman in Styal prison resulted in a coroner's recommendation that a methadone programme be implemented. This did not happen".

The Corporate Manslaughter and Corporate Homicide Act is expected to come into force in April 2008. The impact of this legislation on deaths in custody will not occur until at least 2011.

5.6 Inquest verdicts

Suicide, misadventure, accidental death and open verdicts have commonly been returned by inquest juries in relation to self-inflicted deaths of women in prison. Following the *Middleton* judgment, juries have increasingly returned narrative verdicts which provide the greatest opportunity to respond to the material they have heard during the inquest. These can be more meaningful both for the state agencies

320. Memoranda submitted to the Home Affairs and Work and Pensions Committees: Draft Corporate Manslaughter Bill: Session 2004-05: HC 540-II, Written Evidence, 13 October 2005.

321. *Briefing on the second reading speech of the Corporate Manslaughter and Homicide Bill 2006 for the House of Lords*, 2006, p3.

responsible for implementing policy and practice, and for bereaved families who can see a verdict which reflects a range of conclusions that identify systemic and individual failings.

Too often, the same contributory factors are identified across inquest verdicts, highlighting failures by the Prison Service to identify and address issues as systemic, including:

- Inappropriate and insufficient drug detoxification.
- Insufficient staffing levels.
- Poor staff training, particularly in the management of women at risk of self-harm and suicide.
- Poor communication between staff both within and between prison establishments, including poor documentation and note-keeping of prison records.
- "Insufficient", "inadequate" and "extremely concerning" management of the F2052SH system.
- Use of segregation and isolation for vulnerable women.
- Failure to act on recommendations from Prison Inspectorate reports and previous inquests.

The quality of the inquest, of its evidence, thoroughness and subsequent jury findings often depends on whether the family has had the benefit of good quality legal representation, both before and during the inquest. A more thorough and meaningful inquest into the death takes place when the family is represented as families' lawyers contribute an additional level of scrutiny to the process.

"It has often been lawyers, instructed by families in pushing the boundaries of the inquest system who have helped to expose, through their legal representation, systemic and practice problems that have contributed to deaths. Indeed many of the changes to police/prison training and guidance or public awareness of health and safety issues have been as a direct result of families' representation at inquests and [INQUEST's] lobbying work."[322]

Some coroners are increasingly willing to look at broader issues of concern and will often call witnesses to comment on the appropriateness of prison for women with mental health problems. This is partly the result of improved legal representation for families and increased opportunity for juries to make more detailed findings. For example, the coroner conducting the inquest into the death of a 32-year-old woman at HMP New Hall, where 12 women died in six years,[323] made it clear at the outset that he intended to carry out a full article 2 inquiry into the woman's death. He explored the issue of the lack of alternative facilities for women, referred to the trenchant comments of the Chief Inspector of Prisons and called two members of the PPO staff to speak to their report. The jury returned a narrative verdict that the woman had strangled herself, but importantly they

322. *Deaths in Custody – the current issues: A submission to the Joint Committee on Human Rights – Inquiry into deaths in custody, 2003*, p16.
323. The women died between 2000-2006.

found that she did not intend to die – her actions had been a cry for help. The jury added a comment that prison was "*unsuitable for someone with* [this woman's] *problems*". This is in stark contrast to the coroner conducting the inquest into the death of a woman in HMP Durham who refused to hear any evidence about the content of recommendations of the PPO report into her death.

The scope of the inquest, the evidence to be heard and witnesses to be called is left to the discretion of the individual coroner, which creates inconsistency across the country and a postcode lottery. For example, some coroners refuse to hear any evidence about the content and findings of the PPO investigation, while others will call the investigator and/or the PPO himself to give evidence about the report and its findings and recommendations.

Case study

The jury at the inquest into the death of a 21-year-old woman who died within less than 24 hours of arriving in prison was allowed to add a rider to their verdict of "misadventure and neglect". They used this opportunity to pinpoint major deficiencies in the staffing and procedures both at this prison and across the women's prison estate, and in the prison system as a whole. They identified the lack of an available doctor at reception or nurse on the detoxification wing as neglectful.

The jury recommended that women withdrawing from drug addictions should be automatically treated as a suicide risk for the first 72 hours of their imprisonment. They also expressed the view that the system of care in place was inadequate to prevent this woman's death and should be changed to help prevent future deaths.

5.7 Rule 43 Reports

At the conclusion of an inquest, a coroner can announce that he or she intends to report the circumstances of the death to those authorities with the power to take action to prevent the recurrence of similar fatalities.[324]

Families have been pleased when a coroner has made recommendations under rule 43.[325] They see it as recognition that Prison Service failings had contributed to the deaths of women. Families often seek meaning from their bereavement through the hope that no other family will suffer in the same way, and that learning will come from the death of their loved one. Many coroners value the important preventative role they have and have made reports under rule 43 in relation to a number of deaths of women in prison.

Families believe that these recommendations could prevent further similar deaths if acted upon. Along with experts, they expressed frustration at the general lack of procedure in place to implement both investigation and inquest recommendations.

---

324. Rule 43, Coroners Rules 1984.
325. Interview with Fiona Borrill, 8 December 2005.

Case study

At the inquest into the death of an 18-year-old woman who died at HMP & YOI Styal the coroner was asked by lawyers acting for the family to make a report under rule 43. This was the third death at this prison within a 12 month period. Following consultation with the family's legal team and other parties the coroner raised in public the following matters:

- **Investigation reports into deaths should be given to staff.**
- **The prison should have a responsibility to publish its response and any action plan to those investigation reports.**
- **Regular mandatory training in suicide and self-harm prevention should take place.**
- **A thematic review of the use of segregation in women's prisons should be undertaken.**

"Coroners make recommendations to relevant authorities who write back but the recommendations don't seem to make their way into practice."[326]

"The coroner can make recommendations, as can the PPO report, but there is no way of enforcing or ensuring these changes are made."[327]

> "We would have hoped for recommendations from the coroner or at least a letter stating the obvious shortcomings in the Prison Service's handling of self-harm in women's prisons. Inquests should be able to make recommendations and Parliament should make sure they are brought about." (Mother of a 27-year-old woman who died in prison)

Coroner's reports made under rule 43 are not published, collated, audited or held in a central database making it difficult to monitor official responses or how often recommendations reoccur. This is important given that in some cases coroners can wait over a year for a reply or fail to receive any form of response to their report. There is the ever-present danger that recommendations vanish into the ether.

"There is no mandatory procedure to follow once the coroner has used powers under rule 43 or to react to the detailed findings in narrative verdicts. If agencies choose to ignore reports then they may do so with impunity and without scrutiny."[328]

The same criticism has been made in relation to investigation report recommendations and inquest verdicts and findings. There is an urgent need to cross-reference reports and recommendations of HMCIP and any action plan of the Prison Service with those of the PPO investigation and the inquest to ensure cross-government learning and accountability. Failure to collate these recommendations and verdicts means missed opportunities to identify and address systemic problems.[329] These missed opportunities are also recognised

---

326. Interview with Fiona Borrill, 8 December 2005.
327. Interview with Harriet Wistrich, 25 November 2005.
328. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit*, p107.
329. Interview with Fiona Borrill, 8 December 2005.

by lawyers providing legal representation to families following a death in custody:

"If the coroner does make recommendations, at least if someone else in 12 months or two years time has a similar case, you could go back and say 'well hang on, there recommendations were made, did you do anything about it?' … Some sort of database of recommendations would be helpful."[330]

The lack of monitoring of rule 43 reports and relevant responses undermines the role inquests could potentially play in changing practice, policy and preventing future deaths.

A reformed inquest system should provide a mechanism for implementing, monitoring and subjecting to public scrutiny action taken – or not – in response to coroners' findings and jury verdicts.

The Safer Custody Group is responsible for responding to coroners' recommendations. It does so following consultation with the governor at the prison where the death occurred. Again, there is no specific mechanism for collating or disseminating these responses throughout the Prison Service or ensuring that families receive copies of any formal response.

5.8 Delays

Families often felt that the extended delays between the death of their relative and the subsequent inquest frustrated the opportunity to identify what went wrong and help prevent further deaths. Extended delays also have an impact on all people involved in the aftermath of a death and on public confidence in the credibility of the whole system.[331]

A 19-year-old woman died in HMP Brockhill in 2001. A series of delays meant that the inquest into her death was only held in 2006. Her parents made the following statement when her inquest commenced:

> "We have waited nearly five years for an inquest, that's too long. She should not have been in prison. We want to learn from the inquest why she wasn't got out."[332]

The inquest into the death of a 35-year-old woman was held almost three years after her death. During this period two more women died in the prison. The woman's father made the following comment at the opening of the inquest:

> "It is now over two years since my daughter's untimely death and the family have been deeply concerned over the period that has elapsed prior to the inquest being held. This has been a very traumatic time for all of us. We hope the inquest will explore our belief that those who were entrusted with [our daughter's] care

330. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit*, p107.
331. *Ibid*, p82.
332. *Inquest begins into the death of 19-year-old woman in prison,* 2006.

> did not apply the full duty of care that she was entitled to. We want to know if her right to life could have been more adequately safeguarded with proper consideration to, and management of, her vulnerability."[333]

Following the delivery of a damning verdict by the jury he said, "*once again there was a serious delay from death to inquest which has frustrated the opportunity to learn the lessons and allowed two more women to die.*"[334]

INQUEST raised this in evidence to the JCHR, who concluded that,

"The article 2 obligation to hold a prompt investigation is at risk of breach due to significant delays in the inquest system. INQUEST cite delays of more than two years in a number of recent deaths in custody cases… such delays are particularly disturbing in cases where systemic failings are an issue, and may remain unaddressed pending the inquest."[335]

In most of the cases with which this report is concerned the inquest took place between 18 months and two years after the death:

Table 6. Delays between deaths of women in prison and inquest being held, 2000-2007

Date of death	Weeks before inquest held	Date of death	Weeks before inquest held	Date of death	Weeks before inquest held
28/03/2000	49	18/01/2003	103	15/02/2004	51
08/05/2000	303	19/01/2003	81	18/04/2004	136
26/09/2000	23	06/02/2003	38	18/04/2004	118
31/08/2001	184	21/02/2003	101	08/05/2004	98
05/11/2001	26	21/02/2003	121	08/05/2004	91
01/01/2002	58	20/04/2003	93	01/06/2004	127
04/01/2002	82	01/05/2003	82	07/06/2004	46
26/01/2002	175	04/06/2003	90	28/07/2004	93
12/04/2002	42	21/06/2003	127	29/07/2004	91
10/08/2002	61	16/07/2003	73	12/10/2004	122
18/08/2002	97	12/08/2003	87	02/06/2005	56
19/08/2002	105	04/11/2003	85	20/08/2005	116
17/09/2002	33	12/11/2003	107	19/09/2005	69
02/10/2002	50	24/11/2003	216	20/10/2005	65
26/11/2002	102	04/01/2004	74	10/05/2006	94
14/01/2003	166	13/01/2004	54	08/10/2006	56

Source: INQUEST casework and monitoring

In their response to the JCHR report into deaths in custody, the government expressed its concerns at the delays in holding inquests.

333. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit,* p82.
334. *Damning verdict returned into Wendy Booth's death in condemned Durham prison,* 2005.
335. *Deaths in Custody: Third report of session 2004-2005 Vol.1, op cit,* p87.

"There have been some cases where delay is unacceptable; work is underway to ensure these backlogs are tackled and reduced."[336]

Despite this commitment nothing has been done to address this problem and serious delays continue. A 19-year-old woman died in 2003. The inquest was not held until January 2008, over four years after her death.

Delays can lead to totally unsatisfactory responses by witnesses to the effect that they "would" have done such and such or "must" have done this or that, rather than providing a correct recollection of what happened. At inquests such witnesses have been able to refer to statements made at the time of the death; however, this has not helped when they were asked additional questions. Most often they responded "I don't remember". In cases where witnesses did remember, legal representatives often challenged their recollection of events on the grounds that it happened so long ago.

Extended delays also have a negative impact on bereaved families. While families want thorough investigations, some felt that extended delays between the time of death and the inquest did not take into account their need to get on with their lives, as far as possible, following their loss.

> "[My daughter] died three years ago, the inquest is in March 2006. There are a lot of things I want to know but you get to the stage where you just bury things and try to go on. Now I've got to relive everything." (Mother of an 18-year-old woman who died in prison, speaking before the inquest was heard)

These delays can also affect the mental and physical health of bereaved families:

"The delay clearly causes all concerned great difficulty but this is particularly so for bereaved people who have described how their lives have been put on hold until they have been through the inquest process. INQUEST's evidence-based research on families' experience of the inquest system has highlighted the detrimental effects that delays, in finding out how a relative has died, has placed on the physical and mental health of family members."[337]

Delay in completing inquiries after a death in custody is one of the most serious issues needing to be addressed. It has a detrimental impact on the bereaved family and others involved in the aftermath of a death and affects public confidence in the credibility of the whole system.

Delays not only hamper the extent to which remedial action might be applied; they are also incompatible with the provisions of the Human Rights Act. They obscure the search for the truth and the need

---

336. *Government Response to the Third Report from the Committee: Deaths in Custody Eleventh Report on Session 2004-05*, 2005, p49.
337. *INQUEST's Submission to the Constitutional Affairs Committee into Reform of the Coroner's System and Death Certification in England and Wales, op cit*, p11.

for a prompt effective investigation and, perhaps most significantly, they are utterly inhumane as they serve to prolong and intensify the pain for families.[338]

One of the other problems of delay is that it allows the Prison Service to say "that was then, this is now" and that things have changed, thereby deflecting attention from their ultimate responsibility. Another is that some coroners refuse to make rule 43 reports on the basis that the time lapse has meant that matters have been dealt with – an unsatisfactory state of affairs in highlighting systemic failings and monitoring action taken at a local and national level.

5.9 Disclosure

A number of families were not sent investigation reports into the death of their relative, despite being promised that this would take place.

Pre-inquest disclosure of investigation reports into deaths in custody to bereaved families is fundamental for ensuring such deaths in custody are properly investigated. If it is only the prison that has access to documentary evidence then families cannot bring their perspective to bear on the investigation and ensure additional inquiries are pursued.[339]

Prior to the introduction of voluntary Home Office protocols on disclosure in 1999, families were largely excluded from the investigation process and disclosure was extremely limited. There remains no mandatory right to pre-inquest disclosure of documentary evidence. When and how it occurs will depend on the complexity of the case; the family's relationship with the investigator; and whether the family has legal representation and its quality. Disclosure is complex and time consuming. In some cases disclosure has not allowed sufficient time for adequate preparation for the inquest. Receiving a copy of the draft report is crucial and families need time and resources to have meaningful input into the final report either via their lawyer or independently.[340]

Disclosure assists in removing some conflict from the hearing itself; since 1999 this has been the case where it has operated well. It also reduces unnecessary pain for bereaved people in that they do not have to hear information about how someone died for the first time in public. In all inquests there should be full mandatory disclosure of all information irrespective of whether the coroner intends to call relevant witnesses, and clear rules about when and how it will be made.[341] The Prison Service should disclose all documentary material it holds with a bearing on a death. To withhold any such material simply because no-one has asked for it is tantamount to concealment of evidence.

---

338. *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit,* p84.
339. *Ibid*, p65.
340. *Ibid*.
341. Ibid, p98.

5.10 The adversarial nature of inquests

> "Considering all the defects in the prison system I was surprised at the way the prison staff was very defensive regarding their shortcomings and lack of care for [my sister]." (Brother of a 37-year-old woman who died in prison)

For the family the inquest can be both confusing and unsatisfactory. They are often shocked and perplexed by the narrow definition of 'how' and the limits of the issues that will be discussed, particularly where the death raises concerns about systemic failings. Although they are inquisitorial fact-finding processes, inquests can become reminiscent of adversarial court procedures as prison staff defend their actions or the actions of the Prison Service. This will always occur to some degree as inquests provide families with the opportunity to scrutinise and challenge the duty of care exercised by people working in prisons. However, in some cases the atmosphere at the inquest can become so adversarial it compromises the quality of the investigation.

This is exacerbated by problems with incomplete or non-disclosure of documents with a bearing on the death. For example, the Prison Service suppressed documents with a real bearing on the knowledge they had at the time about the impact of the regimes and conditions on the mental health of a 20-year-old woman from the inquest held into her death.

The inquest process will contribute best to the prevention of further deaths if it allows the actions and decisions of prison staff and management to be discussed openly and frankly so they can be better understood and problems can be addressed.

At some inquests an uncooperative and/or nonchalant attitude was displayed by those connected with the Prison Service. This is worrying for two reasons. First, it suggests an unwillingness to learn from the death so that future deaths in similar circumstances can be prevented. Second, if this is the level of respect shown to the deceased and her family at the inquest, the level of care they provided to the woman when she was alive and in their care is highly questionable.

Case Study

At the inquest into the death of a 22-year-old woman, legal representatives for the Prison Service challenged the family's legal representatives when they wanted to put the investigation report findings to the jury.

Legal argument arose and the coroner decided to put the report recommendations and conclusions but not the findings to the jury. In doing so, the coroner expressed concern that the Prison Service was trying to control and censor how the coroner conducted an inquest. He believed antagonism was creeping into inquest law with inquests becoming adversarial, as opposed to people working together to find out the circumstances of a person's death.

Case Study

The coroner at the inquest into the death of a 37-year-old woman was "astonished" and "surprised" that the Prison Service only realised during the inquest that they did not know if the version of the Prison Service Order (PSO 1700) presented in the investigation report was the policy in place at the time of the woman's death.

The PSO 1700 was a policy document specifying who could determine if a prisoner was fit for cellular confinement. It had been amended on a number of occasions. Some versions stated that only a doctor can make this assessment. Other versions stated that the assessment can be made by either a doctor or nurse.

The Prison Service had the investigation report for almost 18 months prior to the inquest to clarify which version was in place at the time of the woman's death. Even after the problem was raised at the inquest, the Prison Service remained unable to resolve the issue, delaying the inquest.

The attitude of some prison staff attending inquests can be disturbing. At a recent inquest a prison officer was reprimanded by the coroner's officer for reading a newspaper in court while evidence was being heard. It is not uncommon for staff to answer questions put to them by the coroner and family's representatives with belligerence or rudeness, with little regard for the presence of the bereaved family.

5.11 Other opportunities

5.11.1 Prison Inspectorate reports

"When the six women died at Styal Prison there had, prior to that, been a Chief Inspector of Prisons report on Styal detailing the problems at the prison. The prison failed to act on the recommendations of the report and then we had six deaths followed by another Chief Inspector of Prisons report criticising the fact that they hadn't implemented the recommendations." (Mother of an 18-year-old woman who died in prison)

Post-death investigations do not provide the only opportunity for the Prison Service and individual prisons to implement changes that may prevent loss of life. At least once every five years each prison will be inspected by HMCIP and her investigating teams. Inspections may be announced or unannounced.[342] A publicly-available report of the inspection is produced, providing an assessment of the prison's conditions and treatment of prisoners and making relevant recommendations.

342. When an announced inspection is held, the prison is informed in advance of the visit. Unannounced inspections are held without prior notification to the prison. Inspectors cannot be refused entry to the prison. For further detail on inspections and inspectorate reports see www.inspectorates.justice.gov.uk.

Recommendations may prove life-saving, yet often are ignored or fail to be properly implemented. In some cases prisons respond to these recommendations by making action plans. These plans usually address approximately 75% of the recommendations. HMCIP has identified negative attitudes towards action plans – they are rarely reviewed and often list items that are not implemented.[343]

Self-harm and suicide management is assessed as part of a prison inspection.[344] The Inspectorate also looks at action plans in relation to any deaths in custody. They often find these action plans have not been looked at or reviewed.

HMCIP does not have routine access to PPO reports on deaths in custody. This is unacceptable as these reports could provide a useful tool for assessing the establishment's response to the deaths that occur in particular prisons. The reports could also inform their inspections where systemic failings have been identified. They would also benefit from a post-investigation and inquest update from the PPO in terms of issues that emerged at the inquest.

HMCIP also produces an annual report which draws together findings from that year's inspections. It includes a section on women's prisons. This provides a further valuable resource; for example the 2004-2005 annual report stated,

"All prisons inspected had inadequate [first night procedures], even where we had made previous recommendations…Foston Hall had no formal first night strategy, though half the women were experiencing their first custodial sentence. The induction leaflet warned about contact with personal officers: 'YOU ARE ONE OF EIGHT INMATES IN THEIR CHARGE. DO NOT WASTE THEIR TIME.'"[345]

In 2000, the government proposed introducing a Criminal Justice Inspectorate. The idea was to amalgamate a number of currently existing inspectorates into one all-encompassing organisation. The highly public and critical voice of HMCIP could have easily disappeared within the proposed structure, and less priority would be placed on highlighting unacceptable practices and conditions in prisons.

The issue came to Parliament in 2006. Following passionate debate, led by the previous Chief Inspector of Prisons Lord Ramsbotham, it was agreed that a separate inspectorate would be maintained to report on the conditions for and treatment of those in prison, young offender institutions and immigration removal centres. The closed nature of the prison system means that it is vital that it remains open to independent inspection and investigation, and held to account when human rights abuses occur.

---

343. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.
344. Current practice is for an Inspectorate report to outline how the establishment performed against the four tests of a healthy prison which were introduced following the publication of *Suicide is Everyone's Concern: A thematic review by HM Chief Inspector of Prisons* in 1999.
345. *Annual Report of HM Chief Inspector of Prisons for England and Wales 2004-2005, op cit*, p48.

5.11.2 Safer Custody Group newsletters

The Safer Custody Group produces updated information on suicide prevention in prisons. It is disseminated in *Safer Custody News*. This bi-monthly newsletter also provides people working within the Prison Service with practical advice and access to relevant training. Best practice information is also available to prison staff through the newsletter.

5.12 Conclusion

The effectiveness of post-death investigations in preventing further deaths in prison is completely dependent on commitment from those with the power and resources to learn from the deaths and implement the recommendations made at various stages throughout. Concerns raised and transmitted by juries and coroners into women's deaths in custody currently do not lead to coherent policy or changes in practice.

5.13 Recommendations and best practice

Issue	Failure to learn from prior deaths
Description	Post-death investigations provide learning opportunities and potentially act as preventative tools for further deaths. Subsequent deaths in similar if not identical circumstances suggest these opportunities are not being maximised.
Recommendation	• PPO reports should be amended after the inquest to take into account jury findings, coroners' recommendations or comments, and the response of the authorities. • The PPO should use its independence to voice concern about issues emerging both from its investigations, inquests and the impact of criminal justice policy in general. It should be more outspoken and critical where failings have been highlighted. • PPO reports should be publicly and widely disseminated. As a matter of priority they should be made available to prison staff. • The prison should have a responsibility to publish any action plan it makes in response to investigation reports and inquest findings and this should be updated and reviewed to ensure action has been taken.

Issue	Investigating a series of deaths
Description	Some deaths were one of a series occurring at a prison within a relatively short period of time
Recommendation	A wide-ranging inquiry into the deaths of women in prison would provide an even better way of identifying and addressing any systemic failings. Post-death investigations are not able to take into account the wider context of these deaths, including sentencing decisions or alternatives to custody. A wider inquiry could address these issues and involve women in prison, whose first hand experience would be invaluable. Consideration should be given to holding a thematic review where a series of deaths occur in one prison to look both at the specifics of the individual deaths and the broader systemic issues they raise "*There is a crisis in women's prisons highlighted by the increasing number of deaths and incidents of self-harm and the number of women prisoners with mental health and/or drug and alcohol problems. The issues raised by these deaths warrant a wide-ranging independent public inquiry that examines all of the recent deaths, any institutional and systemic failings and most importantly involves bereaved families and women prisoners themselves. A full inquiry could examine all the deaths in this context and make a significant contribution to prevent any further loss of life.*"[346] To date, the government has responded negatively to the call for such an inquiry. It has also resisted a similar call for a full public inquiry into the death of Joseph Scholes, a 16-year-old who died in a Young Offender Institution in 2002. In its publication *In the Care of the State? Child deaths in penal custody in England and Wales*, INQUEST wrote, "*the government's resistance to this call runs counter to the spirit of democratic accountability, transparency and the pressing need to learn from the failure in the system that cost a 16-year-old child his life.*"[347] The government's resistance to a public inquiry into women's deaths in prison further questions its commitment to these principles. Best practice would be to continue to investigate deaths at an individual level, but to then ensure that the broader issues of concern such as sentencing policy, allocation, resources and alternatives to prison can be addressed collectively. This would allow for any ongoing and systemic failings to be identified and addressed. To date, this type of investigation has only been undertaken once and in a very limited manner.[348]

346. *INQUEST Annual Report 2003, 2004*, p8.
347. *In the Care of the State? Child Deaths in Penal Custody in England and Wales, 2005,* p110.
348. See discussion in section 5.4.2 on the investigation on the series of deaths at HMP & YOI Styal.

Issue	Rule 43 reports and jury findings are not monitored
Description	No mechanisms are in place currently for implementing, monitoring and subjecting to public scrutiny action taken in response to coroners' rule 43 reports, jury verdicts and recommendations from PPO investigation reports. Currently PPO reports are placed on their website as anonymous documents and without being amended to reflect inquest evidence, critical jury findings or rule 43 reports.
Recommendation	Create mechanisms for public scrutiny of coroner's recommendations, jury findings and investigation report recommendations as well as those made in prison inspection reports.[349] The individual agency should be required to provide a written response including a report as to what action has been taken, how recommendations have been implemented and if not, to give the reason(s).
Issue	**Lack of joined-up thinking**
Description	There is no mechanism to look beyond individual cases and engage with deaths in prison on a more holistic or collective basis.
Recommendation	The creation of a Standing Commission on Custodial Deaths.[350] In the past, INQUEST has called for the establishment of an independent body, a Standing Commission to examine the wider issues around deaths in custody.[351] Women's deaths in prison would be a thematic strand where the Commission would consider all the issues arising from deaths, their investigation and inquest procedures on an ongoing basis. "*We recommend the setting up of a Standing Commission on Custodial Deaths… Such an over-arching body could identify key issues and problems arising out of the investigation and inquest process following deaths and it would monitor the outcomes and progress of any recommendations. It could also look at serious incidents of self-harm and/or near deaths in custody where there is a need to review and identify any lessons. Arising from this it would develop policy and research, disseminate findings where appropriate and encourage collaborative working. Lessons learnt in one institution could be promoted in the other institutions, best practice could be promoted and new policies designed to prevent deaths could be drafted and implemented across all the institutions. It would play a key role in the promotion of a culture of human rights in regard to the protection of people in custody. It should also have*

349. Publishing and analysing action arising from jury findings and coroner's recommendations was a key proposal in *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit,* pp129-131.
350. A Standing Commission on Custodial Deaths was a key proposal in *In the Care of the State? Child Deaths in Penal Custody in England and Wales, op cit*, pp105-106; *Unlocking the Truth: Families' experiences of the investigation of deaths in custody, op cit,* pp131-132.
351. *Deaths in Custody – the current issues: A submission to the Joint Committee on Human Rights – Inquiry into deaths in custody, op c*it, p4; INQUEST's written memorandum to the Home Affairs Select Committee on Prison Suicides and Overcrowding, 8 November 2005; *In the Care of the State? Child Deaths in Penal Custody in England and Wales, op cit*.

Issue	Failure to learn from prior deaths (continued)
Recommendation (continued)	*powers to hold a wider inquiry where it sees a consistent pattern of deaths. Such an inquiry could give voice to, and a platform for, the examination of those broader thematic issues and those issues of democratic accountability, democratic control and redress over systemic management failings that fall outside the scope of the inquest. One of its functions would also be to lay the past to rest and assist in the process of effecting real and meaningful change."*[352] A major role for this body would be to collate inquest verdicts, rule 43 reports and investigation report recommendations. These could be provided to HMCIP and investigating teams who could then use them to assess whether recommendations and factors identified as contributing to deaths had been addressed in women's prisons. INQUEST made its recommendation for a Standing Commission in evidence presented to the JCHR inquiry into deaths in custody. The JCHR responded sympathetically and recommended the establishment of a cross-departmental expert task-force with a view to adopting a more joined-up response to deaths in custody and their investigations. To date, the government has rejected this recommendation, and instead established the Forum for Preventing Deaths In Custody in November 2005.

Issue	Implementation of action plans following a death in custody
Description	Action plans provide opportunity to prevent further deaths in similar circumstances. But there is not sufficient scrutiny of these at a national level and it should not be left to be picked up by the Inspectorate.
Best practice	At HMP New Hall discussion of death in custody action plans always appear on the minutes of senior management meetings.[353]

352. *Submission to the Joint Committee on Human Rights – Deaths in Custody – the current issues: A submission to the Joint Committee on Human Rights – Inquiry into deaths in custody, op cit,* p4.
353. Interview with Paul Fenning and Michael Loughlin, 25 May 2006.

Part 6: Conclusions and recommendations

"Experience round the world shows that it is very easy to keep people out of prison who should not be there – if it is really decided that that is what we want to do."[354]

"Women's imprisonment in England and Wales at the end of the twentieth century is excessively punitive, totally inappropriate to the needs of women being sent to prison and ripe for abolition on its present form."[355]

Over many years individuals and groups working across the criminal justice system, including the probation service, Youth Justice Board, mental health services and the voluntary sector, have developed innovative projects and worked creatively with individual women involved in, or at risk of, offending. Unfortunately, such work has often been the result of the energy and commitment of individuals and organisations and has not been prioritised or properly supported at a national or policy level. Resources have been increasingly focussed on more politically high profile areas of criminal justice, particularly that of "risk to the public" at the expense of working with women.

Our report provides the first analysis of all self-inflicted deaths of women in prison between 1990 and 2007, and brings into the discussion the largely unheard voices of bereaved families.

Our report also draws on expert opinion and makes first-hand observations of the post-death investigation process.

Based on the findings of this report and INQUEST's work with bereaved families for over 25 years, it is clear that imprisonment is a potentially life-threatening and ineffectual response to women's offending. We recommend that as a matter of urgency, prison must be abolished as the central response to women's offending.

In this section we will be considering some examples of current good practice which illustrate the sort of constructive work being done with women which urgently needs developing as a consistent service around the country.

6.1 Taking gender into account in the criminal justice system

A criminal justice system that can respond to women's offending in a gender-appropriate manner is crucial to abolishing imprisonment as the central response to it. A criminal justice system that can achieve this aim is one that:

- is committed to the Gender Equality Duty;
- has a gender-appropriate organisational structure;
- encourages early diversion away from the criminal justice system.

The Gender Equality Duty

In April 2007 the Gender Equality Duty came into force. The Duty requires public bodies to have due regard to the need to eliminate

354. Baroness Stern addressing the House of Lords: *House of Lords Hansard* debates for 28 October 2004, column 1453.
355. *Women, Crime and Poverty,* 1988, p8.

unlawful sex discrimination and promote equality between men and women. It will affect most organisations and individuals working within the criminal justice system. These organisations will be required to treat women and men appropriately and according to gender-specific needs. Given the impact of imprisonment on women, this duty should reinforce the need to divert women away from prison and into more effective and appropriate programmes to address their offending and related problems.[356] The success of the Gender Equality Duty will depend on its implementation and the leadership by government on this issue.

Case study: The 218 Project

This service, operating in Glasgow, is for women involved with the criminal justice system in Scotland and focuses on substance addictions. The service has three components:
1. Detoxification/stabilisation unit.
2. Supported accommodation unit.
3. Comprehensive day programme with access to a range of mental and physical health resources including methadone prescribing, community psychiatric nurses, psychologists and psychiatrists.

The safe environment, access to resources and high level of support provided by the service assists women to attain a level of stability in their lives so they can address the root causes of their offending.

Women are primarily referred to the service by criminal justice social workers and the courts. Referrals can be made at various points of contact with the criminal justice system.

The 218 Project is funded by the Scottish Executive (criminal justice funding) and delivered by Turning Point (Scotland) in partnership with the Department of Health. Currently, the project has pilot status and is being externally evaluated.

6.1.1 A gender-focussed organisational structure

Current national structures around the criminal justice system do not respond to women who come into contact with it. There is no responsibility accepted for these women at a high government level.

Government needs to consider gender when determining organisational structures to put in place in the criminal justice system. An appropriate structure will be able to include and respond to women's experiences rather than treat them as an adjunct or marginal to the criminal justice system.

A new structure for the Ministry of Justice was announced in January 2008. Its stated intention is to deliver further improvements in reducing reoffending and creating more efficient, effective offender management services in custody and the community; improving access to justice and the effective administration of the justice system;

356. Interview with Holly Dustin, 11 November 2005.

building an effective relationship with the judiciary and delivering constitutional reform; and working for a just and democratic society. There is no focus in the new structure on a gender-specific approach, highlighting a further missed opportunity to recognise that there are women in the criminal justice system with unique needs to be met.

Any discrete structure – such as a National Women's Justice Board,[357] which would hold a comparable position in the criminal justice system as the Youth Justice Board – must have clear lines of accountability and someone who ultimately takes responsibility for it.

The government's recent rejection of Baroness Corston's recommendation that a Women's Commission be created to provide this level of accountability via an inter-departmental ministerial group shows a further lack of commitment to responding to the needs of women in the criminal justice system in a way that ensures high level accountability.

6.1.2 Early diversion from the criminal justice system

Circumstances leading to imprisonment usually involve issues that can be addressed long before a woman appears before the courts. Early and appropriate intervention may prevent the majority of women from committing the offences that result in their imprisonment.

Women should be diverted into community drug rehabilitation programmes, appropriate mental health services and have access to other social services. A number of families supported compulsory referral to secure places for the treatment of drug addiction.

Mechanisms for diverting women into these services should be available from when they first come into contact with the criminal justice system, and at every stage after that. Currently, diversion schemes are patchy, under-funded and not mandatory.[358]

In 2004, the Prison Reform Trust recommended the following, which is relevant to preventing women's deaths in prison:

"An increase in the provision and improvement in the quality of court based diversion schemes. In addition, the government must ensure NHS assessment and treatment for mental health problems is accessible for all defendants who require it in all regions – the lack of such provision is never a sufficient justification for the use of custody".[359]

When women's offending behaviour is connected to mental illness, suggestions for appropriate responses varied among families. In general, placement in medium secure units was seen as a good option. Some families believed the existing secure psychiatric hospitals or special hospitals such as Rampton, Ashworth or Broadmoor were a better alternative to prison.

---

357. The Prison Reform Trust regards the establishment of a National Justice Board for Women as the most important recommendation of the report of the Committee on Women's Imprisonment, *Justice for Women: The need for reform.* The committee has pressed for it ever since the report's publication in 2000. To date, they have had little success. See Appendix B.

358. *Justice and Equality,* 2006, pp11-12.

359. *Lacking Conviction: The rise of the women's remand population, op cit,* p50.

> "They've got doctors and psychiatrists. They do use a lot of drugs to knock people out if they kick off and stuff but it is not like a prison. Although you can't go anywhere you can only stay on that ward, you've got the outside and you have got swimming pools and gyms to keep people occupied. You talk to nurses and stuff like that so it gives them that little bit more freedom than what a prison does; a bit more support." (Sister of a 19-year-old woman who died in prison)

Others were opposed to placing women in these establishments under any circumstances.

> "Don't look at the specials while the specials are what they are, because that is no good to anybody. There may be some other medium security units but I haven't had the experience of them, but certainly the specials are not the place… Because it was appalling there. It had been done up recently, all sort of painted and furnished…quite impressive to look at physically but the atmosphere is utterly appalling. It is more disempowering and more appalling than prison. These are people who aren't really going to get any better probably or they might burn out or something, but they are not going anywhere and what they want them to do is settle down and make their life there and make it all as nice as possible, but none of it is any good to you, nothing is helping you get better or get out… At least in prison, even if a lot of the programmes aren't much good to you, ... you have some sort of thing where if you do this and this and this you will move on to another stage. There is some sort of empowerment to do something for yourself." (Ex-partner of a 48-year-old woman who died in prison)

6.2 Gender-appropriate prison alternatives

Putting in place alternative strategies to deal with women's offending is crucial to removing prison as the response.

In oral evidence presented to the Home Affairs Select Committee on prison suicides and overcrowding INQUEST stated:

"There is very, very grave concern about the lack of alternatives to custody, about the fact that there are very few women-only bail hostels, there [are] very limited numbers of secure psychiatric hospitals. I am not talking about the big hospitals like Rampton and Broadmoor, women do not need that type of security, but there is a need for some women to have secure community provision. We also need to make magistrates and the judiciary generally aware of the alternatives to prison that could better deal with the reasons why these women got into prison in the first place and their many complex needs."[360]

360. Deborah Coles, co-director of INQUEST, presenting oral evidence before the Home Affairs Select Committee on Prison Suicides and Overcrowding, House of Commons, 8 November 2005.

Putting in place effective strategies to deal with women's offending requires:

- Appropriate responses to women who pose a threat to society.
- Gender-appropriate community service schemes.
- Small community based therapeutic centres.
- Considering international best practice for dealing with women in the criminal justice syystem.

Responding to women who pose a threat to society

In the small number of cases where women need to be removed from society due to the threat they pose they should be held in small therapeutic units, as close as possible to their families or other support networks.[361] These units should be open to outside agencies, which can provide appropriate counselling and rehabilitation.[362] In Holland, separate units like this for women are available on men's prison estates.[363]

Gender-appropriate compulsory unpaid work

There is evidence to suggest that women often fail to attend community service schemes due to problems with their partners or children, and child care issues.[364] Schemes which take into account women's experiences should be used as a model of best practice. To achieve this requires proper resourcing. Probation services would play a crucial role in providing gender-appropriate community service orders.

In some cases women-only community service orders may be more appropriate. Under the current system it is possible for a woman to be alone among a group of men working on an isolated worksite. This is particularly daunting for women who have had prior abusive relationships with men.

Small community-based therapeutic centres

These 'one stop shops' could allow women to address their offending and a range of connected issues, including unemployment, education and drug and alcohol problems under one roof. There could be referrals to other relevant services including mental health services. Given the myriad problems an individual woman in prison presents, a multi-agency approach to women's offending will be most effective.

Ideally these centres would be locally based so that women would not be far from family and the community. Currently a few such centres exist. However, access is limited as it is necessary to live (or be sentenced at a court) near these centres to have access to them.

Community-based therapeutic centres are also more cost effective than prison. The average cost of keeping a person in prison in England

361. Interview with Cathy Stancer, 25 November 2005.
362. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.
363. *Ibid.*
364. *Ibid.*

for a year is estimated at £37,000.[365] The estimated annual cost of a community rehabilitation order is about £3,000.[366]

This is not to suggest abolishing women's prisons is the cheap option. As discussed in Lord Coulsfield's report into alternatives to prison, "*the actual annual costs vary depending on the security level of prisons and the costs of interventions in both prisons and the community*".[367] Reducing the number of women offenders requires money being spent outside prison on issues central to the circumstances of their imprisonment, including homelessness, dependencies, mental health, and sexual and physical abuse.[368] Less money spent on imprisonment potentially means more money for these purposes.

Best practice: ASHA Centre

This women-only centre in Worcester is an independent charity. It runs a programme which aims to tackle the reasons behind women's offending such as drug misuse and low self-esteem. The Centre was based on work undertaken by Hereford and Worcester Probation Service from 1993–2001.

Courts are increasingly sentencing women to the ASHA Centre, which also works with many women at risk of offending. The chairperson, Jenny Roberts, commented that it is difficult to imagine the women that use the ASHA Centre coping in prison, yet it is these vulnerable and disadvantaged women who often land up there.[369]

The Centre offers advice, information and training for women lacking access to mainstream education. It runs courses on self-esteem and confidence building and encourages women to access legal services, debt management and career advice and also refers women to services including counselling and legal aid. There is a dedicated drugs and alcohol worker and a Women's Aid office.

The Centre works on a referral basis – self or other agencies. The majority of referrals to the ASHA Centre come from local mental health services and at least half of the women using the Centre's services have mental health issues. Unlike prisons, the ASHA Centre does not find managing these women difficult. Jenny Roberts believes this is because Centre users are operating in a normalising environment. The centre is located within a local community, and the focus is on equipping women with skills so they can better engage with the community. Prison removes women from their normal environment and places them in highly stressful, abnormal surroundings.[370] Women service users described the immense value and support received by the project.

Being an independent charity, securing funding is an ongoing issue for the centre which is run by a small team of qualified staff.

---

365. *Crime, courts and confidence: Report of an independent inquiry into alternatives to prison*, 2004, p21.
366. *Ibid*.
367. *Ibid*.
368. *Abolition and its Enemies*, 2006, p5.
369. *Ibid*.
370. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006.

Best practice: Calderdale Women's Centre

The Calderdale Well Woman Association, a registered charity, runs Calderdale Women's Centre. It is a membership organisation, run by an elected Committee or Board of Trustees. Calderdale is a one-stop shop which offers holistic support to women with a range of needs. It is women-centred and designs packages of support based on individual requirements. The Centre offers a range of education and skills development programmes including parent craft, arts and craft, basic computer skills, management skills in health and social care organisations, basic first aid and volunteer training. It holds one-off focus sessions on issues such as healthy eating, rights as a citizen and budgeting, which are delivered by a range of statutory partners. There is an onsite crèche.[371]

Calderdale has established links with Job Centre Plus, the Citizen's Advice Bureau and legal service practitioners. A drop-in advisory service can support and direct women to services in areas such as mental health, debt and domestic violence. There is also a support group for Asian women. Paid and voluntary staff run the centre. Currently, the Centre is not at police or court disposal and the Probation Service or Prison Service makes few referrals.

6.3 Interim measures

Routine use of diversions and prison alternatives will not occur immediately. As long as women remain in prison their lives remain at risk. Thus, we offer an interim recommendation.

At the end of each part of this report, recommendations have been made and examples of best practice provided for preventing deaths of women held in prison.

These recommendations should be implemented without delay, along with the recommendations made in other relevant reports.[372] Each prison should be required to detail its strategy and policies demonstrating compliance with all relevant applicable human rights standards.

Ultimately these are only short term measures. The abolition of imprisonment as the central response to women in the criminal justice system is the key to preventing deaths of women in prison. Steps should be taken to ensure this occurs as a matter of urgency.

"The death toll exposes a crisis in women's prisons; it is an indictment of a criminal justice system that uses prison as a dumping ground for some of the most vulnerable people in society. Too many women are being sent to prisons that cannot protect their right to life and yet the government have failed to address the wider policy questions that arise, particularly about the overuse of prison for women. Instead of so doing, the government follow announcements about the closure of existing women's prisons with news that they are to be replaced by new ones. Reinventing the wheel is not the answer. Diversion of women from custody and

371. *Ibid.*
372. See reports listed in Appendix B.

investment in community-based alternatives may well save money as well as lives."[373]

373. 'Women in Prison: Failing to protect their right to life', 2005.

Appendix A

Role of government

"Government policy on women offenders is shot with contradictions. Committed to reducing women's imprisonment, it is still pressing ahead with opening two new private prisons to hold a further 800 women. Promising to remove girls from prison, the Home Secretary is spending £16 million on specialist jail units for under 18s. The first therapeutic prison for women has recently been uprooted to make space for men moving from overcrowded jails."[374]

To date, the government's commitment to addressing issues around women's imprisonment has been high on rhetoric but lacking in the action and funding.

Women's Offending Reduction Programme

The government's key response to issues around women's imprisonment has been the introduction of the Women's Offending Reduction Programme (WORP).[375]

WORP aims "*to reduce women's offending and the number of women in custody, by providing a better-tailored and more appropriate response to the particular factors which have an impact on why women offend. The intention is not to give women offenders preferential treatment but to achieve equality of treatment and access to provision.*"[376]

WORP's multi-agency approach is concerned with meeting the needs of women prisoners including substance misuse and mental health needs as well as making community interventions more accessible for women.

In 2005 the government introduced the Together Women Programme as part of WORP, a four year scheme costing £9.15 million. It targets women offenders and women at risk of offending and aims to tackle the cause of crime and re-offending among this group and reduce the need for custody.

Two demonstration projects delivering alternatives to custody will

374. Interview with Juliet Lyon, 6 December 2005.
375. This programme was introduced in March 2004.
376. *Women's Offending Reduction Programme: Action Plan*, 2004, p5.

be set up as part of the Together Women Programme in the North West and in Yorkshire and Humberside. Through key/link workers and a one-stop shop approach they will route women into programmes that meet their needs. There will be the capacity to divert women into these projects at every stage of their interaction with the criminal justice system. If they achieve their aims, it is hoped they will continue to be funded in the future. Comparing the cost of introducing these two projects (£9.15million) to the £350-450 million spent building HMP Bronzefield reinforces that alternatives to custody are the more sensible option.[377]

The Corston Review of women in the criminal justice system with particular vulnerabilities

In response to the six deaths at HMP & YOI Styal between August 2002 and August 2003 the government commissioned an independent review into women in the criminal justice system with particular vulnerabilities. The review was announced in March 2006.

The review was chaired by Baroness Jean Corston, who established a small reference group comprising senior representatives from the Home Office, Prison Service, the PPO, healthcare and independent sector. Deborah Coles, co-director of INQUEST, was invited to sit on the review panel by Baroness Corston. INQUEST had initially called for a public inquiry into deaths of women in prison following the Styal report, but gave its support to the review on the basis that the views and experiences of those most affected by the deaths, the families, would be central to the review. INQUEST facilitated a meeting between families and Baroness Corston.

A literature review was undertaken as well as visits to women's prisons and community centres. A number of consultation events and meetings were held to gather stakeholder views.

The review published its findings and recommendations in March 2007. The report called for a greater focus on women in the criminal justice system and the need for a radical new approach to address the complex and multiple needs of women who offend or are at risk of offending. In the report, Baroness Corston concluded that "there needs to be an extension of the network of women's community centres to support women who offend and are at risk of offending and to direct young women out of pathways that lead to crime."[378]

The report made 43 recommendations including the need for:

- A strong, consistent message from the government with full reasons in support of its stated policy that prison is not the right place for those women offenders who pose no risk to the public.

---

377. Interview with Jenny Roberts and Chris Cawthorne, 5 June 2006. HMP Bronzefield is a modern purpose built prison for women. It opened in 2004. It provides the services of a local prison but is run by the United Kingdom Detention Services (UKDS).

378. *The Corston Report: A review of women with particular vulnerabilities in the criminal justice system, op cit,* p2.

- A high level champion for women to ensure the needs of women offenders and those at risk of offending are met.
- An inter-departmental Ministerial Group to steer change for women who offend or are at risk of offending.
- Accelerated preparations by all criminal justice agencies to implement the Gender Equality Duty and radically transform the way they deliver services for women.

The review made many important findings and potentially life-saving recommendations. It is crucial that it become a catalyst for change.

The government published its response to the Corston Review on 6 December 2007. While the government agreed with Baroness Corston's analysis and met either wholly or partially all of her recommendations, it did so in a largely unsubstantial manner. No money or resources were allocated to addressing the issues around women's imprisonment or alternatives, a Women's Commission was rejected, as was the recommendation that public funding be provided for bereaved families for proper legal representation at an inquest.

Appendix B

Other Research

Penal reform groups and others with relevant expertise have conducted research on a broad range of issues around women's imprisonment. The reports of this research identify problems, make cogent recommendations and offer action plans and agendas for change. The Prison Reform Trust's in-depth report on women on remand, *Lacking Conviction*, highlights what so many of these reports do, proposing "*…a common sense agenda for change which could be undertaken by government without delay, avoiding further harm to vulnerable women.*"[379]

There are three reports of particular relevance to this project:

Women and the criminal justice system[380]

The Commission on Women and the Criminal Justice System was set up by the Fawcett Society as a result of concerns about the impact of current laws and criminal justice practices on women in England and Wales.

It makes a number of excellent and relevant recommendations concerning women's experiences in court or before the judiciary. It strongly supports the Sentencing Guidelines Council taking account of gender when formulating new sentencing guidelines. It also makes recommendations to improve probation and prison services for women and suggests amendments to the Sex Discrimination Act to ensure better performance by public authorities of their statutory duties.

Justice for Women: The need for reform[381]

In 1998 the Prison Reform Trust established a committee on women's imprisonment to inquire into the use of prison for women and explore reliance upon custody. The committee was chaired by Professor

379. *Lacking Conviction: The rise of the women's remand population, op cit,* p52.
380. *Women and the Criminal Justice System A Report of the Fawcett Society's Commission on Women and Criminal Justice System, op cit.*
381. *Justice for Women: The need for reform, op cit.*

Dorothy Wedderburn and published its findings in 2000. The report called for an overhaul of the criminal justice system's attitude to women, new approaches to mental health problems, alternatives for remand prisoners and the creation of a National Justice Board for Women. The report was seen as a seminal piece of work both by the government and campaigners in the area.

The Hurt Inside: The imprisonment of women and girls in Northern Ireland[382]

In July 2003, the Northern Ireland Human Rights Commission conducted research into the human rights of women in prison in Northern Ireland. The research remit was to examine the extent to which the treatment of women and girls in custody in Maghaberry Prison complied with international human rights law and standards, in particular articles 2 and 3 of the ECHR. The research findings were alarming and highly critical of the care provided to women in prison. For example, the report details inadequate healthcare provided to women. During the research a series of significant and disturbing events took place including the death of a woman in her cell at Mourne House, the treatment of a 17-year-old child held in isolation and the transfer of women to Hydebank Wood – an institution for young male offenders. The research report, published in October 2004, made a number of important recommendations to the Northern Ireland Prison Service and other bodies with statutory responsibility for prison issues.

Other publications with recommendations relevant to this project include:

- *Lacking Conviction*, Prison Reform Trust
- *Suicide and self-harm prevention, Repetitive self-harm among women and girls in prison,* The Howard League for Penal Reform
- *Suicide is Everyone's Concern: A Thematic Review by HM Chief Inspector of Prisons for England and Wales,* Sir David Ramsbotham
- *The Decision to Imprison: Sentencing and the prison population,* Prison Reform Trust
- *Troubled Inside: Responding to the mental health needs of women in prison*, Prison Reform Trust
- *Using Women*, Drugscope
- *Women in Prison: A Thematic Review by HM Chief Inspector of Prisons for England and Wales.*

The Prison Service has also produced its own research on women's deaths in prison that identifies warning signs and women at risk of suicide, including:

- *Safer Custody Report for 2001: Self-Inflicted Deaths in Prison Service Custody,* Safer Custody Group, HM Prison Service
- *Self- inflicted deaths of Women in Custody,* Nicola MacKenzie, Chris Oram, and Jo Borrill; Safer Custody Group, HM Prison Service

382. *The Hurt Inside: The imprisonment of women and girls in Northern Ireland, op cit.*

• *Self inflicted deaths of prisoners serving life sentences 1988-2001*, Jo Borrill; Safer Custody Group, HM Prison Service

Dissemination of these research findings throughout the Prison Service should have raised awareness and assisted in the prevention of further deaths.

Too often these reports are read, applauded and even supported by the government, whose rhetoric reassures that there is concern about the issue and action must be taken.

All too frequently this turns out to be hollow noise as change is slow, if it occurs at all. There is often a failure to provide the funding needed to implement the changes.

There is no need to re-invent the wheel when addressing women's deaths in prison. The implementation of recommendations made in this and prior research reports should be undertaken as a matter of priority.

Appendix C

Methodology

The report comprised five complementary dimensions and took two years to complete.

Literature review

A search for literature on women's deaths in prison and other relevant issues surrounding women's imprisonment was undertaken. This background provided context for the project and assisted analysis of issues that arose.

Case file analysis

INQUEST has records and/or case files relating to every female death in prison from 1990-2007. The information available on each death varied according to the level of the organisation's involvement with the bereaved family. Using this information we created a database of all women's deaths in prison custody from 1990-2007. From this database we identified and analysed key trends and issues arising and collated this information in an issues paper. This paper also identified questions to ask key stakeholders including bereaved families and relevant experts.

Contact with bereaved families

Where possible, we contacted families of women who died in prison to find out their views on the following:

- The factors in and/or out of prison that contributed to their relative's death.
- What could have been done to prevent the death.
- In general, what can be done to prevent further deaths.
- Treatment of the family following the death.

We made contact with 29 families. The impact of the death on the family often hampered their ability to take part in the project. Some families did not wish to take part as they found discussing their relative's death too traumatic.

In 10 cases we held lengthy one-on-one interviews with families. Most often these meetings took place in the family's home. We received written responses from six other families.

In June 2006 we invited these 16 families to a meeting at INQUEST's offices in London. The purpose of the meeting was twofold – to discuss the recommendations to be made in the report and to bring together families who had experienced a common tragedy. Throughout the research families described feeling very alone in their experience. Eleven family members attended the meeting. Many families were unable to travel to London to take part due to health problems developed since their relative's death. Parents described deteriorating health of themselves and extended family members since the death or the onset of stress or anxiety related disorders.

The families involved gave many hours to this research project, painstakingly recalling circumstances surrounding their relative's death. We recognise how difficult this was and thank them for their assistance.

INQUEST uses the word 'families' to refer to the bereaved persons we interviewed as part of this project. In addition to mothers, fathers and siblings, this term includes long-term partners and ex-partners interviewed.

Interviews with experts

INQUEST identified and interviewed 17 experts.[383] They represented penal reform groups, women's rights groups, law firms that represent families at inquests, HM Prison Inspectorate, HM Prison Service, universities, prison alternative centres and groups with expertise in drugs.

We thank all of them for their time and valuable contribution to this project.

Attendance at inquests

During the project we were involved with the inquests of more than twenty women who died in prison. In some cases, INQUEST was involved with the bereaved family and attended the inquest as part of its casework service. In other cases we attended purely to observe the proceedings for the purpose of compiling this report. In both circumstances valuable observations of the inquest process were made.

383. In two cases, individuals unattached to organisations were interviewed.

Glossary

ACCT	**Assessment, Care in Custody and Teamwork Plan**. See section 3.6.3
Article 2	Article 2 of the ECHR; the right to life.
ECHR	**The European Convention on Human Rights**, incorporated into domestic law in the **Human Rights Act 1998.**
FLO	**Family liaison officer**
F2052SH	The Prison Service form opened to record the monitoring of prisoners assessed as being at risk of suicide and/or self-harm. Replaced by April 2007 by **ACCT**. See section 3.6
HMCIP	**HM Chief Inspector of Prisons for England & Wales**
HMIP	**HM Inspectorate of Prisons for England & Wales**
HMP	**Her Majesty's Prison**
JCHR	**The Parliamentary Joint Committee on Human Rights**
NOMS	**National Offender Management Service**
PPO	**Prisons and Probation Ombudsman**
PCT	**Primary Care Trust**
Properly interested person	Rule 20(2) of the Coroners Rules 1984 defines a properly interested person at an inquest as: (a) a parent, child, spouse and any personal representative of the deceased; (b) any beneficiary under a policy of insurance issued on the life of the deceased; (c) the insurer who issued such a policy of insurance; (d) any person whose act or omission or that of his agent or servant may in the opinion of the coroner have caused, or contributed to, the death of the deceased; (e) any person appointed by a trade union to which the deceased at the time of his death

	belonged, if the death of the deceased may have been caused by an injury received in the course of his employment or by an industrial disease; (f) an inspector appointed by, or a representative of, an enforcing authority, or any person appointed by a government department to attend the inquest; (g) the chief officer of police; (h) any other person who, in the opinion of the coroner, is a properly interested person.
Rule 43	Under rule 43 of the Coroners Rules 1984, the coroner may write to the person or authority who may have power to take action to prevent the recurrence of fatalities similar to those which the inquest has investigated. See section 5.7
SCG	**Safer Custody Group** – the section of the Prison Service, later NOMS, with responsibility for safer custody policy including Safer Prisons and accommodation for offenders, suicide prevention and violence reduction.
YOI	**Young Offender Institution**; also **HMYOI** – **Her Majesty's Young Offender Institution**

References

Legislation

The Coroners Act 1988
The Coroners Rules 1984
European Convention on Human Rights 1950

Cases

R (Middleton) v West Somerset Coroner [2004] 2 WLR 800.
R v Her Majesty's Coroner for the County of West Yorkshire (appellant) ex parte Sacker (FC) 11 March 2004, House of Lords.
R (Sacker) v West Yorkshire Coroner [2004] 1 WLR 796.
R v Coroner for North Humberside ex parte Jamieson [1995] QB 1.
McGlinchey v UK (2003) 37 EHRR 41.
R v. Secretary of State for the Home Department ex parte Amin [2003] UKHL 51 para 31.

Publications

Allison, E. (2006) 'Shameful Admission' in *The Guardian,* 27 September 2006.
Borrill, J. (2002) 'Self-inflicted deaths of prisoners serving life sentences' in *The British Journal of Forensic Practice,* Volume 4, Number 4, Pavilion.
Borrill, J., Snow, L. Medlicott, D., Teers, R., and Paton, J. (2005) 'Learning from 'Near Misses': Interviews with women who survived an incident of severe self-harm in prison' in *The Howard Journal* Volume 44, Number 1, Howard League for Penal Reform.
Borrill, J., Mackenzie, N. and Oram, C.(2003) 'Self-inflicted deaths of women in custody' in T*he British Journal of Forensic Practice* Volume 5, Number 1, Forensic Psychiatric Nurses Association.
Caddle, D. and Crisp, D. (1997) *Mothers in Prison: Research Findings No. 38*, Home Office Research and Statistics Directorate.
Carlen, P. (1983) *Women's Imprisonment,* Routledge and Keegan Paul.
Carlen, P. (1988) *Women, Crime and Poverty*, Open University Press.
Carlen, P. (2006) "Abolition and its Enemies", presentation to Howard League for Penal Reform conference, 27 June 2006.

Colbourne, T. (1999) *Desperate Measures: Prison Suicides and their prevention*, The Howard League for Penal Reform.

Coles, D. (2005) 'Women in Prison: Failing to protect their right to life' in *The Legal Executive*, Institute of Legal Executives.

Corston, J. (2007) *The Corston Report: A review of women with particular vulnerabilities in the criminal justice system,* The Home Office.

Cragg, S. (2004) 'Middleton & Sacker: major development in inquest law', *Inquest Law* issue 7, INQUEST.

Department of Health (2003) *Transfer of prison health to the NHS* – update March 2003, Department of Health

Farrell, M. and Marsden, J. (2005) *Drug-related mortality among newly released offenders 1998 to 2000, Home Office Online Report 40/05,* The Home Office.

Fawcett Society (2005) *Black and Ethnic Minority Women in the UK,* The Fawcett Society.

Fawcett Society (2004) *Women and the Criminal Justice System – A Report of the Fawcett Society's Commission on Women and Criminal Justice System*, The Fawcett Society.

Fawcett Society (2005) *One Year On*, The Fawcett Society.

Gallop, R. and Santa Mina, E. (1998) "Childhood sexual and physical abuser and adult self-harm and suicidal behaviour: A literature review", *The Canadian Journal of Psychiatry* Volume 43, Canadian Psychiatric Association.

George, R. (2004) 'Some try to kill themselves ten times a day', in *The Guardian,* 2 December 2004.

GLC Women's Equality Group (1985) *Breaking the Silence: Women's Imprisonment*, London Strategic Policy Unit.

Goldson, B. and Coles, D. (2005) *In The Care Of The State? Child Deaths in Penal Custody in England and Wales*, INQUEST.

Hale, B. (2005) "The Sinners and the Sinned against – Women in the Criminal Justice System", The Longford Lecture.

Hansard (2007) House of Commons debate, 28 November 2007, The Stationery Office

Hansard (2004) House of Commons written answers, 7 September 2004, The Stationery Office.

Hansard (2005) House of Commons written answers, 21 February 2005, The Stationery Office.

Hansard (2005) House of Commons written answers, 2 October 2006, The Stationery Office.

Hansard (2004) House of Lords debate, 28 October 2004, The Stationery Office.

Herbert, I. (2005) 'Staff blamed for death of prison inmate', in *The Independent,* 27 April 2005.

HM Chief Inspector of Prisons (2005) *Annual Report of HM Chief Inspector of Prisons for England and Wales 2003-2004*, The Home Office.

HM Chief Inspector of Prisons (2006) *Annual Report of HM Chief Inspector of Prisons for England and Wales 2004-2005,* The Home Office.

HM Chief Inspector of Prisons (2006) *Foreign National Prisoners: A thematic review*, The Home Office.

HM Chief Inspector of Prisons (2004) *Report on an unannounced inspection of HMP Durham 5-9 January 2004*, The Home Office.

HM Chief Inspector of Prisons (2005) *Report on an unannounced follow-up inspection of HMP Durham (Women's Unit) 7-8 June 2005,* The Home Office.

HM Chief Inspector of Prisons (2004) *Report on an announced inspection of HMP/YOI New Hall 10-14 November 2003*, The Home Office.

HM Chief Inspector of Prisons (2004) *Report on a full unannounced inspection of HMP/YOI Styal 19-23 January 2004*, The Home Office.

HM Chief Inspector of Prisons (2006) *Report on an unannounced full follow-up inspection of HMP/YOI Styal 26 October – 4 November 2005*, The Home Office.

HM Chief Inspector of Prisons (1999) *Suicide is Everyone's Concern: A thematic review by HM Chief Inspector of Prisons,* The Home Office.

HM Chief Inspector of Prisons (1997) *Women in Prison: A thematic review by HM Chief Inspector of Prisons,* The Home Office.

HM Chief Inspector of Prisons and the Chief Inspector of Criminal Justice in Northern Ireland (2005) *Report on an unannounced inspection of the imprisonment of women in Northern Ireland Ash House, Hydebank Wood Prison 28-30 November,* The Home Office.

Home Affairs and Work & Pensions Select Committee (2005) *First joint report: Draft Corporate Manslaughter Bill, 2005-06*, HC 540-I, House of Commons.

Home Office (2004) *Women's Offending Reduction Programme: Action Plan*, The Home Office.

Home Office Research Development and Statistics Directorate (1999-2003 publications) *Statistics on Women and the Criminal Justice System – A Home Office publication under Section 95 of the Criminal Justice Act 1991*, The Home Office.

Home Office Research Development and Statistics Directorate (2003) *Offender Management Caseload Statistics 2002, England and Wales RDS NOM*, The Home Office.

Home Office Research Development and Statistics Directorate (2005) *Offender Management Caseload Statistics 2004 17/05 England and Wales RDS NOM*, The Home Office.

Home Office Research Development and Statistics Directorate (2006) *Offender Management Caseload Statistics 2005 18/06 England and Wales RDS NOM,* The Home Office.

Home Office Research Development and Statistics Directorate (2006) *Population in Custody Monthly Tables England and Wales RDS NOM,* The Home Office.

Hooper, C.A. (2003) *Abuse, Interventions and Women in Prison: A Literature Review,* The Home Office.

Hough, M., Jacobson, J. and Milne, A. (2003) *The Decision to Imprison: Sentencing and the prison population,* The Prison Reform Trust.

House of Commons Home Office Affairs Committee (2005) *Rehabilitation of Prisoners, First Report of Session 2004-05,* Volume 1, The Stationery Office.

Howard League for Penal Reform (2006) "England and Wales lead the pack on European imprisonment rates" press release, 18 January 2006, Howard League for Penal Reform.

Howard League for Penal Reform (2001) *Suicide and self-harm prevention – Repetitive self-harm among women and girls in prison*, Howard League for Penal Reform.

INQUEST (2004) *Annual Report 2003*, INQUEST.

INQUEST (2003) "Beverly Fowler inquest verdict returned" press release, 19 September 2003, INQUEST.

INQUEST (2006) *Briefing on the second reading speech of the Corporate Manslaughter and Homicide Bill 2006 for the House of Lords,* INQUEST.

INQUEST (2005) "Damning verdict returned into Wendy Booth's death in condemned Durham prison" press release, 2 December 2005, INQUEST.

INQUEST (2003) *Deaths in Custody – the current issues: A submission to the Joint Committee on Human Rights inquiry into deaths in custody*, INQUEST.

INQUEST (2000) "Funeral of young black woman found dead in Holloway Prison" press release, 28 June 2000, INQUEST.

INQUEST (2004) *INQUEST's Further Evidence to the Joint Committee on Human Rights September 2004: Deaths in Custody – the Current Issues*, INQUEST.

INQUEST (2006) "Inquest begins into the death of 19-year-old woman in prison" press release, 16 June 2006, INQUEST.

INQUEST (2007) "Inquest opens into death of Mandy Pearson at HMP New Hall" press release, 9 February 2007, INQUEST.

INQUEST (2003) *Inquests – An information pack for friends, families and advisors,* INQUEST.

INQUEST (2007) "Jury condemns prison service management following death of mentally ill woman in HMP Durham – government response to Corston Review inadequate to prevent further deaths" press release, 6 December 2007, INQUEST.

INQUEST (2007) "Jury return critical verdict on 'dearth of effective alternatives' for women in the justice system" press release, 23 February 2007, INQUEST.

INQUEST (2004) "Jury slate systems at HMP Styal in damning inquest verdict" press release, 18 November 2004, INQUEST.

INQUEST(2005) "Prison Ombudsman finally releases report into HMP Styal two years after completion" press release, 17 November 2005, INQUEST.

INQUEST (2000) *Report on the deaths of Katherine Woods and Tracy Logan 1996/7,* INQUEST.

INQUEST (2006) *Response to the draft coroner's reform bill,* INQUEST.
INQUEST (2006) "Shocking over-use of force, segregation and isolation for suicidal women" press release, 9 May 2006, INQUEST.
INQUEST (2006) *Submission to the Constitutional Affairs Committee into Reform of the Coroner's System and Death Certification in England and Wales*, INQUEST.
INQUEST (2005) Written memorandum to the Home Affairs Select Committee on Prison Suicides and Overcrowding, INQUEST.
JUSTICE (2005) *Inquiry Into the Draft Corporate Manslaughter Bill: Submission to House of Commons Home Affairs and Work & Pensions Sub-Committees*, JUSTICE.
Kimmett, E. (2004) *Lacking Conviction: The rise of the women's remand population*, The Prison Reform Trust.
Liberty (2006) *Corporate Manslaughter and Corporate Homicide Bill: Liberty's Briefing and Amendments for Committee Stage in the House of Commons*, Liberty.
Liebling, A. (1994) 'Suicide among women prisoners' in *The Howard Journal,* Volume 33, Number 1, Howard League for Penal Reform
Liebling, A. *et al* (2005) *An Evaluation of the Safer Locals Programme: A summary of the main findings,* Cambridge Institute of Criminology Prisons Research Centre.
Ministry of Justice (2007) *The Government's Response to the Report by Baroness Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice System*, Ministry of Justice.
Ministry of Justice Research Development and Statistics Directorate (2007) *Offender Management Caseload Statistics 2006*, Ministry of Justice.
Morris, N. (2006) 'Soaring prison population sparks safety fears' in The Independent, 30 November 2006.
Parliamentary Joint Committee on Human Rights (2004) *Deaths in Custody Third report of session 2004-2005,* Volume 1, The Stationery Office.
Parliamentary Joint Committee on Human Rights (2005) *Government Response to the Third Report from the Committee: Deaths in Custody Eleventh Report on Session 2004-05*, The Stationery Office.
Prison and Probations Ombudsman (2005) *The Styal Report – The death in custody of a woman and the series of deaths in HMP/YOI Styal August 2002 – August 2003,* Prison and Probations Ombudsman.
Prison Reform Trust Committee of Women's Imprisonment (2000) *Justice for Women: The need for reform,* The Prison Reform Trust.
Prison Reform Trust, The (2005) *Response to Corporate Manslaughter: The Government's Draft Bill for Reform,* The Prison Reform Trust.
Radical Alternatives to Prison (1983) *The Abolitionist*, Number 15, no.3, Radical Alternatives to Prison.
Rickford, D. (2003) *Troubled Inside: Responding to the mental health needs of women in prison,* The Prison Reform Trust.

Roberts, M. (2005) *Using Women*, DrugScope.
Safer Custody Group (2002) *Safer Custody Report for 2001: Self-inflicted deaths in Prison Service custody*, HM Prison Service.
Safer Custody Group (2002) *Safer Custody News*, Issue No.15, HM Prison Service.
Safer Custody Group (2004-2007) *Safer Custody News*, HM Prison Service/NOMS.
Sattar, G. (2001) *Rates and causes of death among prisoners and offenders under community supervision*, Home Office Research Study No 231, The Home Office.
Scraton, P. and Chadwick, K. (1987) *In the Arms of the Law: Coroners' Inquests and Deaths in Custody*, Pluto.
Scraton, P. and Moore, L. (2005) *The Hurt Inside: The imprisonment of women and girls in Northern Ireland,* Northern Ireland Human Rights Commission.
Shaw, H. and Coles, D. (2007) *Unlocking the Truth: Families' experiences of the investigation of deaths in custody,* INQUEST.
Sim, J. (1990) *Medical Power in Prisons*, Open University Press
Singleton, N. *et al* (1998) *Psychiatric Morbidity among Prisoners in England and Wales,* Office for National Statistics.
Social Exclusion Unit (2002) *Reducing Re-offending by Ex-prisoners,* Office of the Deputy Prime Minister.
Solomon, E. (2004) *A Lost Generation: The experiences of young people in prison*, The Prison Reform Trust.
Wolfe, T. (1998) *Counting the Cost: The social and financial consequences of women's imprisonment*, The Prison Reform Trust.

DYING ON THE INSIDE provides a comprehensive examination of INQUEST's casework on women's deaths in prison from 1990 – 2007. Concerns about inadequate treatment and neglect raised by the increasing number of women dying in prison resulted in the Women's Deaths in Prison project which examined the issues arising in detail.

The report:

- Documents and examines the individual deaths in the context of the policies and practices in place across the women's prison estate and the role of other state agencies and the wider criminal justice system.
- Uniquely brings the views of bereaved families to the discussion.
- Makes extensive recommendations and presents families' suggestions for changes in practice.
- Identifies trends and patterns arising from the deaths.
- Makes three overarching recommendations for the abolition of prison as the central response to women in the criminal justice system and the greater use of radical community-based alternatives; non means-tested public funding for families' legal representation following deaths; and for the creation of a Standing Commission on Custodial Deaths which would include a thematic stream on the deaths of women in prison.

DYING ON THE INSIDE is essential reading for all those with an interest in the issue of women's imprisonment.

Deborah Coles is co-director of INQUEST and a leading authority on deaths in custody and their investigation. She undertakes policy, research and consultancy work on the strategic issues raised by contentious deaths, their investigation, the treatment of bereaved people and state accountability. Deborah is Chair of the charity Women In Prison and a trustee of the Centre For Corporate Accountability and the Buwan Kothi International Trust. She is co-author with Barry Goldson of *In the Care of the State? – Child Deaths in Penal Custody in England and Wales* (INQUEST, 2005) and with Helen Shaw of *Unlocking the Truth – Families' Experiences of the Investigation of Deaths in Custody* (INQUEST, 2007).

Marissa Sandler has advocated for women's human rights issues in Australia. She worked at Australia's Human Rights and Equal Opportunities Commission on issues of gender equality, including women's experiences in the criminal justice system.

ISBN 9 780 9468 5822 4

INQUEST
Working for truth, justice and accountability
• Advice • Support • Information
• Policy • Research • Campaigning
89-93 Fonthill Road, London N4 3JH
Tel: 020 7263 1111 Fax: 020 7561 0799
Email: inquest@inquest.org.uk
Website: www.inquest.org.uk

Also available from INQUEST: