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Preventing the deaths of women in prison: the need for an alternative approach

June 2013

(statistics up to date as of 1 October 2013)

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Summary

INQUEST's monitoring of deaths in custody in England and Wales over the last 30 years has been central to the identification of emerging trends and patterns, including the sharply upward trend of women's deaths in prison between 1998 and 2003. INQUEST's specialist casework, research and evidence based policy work was critical in generating public and parliamentary debate on women's deaths in prison and directly influenced the Government's decision to commission Baroness Corston's review[1] following the deaths of 6 women at Styal prison in a twelve month period.

INQUEST's unique statistics, casework and research discussed in this report highlight the shared characteristics and experiences of the 100 women who have died in prison over the last decade (from 2002 to date) and focuses in particular on the 38 deaths that have occurred in the six years since the Corston report was published in March 2007. Behind these figures are stories of preventable tragedies. To develop a more in-depth understanding of the context in which the deaths of women occurred, and the special vulnerability of women in prison, this report contains the individual stories of six of the women who have died in prison since March 2007.

Although there has more recently been a welcome fall in the number of deaths of women in prison, INQUEST's casework and research shows that the underlying issues remain stubbornly familiar and go beyond the prison walls, regimes and conditions to which women are subjected. Rather, the roots of the problem are situated in the inequality and injustice that characterise women's lives. Many of the deaths highlighted raise issues that should impact on wider policies on social exclusion and poverty, drug and alcohol use, homelessness, mental health, childcare and family disruption and racism.[2]

The government has not implemented the Corston report's key recommendation – the dismantling of the women's prison estate. As a result, there has been little structural change which would address the *"sadly familiar patterns"* in the deaths of women in prison that INQUEST and Baroness Corston have identified. Though the vulnerabilities and needs of women prisoners are well established, the criminal justice system continues to sentence them to custody in unsafe institutions that are ill equipped and under resourced to deal with their complex needs. The continuing, high levels of self harm and the deaths of 4 women in 2012 and 3 deaths in 2013[3] underline how harm, damage and death are persistent features of women's experiences in prison.

This report highlights the failure of the government to ensure fundamental changes to policy and practice following the Corston review and the inability of the prison estate to learn from previous investigations and inquests. In light of this, and in order to prevent further deaths, we make recommendations for a way forward including a complete rethink of the way women are treated in the criminal justice system[4].

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[1] Corston, J. (2007) *A Review of Women with Particular Vulnerabilities in the Criminal Justice System*, London: Home Office.

[2] For further analysis see p43 ff, Coles, D "Deaths of women in prison: the human rights issues arising" in Malloch, M and McIvor G eds (2012) *Women, Punishment and Social Justice*, London: Routledge

[3] Correct as of 1 June 2013

[4] This Report is based on the written evidence INQUEST gave to the parliamentary Justice Committee in January 2013 as part of their inquiry into Women Offenders (the Committee is expected to report later in 2013). It has been

INQUEST's expertise

1. INQUEST is the only independent organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths, their investigation and the inquest process to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. Through our specialist casework service we have worked with and supported the families of women who have died in custody (and those advising them) through the investigation and inquest process. It has been properly conducted inquests into custody deaths, where families have been legally represented, that have exposed the regimes and conditions operating within the closed world of prisons and how the criminal justice system treats some of the most vulnerable in society.

2. INQUEST's monitoring of deaths in custody in England and Wales was important in identifying the sharply upward trend of women's deaths in prison between 1998 and 2003. In 2003 women represented only 6 per cent of the prison population and accounted for 15 per cent of self inflicted deaths[5]. Subsequent evidence based policy and lobbying work was crucial in generating public and parliamentary debate on women's deaths in prison and directly influenced the Government's decision to commission the Corston review following the deaths of six women at Styal prison. INQUEST's co-director Deborah Coles was a member of the reference group advising Baroness Corston's review. She is also a founding member of the cross government sponsored *Independent Advisory Panel on Deaths in Custody*.

3. In 2008 INQUEST published the first detailed analysis of women's deaths by Deborah Coles and Marissa Sandler: *Dying on the Inside: Examining Women's Deaths in Prison*. This examined the issue in detail and, uniquely, documented families' experiences and brought their voices and concerns into the discussion[6]. Drawing on this experience and evidence, INQUEST has consistently raised concerns about the effectiveness of the state's investigative processes for identifying and rectifying dangerous practices and procedures in order to ensure that lessons are learned and further fatalities prevented (including through our role as a member of the cross-departmental *Ministerial Board on Deaths in Custody)*. Most recently INQUEST published *Learning from Death in Custody Inquests*[7]*,* a report examining the narrative verdicts returned by inquest juries and the rule 43 reports written by coroners to bring the circumstances of deaths to the attention of those public authorities with the power to take action and prevent the recurrence of similar deaths. The report highlighted the serious flaws in the learning process following an inquest into a death in custody.

4. This report draws on INQUEST's unique knowledge and expertise. It includes statistics and information about deaths of women in prison in England and Wales in the ten years between 2002 and 2012 but focuses on the deaths, inquests and investigations that have taken place since March 2007 following publication of the Corston review.

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updated in light of the UN Committee on the Elimination of Discrimination against Women's examination of the UK Government's periodic report which is due to take place in July 2013.

[5] Page 19, Corston Report, op cit1

[6] See also Coles, D "Deaths of women in prison: the human rights issues arising", op cit 2

[7] Coles, D and Shaw, H (2012) *Learning from Death in Custody inquests: A new framework for action and accountability,* London: INQUEST

5. The Government's record on the treatment of women in prison will be examined by the United Nations Committee on the Elimination of Discrimination against Women in July 2013[8]. The CEDAW Committee has asked the UK Government to provide information on the implementation of the Corston report and in particular on measures which "*aim at providing quality mental health services for women in prison, as well as measures undertaken for gender-sensitive handling of detainees*[9]*.*" INQUEST has submitted this report to the Committee to inform that examination.

Deaths of women in prison – the statistics[10]

How many women are dying in prison?

6. From 2002 to date[11] there have been 101 deaths of women in prison. Over half (60) of these deaths have so far been classified as "self-inflicted deaths". There have been 5 "non-natural causes" deaths which are predominantly drug-related (eg overdoses). Amongst the other 35 women whose deaths have been classified as "non-self inflicted" or "natural causes" during the same period, the investigation and inquest process has raised concerns about the quality of physical and mental health care for women and the treatment and management of drug problems[12]. The table below sets out a breakdown of these statistics for the deaths by year since 2002.

Source: INQUEST casework and monitoring.

[8] For full details of the 55th session which will take place between 8-26 July 2013 please see: http://www2.ohchr.org/english/bodies/cedaw/cedaws55.htm

[9] Paragraph 20, *List of issues and questions with regard to the consideration of periodic reports: United Kingdom and Great Britain* (CEDAW/C/GBR/Q/7, 2 November 2012)

[10] Derived from INQUEST's Statistics, Monitoring and Casework databases. The quantitative data in these databases is derived from research conducted by INQUEST between 1990 to date. Sources include: INQUEST's casework, media monitoring, official statistics, and questions asked in Parliament, as well as (from 1996) individual notifications of each death in prison and detailed statistical tables provided to INQUEST by the Prison Service/National Offender Monitoring Service/Ministry of Justice.

[11] Correct as of 1 October 2013

[12] 1 death is currently "awaiting classification"

7. Narrowing the figures down, since the Corston Report was published in March 2007, INQUEST's statistics record that:
    - there have been 39 deaths of women in prison;
    - 15 of these deaths were self-inflicted (38%);
    - half (19 of the deaths) have so far been classified as non-self inflicted;
    - 10% (4 of the women who died) were from a Black and Minority Ethnic background;
    - The most common age of the women who died was 32 years old (7 of the deaths) with 21% aged 30 years old or younger when they died;
    - Nearly half (19) of the women who died had been charged with or convicted of drug-related offences or crimes such as theft or burglary.

8. While there has recently been a welcome fall in the number of deaths of women in prison, INQUEST's analysis of our casework shows that, since the Corston report was published six years ago, the underlying issues remain stubbornly familiar and the women who are dying in prison continue to share common characteristics.

Who are the women who are dying in prison?

9. The 2008 research report *Dying on the Inside*, by Coles and Sandler, was a comprehensive examination of INQUEST's casework with the families and legal representatives of the 115 women who had died in prison between 1990 and 2007. It revealed that women dying in prison shared a number of common characteristics[13] and that those who died were most likely to be:

    - young (with 28 years old being the average age and 20 years old the most common age of the women who died). Over a fifth of the women (21%) were aged between 18 and 21;
    - white (88% of those who died);
    - mothers (with at least a third of those who died having at least one child);
    - already at risk of suicide (previous government research has suggested that half of women prisoners on remand had tried to kill themselves in the year before entering custody);
    - misusing drugs (at least 40% of those who died were misusing drugs or had a known history of misuse when they arrived at prison. In 52% of cases it was unknown if the women had a history of drug use which suggests 40% is a conservative estimate of the scale of the problem);
    - charged with or convicted of drug-related offences or crimes such as theft and handling stolen goods (among women who died while on remand 29% were charged with theft and handling stolen goods suggesting that many of these women may not have gone on to receive custodial sentences).

    The women who died were also more likely to:

    - die in the early stages of custody (with 22% dying within the first week of imprisonment and 40% within the first three months);

[13] The following statistics are taken from detailed research conducted for *Dying on the inside* and are based on the self-inflicted deaths of women between 1990-2007. Examination of recent INQUEST casefiles on the deaths of women in prison between 2007 to date suggests that similar statistical trends persist (see paragraph 7 of this report)

- die by hanging themselves (89% of those who died self-inflicted deaths hanged themselves including a number from cell bar windows and curtain rails in cells).

Self-harm and suicide attempts by women in prison

10. Deaths in custody represent the extreme end of a continuum of near deaths, suicide attempts and self harm. The statistics above barely scratch the surface of the distress, vulnerability and damage done to women in prison which emerges at the inquests. Neither do they fully represent how this continues as a permanent and enduring feature of prison life. Coles has noted that:

> *in many cases women harm themselves primarily as a means of coping with their incarceration – imprisonment exacerbates mental ill health and is a response to the prison environment, isolation and separation from family and children – on average 18,000 children each year are separated from their mothers as a result of her imprisonment*[14]*."*

11. Serious mental health problems are endemic in women's prisons. It is estimated that up to 80 per cent of women suffer from one or more mental health disorders and there is a strong correlation between mental ill health and childhood abuse, domestic violence and drug dependency. The Corston report recorded that of all the women who are sent to prison, 37% say they have attempted suicide at some time in their life[15]. More recent figures confirm that around 29 per cent of all self harm incidents in prison are committed by women despite them constituting only 5 per cent of the prison population[16].

12. Inspection reports from the Chief Inspector of Prisons have highlighted that the high levels of self-harm in women's prisons remains a matter of concern:

> *Our report on Bronzefield described a shocking level of self-harm (although not one that is untypical in a women's local prison). In the 12 months before the inspection there had been 2,771 self-harm incidents – more than seven a day. Of those, six out of 10 had involved tying ligatures and just over half of the women involved had harmed themselves more than once. One woman had harmed herself 93 times in one month. Records for the use of force by staff showed that a high proportion were interventions to prevent women tying ligatures to themselves*[17]*.*

Deaths of women in prison – the individual stories

13. To ensure a fuller understanding of the experiences and treatment of the women behind the statistics, we include six stories of women who have died in prison in the six years since the Corston report was published in March 2007. As well as INQUEST's case files and work with bereaved families and their legal representatives, the sources used to draw up these individual stories include Prisons and Probation Ombudsman (PPO) investigation reports, witness

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[14] Op cit 2

[15] 18, Corston (2007)

[16] Table 3, Ministry of Justice (2012) Safety in Custody Statistiics, Update to December 2012, London: Ministry of Justice

[17] Page 5, HM Chief Inspector of Prisons (2010) *Report on a full unannounced inspection of HMP Bronzefield 13 – 22 October 2010* London: Ministry of Justice

statements and legal notes from the inquest hearings, narrative verdicts and coroners rule 43 reports.

Kerry Devereux was found hanging in the segregation unit at HMP Foston Hall on 18 April 2007. She was 32 years old and had two children aged 11 and 6 years old. It was her first time in prison. She was serving a three year sentence for supplying drugs. She was eligible for release in August 2007.

Kerry was brought up in Newcastle area, the eldest of three children. She had a troubled childhood and when Kerry was 13 years old she was taken into care. She constantly ran away from social services accommodation and left her school with no formal academic qualifications. When Kerry was 17 years old she met her partner and had two children with him. She became a drug user from her late teens.

Kerry was initially imprisoned in HMP Low Newton but she was then transferred to HMP Foston Hall which was a much greater distance away from her young children and her mother preventing them from being able to visit her. When Kerry arrived at HMP Foston Hall her medical records (including a record of the ACCT (self-harm monitoring) form that had been opened at Low Newton) were not referred to.

In the weeks leading up to her death, Kerry's self-harming behaviour got worse, including one incident where she cut her wrists with a razorblade. The day before her death Kerry was transferred to the Segregation Unit. Once there, she told the prison staff that she tried to hang herself earlier in the day but that the ligature had snapped. Red marks could be seen in her neck. Despite this her cell was not checked for potential ligatures and she was not put on constant observations. The staff found her body the next morning. She was suspended from a ligature made from her leather belt that was attached to the cell window frame.

At the time of her death, Kerry was being monitored under the ACCT process. During her 9 weeks in HMP Foston Hall, three ACCT documents were opened in response to Kerry's acts of self harm. The three assessments were not collated together so staff opening each new ACCT did not see the previous documents and notes and there was no single file containing a complete record of Kerry's serious self-harming.
The inquest took place in October 2009 - two and a half years after Kerry's death. The jury returned a critical verdict recording that her death was *"contributed to by neglect, the failure of systems and procedures*".
Following the inquest, the coroner wrote to the Secretary of State for Justice and recommended that when making an ACCT assessment, staff should have all previous ACCT documentation available to them. In reply, the National Offender Management Service stated that *"some of these documents are sizeable and therefore it would be physically impossible to have the actual ACCT documents available together for all staff".* Instead HMP Foston Hall was aiming to set up a database to highlight the existence of previous ACCT documents so that staff could then go to the documents themselves in the Safer Custody office if required.

14. Since Kerry's death there have been two further self-inflicted deaths at HMP Foston Hall: 32 year old Samantha Dainty was found hanging in the shower area of her cell on 30 January 2009 having used her dressing gown cord as a ligature. Most recently, 51 year old Trudie Wragg was found unresponsive in her cell on 10 December 2012. Her death has initially been classified as self-inflicted as, like Samantha Dainty, she appears to have used her dressing gown cord as a ligature.

24 year old **Jaime Pearce** died in HMP Holloway on 10 December 2007. Two days earlier, on 8 December, Jaime had been remanded to prison for shoplifting and two counts of failure to appear in court. It was her first time in custody.

Jaime's family have described her as a *"shy girl with a caring and loving nature*". She liked hair and make up and wanted to be a beauty therapist. As a teenager, she had always been anti drugs and was very critical of her sister's drug use. Until eighteen months before her death she was in a long-term relationship and in 2005 gave birth to a much wanted daughter. Jaime was devastated when the relationship ended and she was faced with the prospect of bringing up her daughter alone. She had vowed that she would never be a single mum because she knew how much her own mother had struggled. Around this time Jaime's sister and friends started frequenting her house and after a while, to her family's surprise, Jaime also became a heavy drug-user.

Following Jaime's arrest on charges of shoplifting and failure to appear in court the magistrates' court decided to remand her to custody pending a full hearing of her case. Jaime arrived at HMP Holloway late on 8 December and was diagnosed by the Reception doctor as opiate and alcohol dependent and alcohol detoxification medication was begun.

At about 3am on 9 December staff were called to a disturbance in the room Jaime was sharing with three other women – they found her sitting on a bed looking *"ashen"* with one of her cell-mates screaming at her. Staff noted blood round Jaime's nostrils and, after being told she had been hit, they took a decision to move her from the cell where she had been bullied to another shared dormitory.

Jaime became very unwell during the next day, with a temperature and persistent vomiting. Evidence uncovered during the PPO investigation noted Jaime had kept back tablets from her medication and had apparently been snorting the contents in her cell. Jaime was not checked on by prison staff during the night. Shortly before 7am on 10 December, staff visited Jaime's cell to wake her in time for her court appearance and discovered she was dead.

The jury at the 2009 inquest into her death ascribed her death to "natural causes". In the report into Jaime's death the Prisons and Probation Ombudsman stated he had *"raised a number of concerns about the care offered to the woman at Holloway, and have made several recommendations including a full review of detoxification and withdrawal monitoring. The investigation has found that there is a strong incentive to women to lie about their alcohol use in order to obtain medication to tide them over withdrawal from opiates.* ***I am also concerned that several of my recommendations echo those I made after the death of another woman at Holloway in 2005.***[our emphasis]

15. Since Jaime's death there have been two other non self-inflicted deaths at HMP Holloway: 37 year old Margaret Meikle died on 29 August 2010 in the detoxification unit and an open verdict was recorded at her inquest, and; on 5 January 2012 Tran Thi Hien (a 53 year old Vietnamese national) was discovered frothing at the mouth and unresponsive in her cell. She died in hospital shortly afterwards. The inquest into her death has yet to take place.

Lisa Marley was 32 years old when she died on 23 January 2008 at HMP Styal. She was on remand for common assault.

Lisa suffered from mental health problems including severe borderline personality disorder and made repeated attempts of self-harm throughout her life. She also had a history of drug dependency. Lisa had left her family home at the age of 13, to live with a neighbour. She moved schools frequently and was seen by Social Services every week. At the time of her death, Lisa had a much loved 8 year old daughter but found it hard to cope with being a mother.

Lisa had previously been a prisoner at HMP Styal after assaulting a police officer who was providing assistance after Lisa had attempted to cut her own throat. Within 48 hours of her first remand to HMP Styal in October 2007 Lisa attempted to take her life by tying a ligature to the curtain rail in her cell. Although she stopped breathing, she was later revived in hospital. Her family noted that the incident left her with a permanent impairment to her speech. She was subsequently released from Styal on licence in November 2007.

In January 2008, Lisa was remanded into custody for a second time after she spat at a security guard and became aggressive at the benefits agency when she found out that her support had stopped. When she was arrested by police she told her sister *"you won't see me again".* She also told the staff in reception at Styal that she would harm herself again and that this time she would not be found.

Lisa was placed in what HMP Styal termed a "reduced risk" cell on the Keller Unit. Despite its name, a gap around the casing which surrounded the television in her cell provided a ligature point above the toilet in the only part of the cell that could not be observed by prison officers looking through the observation hatch. Lisa was also provided with ordinary bedding. Despite her ACCT document stating that she should be observed five times an hour, on the morning of her death she was not checked and when red marks were noticed on her neck, no action was taken. On 19 January, Lisa hanged herself using her bedding which she had ripped to make a ligature. She was found suspended from the casing around the television set.

At the inquest into Lisa's death two years later, the coroner noted that he found it *"sadly ironic that an individual identified as at acute risk of self-harm and for that reason housed on the Keller Unit should find the physical means to end her life, less than 48 hours after being sent there".* The jury found that inappropriate cell design with a clear ligature point contributed to Lisa's death. During the inquest they heard evidence from a specialist who conducted a clinical review on behalf of the Prisons and Probation Ombudsman that the Keller Unit was "*not fit for purpose".*

The inquest jury also criticised Styal prison for failing to provide adequate mental health training for staff working on the Keller Unit and the coroner noted that despite her complex needs, Lisa Marley only had *"fleeting contact"* with a mental health professional during her time in HMP Styal and that the Keller Unit *"fell far short of its operating philosophy of providing a multi-disciplinary approach".*

Most shocking to the family was the discovery that there was CCTV showing an officer laughing and joking as Lisa received emergency medical treatment inside the cell where she was found.

16. The Corston report was triggered by six previous deaths at HMP Styal and raised grave concerns about the treatment afforded to women who were vulnerable on account of their drug use and/or mental illness. One of the most shocking aspects of Lisa Marley's death is that, less than a year after Baroness Corston's report was published, the prison regime at Styal was still not able to ensure a woman like Lisa was kept safe in custody.

17. The deaths at Styal have continued. On 8 January 2009, a year after Lisa Marley died, 36 year old Alison Colk hung herself in HMP Styal on her first night in prison. Alison was a mother of one serving a 28 day sentence for abstracting an electricity supply. At the time of her death Alison was supposed to be under close supervision and monitoring for withdrawal from drugs. At the inquest into her death the coroner criticised the effectiveness of the withdrawal monitoring system and Styal Prison's use of inexperienced agency staff noting his *"concerns that a nurse with no relevant experience should be in charge of a group of people at a particularly vulnerable time – the first night in custody."*

Sarah Higgins died in HMP Bronzefield on 8 May 2010. She was 30 years old and had three children aged 5, 6 and 11. Sarah was on remand for the offence of possession of class A drugs and assaulting an officer in the execution of their duty.

Sarah had a history of drug dependency and had been a drug user since the age of 17. When she had her first child, she was able to stop using drugs but she relapsed when things became difficult again.

On arrival at HMP Bronzefield, Sarah was seen by medical staff and was put on a detoxification programme. She died later that day on her first night in prison.

Sarah's death came as a shock to the family. Her children have been affected the most, particularly her 11 year old son who keeps asking exactly why and how his mother died. So far, his questions remain unanswered as the inquest into Sarah's death, where the cause of death will be determined, will not take place until October 2013.

Sarah's family are concerned that she was not given appropriate or adequate medical care in prison. At the time of Sarah's death healthcare at HMP Bronzefield was the responsibility of the private contractor Sodexo. Nurses were therefore employed by Sodexo although the provision of General Practitioners was sub-contracted to a separate private company, Cimarron UK Ltd. The adequacy of the local healthcare policies and clinical guidelines in place at the prison is something the family is concerned about and which they hope will be addressed at the inquest.

Helen Waight was 32 years old when she was found unresponsive in her cell in HMP Bronzefield on 7 March 2011. She was serving a 14 week sentence for theft. Helen died in HMP Bronzefield ten months after Sarah Higgins (see above).

Helen had 5 young children who are all under the age of 15 and who are now cared for full time by Helen's mother. Helen had struggled with drug dependency for several years. Her mother had asked Social Services for a residential detoxification placement many times but this was not provided. At the time of her death, Helen's family were making plans for her release, and had been informed that she was doing well on her detoxification programme. Her death subsequently came as a complete shock to her family.

On her remand to HMP Bronzefield on 14 January 2011, Helen was seen by a doctor specialising in drug dependency management and was put on a detoxification programme. She died just over seven weeks later – seven days before she was to be released from prison.

The family are desperate to find out exactly what caused Helen's death and whether or not it could have been prevented. Nearly two years after her death, the inquest has yet to take place and it is provisionally due to be heard during 2013.

Helen Waight's family are concerned about the clinical decision making, monitoring and management of Helen's detoxification regimes and the care she received from the sub-contractors and healthcare staff at HMP Bronzefield, particularly as the healthcare regime at the prison had previously been the subject of criticism by Her Majesty's Chief Inspectorate of Prisons. The adequacy of the local healthcare policies and clinical guidelines in place at the prison, and the response to criticisms by inspection bodies, is something the family and their legal team are now exploring as they wait for the inquest to take place.

Melanie Beswick was 34 years old when she took her own life in HMP Send on 21 August 2010. The investigation report from the Prison Probation Ombudsman into Melanie's death notes: *"Sadly, I believe that much of what Baroness Corston wrote holds true for Ms Beswick"*.

Melanie had a history of depression and self harm. After the birth of her first child, she suffered from post natal depression. From then on she struggled to cope and was prescribed anti-depressants. After a business venture failed and she got into debt, Melanie worked at a local Citizens Advice Bureau from whom she started to take money. In March 2009 she was given a nine month sentence for fraud. It was her first offence and her first time in custody. The sentencing judge said: "*There is no alternative other than send you to prison immediately… Go with the officer please and I want this to be carefully noted by the prison authorities, this woman is a serious suicide risk and she is to be watched carefully by those who now responsibility for her safety"*

During her imprisonment at HMP Bronzefield, Melanie carried out serious acts of self harm and on one occasion attempted to take her own life by forming a ligature.

Following her release, confiscation proceedings were brought and Melanie was ordered to repay the money she took within 6 months or serve a further 12 month prison sentence in default. Short of selling the family home and making her husband and two young children homeless Melanie could not repay the money in time and was sent back to prison.

The second term of imprisonment proved very hard for Melanie who missed her children and it had a devastating impact on her already poor mental health. She continued to self harm throughout her time in custody in both HMP Eastwood Park and, following a transfer, in HMP Send. In the months before her death, she had been subject to three ACCT documents (Assessment, Care in Custody, and Teamwork – the system used for prisoners who are at risk of self harm). She had also reported bullying on several occasions and expressed fear that she would not be able to repay the money and so face further imprisonment.

On 21 August 2010, the day of her death, Melanie had been found unresponsive and motionless in her cell and, despite no obvious signs of physical ill health, was taken to hospital where she was agitated and tried to harm herself several times. The Accident and Emergency doctor eventually discharged her but instructed prison staff that she was at high risk of self-harm and needed constant observation and mental health input. After returning to HMP Send, senior prison staff decided, primarily on Melanie's presentation at an assessment meeting rather than information from the hospital, that she would be placed on hourly observations. Shortly before her death, Melanie asked to speak to a Listener (prisoners trained by the Samaritans to support other prisoners in distress) but was told to wait. Less than an hour later, Melanie was found hanging from a ligature made from shoelaces attached to the window of her cell.

The jury at the April 2013 inquest into Melanie's death found that failures in communication between the prison and the hospital, and internally within the prison, contributed to Melanie's death. The Coroner made two rule 43 reports recommending changes in the way information is shared between hospitals and prisons nationally and changes in the way suicide risk is managed at HMP Send.

18. Melanie Beswick was a first time, non violent offender with mental health problems, a history of self-harm and had been recognised as a serious suicide risk. She was a mother of two young children. However, inquests into individual deaths such as Melanie's cannot scrutinise the broader issues about sentencing and allocation and, in INQUEST's experience, these deaths frequently raise fundamental question as to why a woman was imprisoned in the first place.

19. Responding to the jury's verdict at the inquest into Melanie Beswick's death, INQUEST's co-director Deborah Coles commented:

> *"Six years ago Baroness Corston's report warned that a fundamental overhaul of the way women were dealt with in the criminal justice system was needed as a matter of urgency. Everything highlighted in her review sadly holds true for this case and demonstrates the dire consequences of not implementing her recommendations."*[18]

Deaths of women in prison – the *"sadly familiar patterns"*

20. As part of the Corston review INQUEST facilitated a meeting of bereaved people whose relatives had died in women's prisons to share their experiences. Baroness Corston subsequently wrote:

> *I am particularly grateful to these families for sharing their sad and personal stories with me. I greatly admire their courage and was struck time and again by their overwhelming concern that others should not suffer as they had done.* ***Their stories followed sadly familiar patterns*** [our emphasis] (Corston 2007: 33).

21. Analysis of the individual stories, INQUEST's statistics and research[19] set out in this report reveal those *"sadly familiar patterns"* to be:

Histories of significant disadvantage and complex needs

22. Critical official and academic research has highlighted the qualitatively complex and distinct needs of women in prison who are among the most powerless, marginalised and disadvantaged in society largely due to presence of the following factors in their lives: drug and alcohol misuse, mental illness, personality disorders, self harm, periods of homelessness, poverty, lack of education, time spent in care, sexual and physical abuse and domestic violence.

23. Many of the women whose individual stories have been included in this report had varying degrees of interaction with community agencies, including social services and mental health services but had been unable to access the support needed. The majority (five out of six) had been drug dependent for several years before entering prison.

Inappropriate use of imprisonment given the offence

24. Women often bear the brunt of social, health and economic inequalities and this is reflected in the types of offences women are imprisoned for. For example, theft and handling accounted for 37% of all women entering custody under sentence in the 12 months ending June 2012 and

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[18] See INQUEST Press Release "Jury highlights prison failures in death of vulnerable woman Melanie Beswick at HMP Send" (1 May 2013) available from: www.inquest.org.uk

[19] See in particular Coles, D and Sandler, M *Dying on the inside: examining women's deaths in prison* (INQUEST, 2008)

was the most common offence[20]. It is notable that of the six women whose stories are set out in INQUEST's report, two had been imprisoned for theft/shoplifting and two for drug-related offences.

25. Three of the deaths examined in this report took place when the women were on remand. INQUEST's previous research[21] on the deaths of women in prison between 1990 and 2007 revealed that of those who died on remand, 29% were charged with theft and handling stolen goods, suggesting that many of these women may not have gone on to receive custodial sentences.

26. In light of recently published government statistics showing that 68% of women entering prison under sentence were to serve six months or less[22], questions urgently need to be asked about the appropriateness of sending women on short sentences to prison with the disruption it causes to their lives and that of dependent children. A stark example of the problem can be found in the case of Helen Waight who was serving a 14 week sentence for theft when she died at HMP Bronzefield.

27. The deaths highlighted in this report raise fundamental concerns about why these women were imprisoned in the first place and yet the question of sentencing and allocation is largely outside the remit of the investigation and inquest. This means that an issue crucial for understanding how women come to die in prison is not being publicly scrutinised by the official bodies and processes charged with protecting the right to life and preventing further deaths. It also means that responsibility and accountability for these deaths beyond the prison service is rarely examined in any detail.

Isolation from families

28. INQUEST's previous research has suggested that a third of the women who die in prison are mothers. All six women whose individual stories are set out in this report were mothers. Separation from children, family and support networks often has detrimental effects on already vulnerable women's mental health particularly as women are often imprisoned at long distance from their home area making regular family visits and contact with their children near impossible.

29. Imprisonment also impacts on the human rights of children and can cause significant emotional trauma. As a result of the deaths of the women examined above, 14 children have been have been left without a mother.

Prisons unable to meet women's complex needs

30. The evidence from the inquests and investigations into the deaths demonstrates that prison is a damaging and inappropriate environment to deal with women's complex needs. Inquests into the deaths frequently found (and continue to find) that prison was entirely unsuitable, there were individual and systemic failings in the treatment and care of the deceased, and juries and coroners regularly comment on a dearth of community based alternatives.

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[20] page 31, .Bromley Briefings Prison Factfile, November 2012, London: Prison Reform Trust.
[21] See *Dying on the Inside* op cit 10
[22] Ministry of Justice (2012) Offender Management Caseload Statistics, London: Ministry of Justice

31. Conditions and treatment experienced by women in custody documented in HMIP reports following inspections, in investigation reports and inquest evidence, include:

- use of isolation, segregation and long hours of lock-up (including for suicidal women);
- failure to manage bullying;
- inappropriate and punitive management of self-harming and suicidal women and the lack of supportive and therapeutic strategies for women suffering mental ill-health;
- systemic neglect of women's physical and mental health;
- inadequate healthcare provision;
- inappropriate drug detoxification and management of drug problems;
- failure to implement suicide prevention guidelines;
- lack of staff training and poor communication.

Poor medical care and limited access to therapeutic services in prison

32. In a number of cases set out in this report, women had complex histories of mental health, drug, and/or alcohol problems and should have been treated in a therapeutic setting and the community rather than prison. As the father of a woman who took her own life in HMP Durham accurately observed after his daughter's death:

> *Many people in prison have serious mental health issues…problems that should not be subjected to the isolation of the prison regime. They should be placed in suitably designed secure psychiatric units where they can receive the proper help they need towards preparing their lives. Prison staff in general do not have the experience nor should they be expected to deal with these type of problems*[23].

33. In many cases, the investigations and inquests have revealed numerous failures in the treatment and care provided to individual women. INQUEST's co-director Deborah Coles has previously argued that: *"regardless of the appropriateness of the decision to imprison the women, the failure to provide adequate and appropriate care once in prison heavily contributed to their deaths. For example, drug withdrawals and detoxifications were poorly managed and framed in the context of punishment rather than care, symptoms of mental illness were too often responded to with discipline, and women on suicide watch were not adequately observed.*[24]*"*

34. Sarah Higgins and Helen Waight both died at Bronzefield prison, in the space of less than a year, whilst on detoxification programmes. When they take place, their inquests will determine the medical causes of death and will be an important opportunity for the full evidence relating to their experiences in prison and the adequacy of the healthcare at the prison to be publicly scrutinised.

Unsafe prison environments and cells

35. It is sobering to note that three of the women whose experiences in prison are set out above had known mental health problems and self-harming behaviour. Yet all three were able to take their own lives in prison. At the time of their deaths, Kerry Devereux, Lisa Marley and Melanie Beswick were all subject to the Assessment, Care in Custody and Teamwork (ACCT) process which is supposed to monitor and safeguard vulnerable women at risk of self-harm.

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[23] Page 29, Coles, D and Sandler, M op cit 10
[24] Page 43, op cit 2

36. Taken together with INQUEST's previous analysis of the deaths of women in prison, this evidence raises serious questions over the ability of officers and practitioners accurately to identify those at risk of harm and the system for managing them and keeping them safe.

37. This unsafe environment is compounded by inappropriate cell design and safety. Despite numerous inquest findings and rule 43 reports this problem continues to feature in the inquests following the deaths of women in prison. Prison Service guidance highlights that "*window bars and beds are most frequently used to attach ligatures*",[25] yet all three of the self-inflicted deaths of women examined in this report involved the use of ligatures[26].

38. The term 'ligature-free' cells, so-called because they are designed to hold women identified as being at risk of harm safely, was shown to be a misnomer after the death of Lisa Marley, who died in what was termed a 'reduced-risk' cell on the specialist Keller Unit at HMP Styal.

39. In future, the repeated failures by the Prison Service and others to address known flaws in cell safety may well be open to more scrutiny in light of the Corporate Manslaughter and Homicide Act 2008 which from September 2011 now applies to all places of custody. It is also to be welcomed that the health and safety issues presented by these deaths are increasingly being examined by external agencies, including the Health and Safety Executive (HSE). For example, in February 2012 the HSE formally censured the Prison Service for allowing so called 'safer cells' at HMP Bullingdon to be modified to include shower rails with ligature points.[27]

40. The UK government is proposing to bar access to legal aid and specialist legal representation to individuals wanting to challenge their treatment in prison on, amongst others, the following matters:

> *"Treatment By Staff – help where a prisoner allegedly has cause to complain about HMPS staff from general bullying to abuse.*
> *Discrimination – help about discrimination in relation to rights & privileges issues.*
> *Communications & Visits – help with issues surrounding correspondence which, on occasion, may be withheld or visits being barred from family members, friends etc.*
> *Mother & Baby Issues – help to mothers who are refused places on the units (and therefore the ability to be with their babies).*
> *Compassionate Release – this is where a prisoner seeks release on severe health grounds."*[28]

41. The individual stories in this report illustrate that it is precisely these kinds of issues that may impact negatively on a women's state of mind and increase the risk of serious self-harm or death. Legal assistance should be available for women in prison to challenge poor or harmful treatment and INQUEST has urged the government to withdraw their proposals.[29]

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[25] See PSO 2700, Annex 10C Safer Custody Accommodation Protocol Table - http://pso.hmprisonservice.gov.uk/pso2700/PSO%202700_-_annexes_9-15.htm#ANX10c

[26] Use of ligatures accounted for 52 of the 57 self-inflicted deaths of both men and women in prison in 2011. See Table 1.13, Ministry of Justice (2012) Safety in custody statistics quarterly bulletin January to March 2012, London: MoJ

[27] Casenote on death of Danny Rooney at HMP Bullingdon, *Inquest Law* journal, Issue 24, July 2012

[28] See Page 111 of *Transforming Legal Aid* (CP 14/13), Ministry of Justice, London.

[29] For more details see INQUEST's response to the consultation: www.inquest.org.uk/pdf/briefings/INQUEST_response_to_Transforming_Legal_Aid_consultation.pdf

Preventing the deaths of women in prison

42. In recent years there has been a welcome reduction in the numbers of self-inflicted deaths of women in prison in England and Wales. This has been as a result of the scrutiny afforded to deficiencies in operational policies and practices at inquests where bereaved families are represented by specialist lawyers. Some of these inquests led to improvements to the treatment and management of women in prison with substance misuse problems.

43. However, this report demonstrates that the "*sadly familiar patterns"* underlying the deaths of women in prison remain. INQUEST's co-director Deborah Coles has expressed concerns that: '*the enduring nature of women's prisons is reflected in the fact that in the five years since Baroness Corston reported the rate and demography of the women imprisoned and the same structural problems remain largely unchanged.'*[30]

44. Indeed, with the economic recession in the UK impacting disproportionately on women and cuts being made to crucial front line social and welfare services, it is likely that more women will be criminalised because of poverty and social inequality. It is worrying that the limited, but positive, changes that have occurred (particularly around diversion schemes and funding for women's centres) are now under threat because of a lack of sustainable funding. Current government proposals to remove access to specialist criminal defence solicitors (who know the particular mental health or other vulnerabilities of the women they represent) may also, if carried forward, compound the negative impact on women caught up in the criminal justice system. Ultimately, we are concerned that, as a result of these government policies, more women will end up in prison.

45. We note that the government has recently committed to undertaking a review of the women's prison estate and establishing an Advisory Board for Female Offenders.[31] A cross-government focus on women in the criminal justice system is to be welcomed but, given the wealth of evidence available from both the wide-ranging and thorough Corston review, and the work of academics and non-governmental organisations such as INQUEST and Women in Prison, what is needed is action rather than more deliberation and review.

46. However, the government's proposed approach does not address some fundamental questions including:

- why demonstrably vulnerable women are still being sent to prison;
- why there is still limited follow up and implementation of the recommendations made by investigators and inquests; and,
- why the government has not built on the Corston review and pursued the key recommendation that the existing women's prison estate should be replaced by small, local, multi-functional custodial units designed specifically for the very small number of women who need secure containment.

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[30] page 48, Coles op cit 2

[31] See, for example, the evidence given by the Parliamentary Under-Secretary of State for Justice, Women and Equalities to the Justice Committee inquiry into women offenders on 26 March 2013: www.publications.parliament.uk/pa/cm201213/cmselect/cmjust/uc742-v/uc74201.htm and her Written Ministerial Statement to Parliament on 22 March 2013: www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130322/wmstext/130322m0001.htm#13032265000097

47. INQUEST believes the following action is needed to address these questions and tackle the patterns underlying the deaths of women in prison.

(1) Scrutiny of decisions to send demonstrably vulnerable women to prison

48. A stark issue raised by the statistics and the six individual stories set out in this report is why the women who died were imprisoned in the first place. This is often a key concern for bereaved families. However questions around sentencing policy and the options available to judges are largely outside the remit of the inquest and are not routinely addressed by coroners. INQUEST believes a brief review of sentencing and the alternatives to custody which were available to criminal courts should be part of any investigation following a death or serious injury in prison. Such a focus would also help ensure responsibility and accountability for these deaths beyond just the prison service.

(2) Robust follow up and implementation of investigation and inquest recommendations

49. The inquests and investigations into deaths of women should be a mechanism by which lessons can be learned. However, potentially life-saving recommendations disappear into the ether. The patterns and trends set out above continue to feature in deaths and arise time and again in official investigators' recommendations, inquest juries' narrative verdicts and coroners' rule 43 reports[32].

50. One reason for this is that inquests into deaths in custody are often subject to serious delays, which frustrates the learning process as well as placing an intolerable strain on families[33]. A further reason is that, at present, there is no central collation, monitoring, auditing, analysis or full publication of narrative verdicts and coroners' rule 43 reports. There needs to be public scrutiny and detailed analysis of the follow-up to these. The Ministry of Justice *Summary of Rule 43 reports and responses* contains only headline analysis and brief summaries of cases selected for inclusion. We repeat our previous suggestion that a national, accessible database of all jury verdicts and coroners' recommendations on deaths in custody be established[34]. With the new Chief Coroner for England and Wales Peter Thornton QC now in post, his office may (if properly resourced to conduct the required analysis) play a key role in this area.

51. Likewise the Prisons and Probation Ombudsman (PPO) should collate and publish all the recommendations that have been made in respect of individual women's prison. Consideration should be given to the PPO being able to follow up with prisons as to what actions have taken place in response to recommendations made in their fatal incident reports. This too should be published.

52. There is still no mechanism to compel relevant government departments, public authorities and prisons to ***act*** on PPO recommendations, inquest findings and rule 43 reports (rather than merely respond). INQUEST thinks there is a good case for strengthening the legislation in this area.

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[32] Rule 43 reports are written by coroners to bring the circumstances of deaths to the attention of those public authorities with the power to take action and prevent the recurrence of similar deaths

[33] An analysis conducted in July 2011 of 500 of INQUEST's death in custody cases where the death *and* inquest occurred between 2000- June 2011 showed that 48% of cases took two years or more to conclude, 24% took three years or more and 9% of cases took four years or more before the inquest was heard.

[34] Coles, C and Shaw, H (2012) *Learning from Death in Custody inquests: A new framework for action and accountability,* London: INQUEST

(3) Rethinking the approach to imprisonment of women

53. In order to protect the human rights of those in prison and to prevent violations occurring there needs to be a complete rethink of the way in which women are treated in the criminal justice system and the use of imprisonment for women.

54. The Corston report's central recommendation was to replace the existing prison estate within ten years with small, local, multi-functional custodial units designed specifically for women. This recommendation was informed by a holistic examination of women's social and economic circumstances and their experiences of prison. It was suggested that these centres would, over time, be removed from Prison Service control and run by specialists working with women. That was supposed to take place alongside a dramatic reduction in the number of women sent to prison. Such a shift in approach requires political will, courage and accountable leadership. It is deeply frustrating that the recommendation for fundamental change has been discarded.

55. INQUEST's work has led us to the conclusion that prison should be abolished as the dominant form of punishment for women in conflict with the law – and instead investment should be made in community based alternatives. Reallocated criminal justice resources should be invested in refuges and rape crisis centres, drug and alcohol support services, gender appropriate community service schemes and small community based therapeutic centres. Strategies and interventions that address the many complex reasons why women enter the criminal justice system – sexual and physical abuse, poverty, homelessness, addiction, and mental and physical ill health – offer the best option for tackling the issues that underlie the deaths of women in prison.

56. This approach would not only benefit individual women but also the public purse. The financial costs of imprisoning women are huge and do not represent good value for money given the approach plainly does not work (as demonstrated by the significant numbers of women who currently return to prison after release). As the criminologist Pat Carlen has cogently argued: "*the choice is between continuing to squander millions of pounds on prisons or taking bold steps to stop legislators and sentencers seeing the prisons as being the ultimate panacea for all social, political and penal ills".*

Concluding comments

57. The state's responsibility for the deaths of the women featured in this report go beyond the prison walls and extend to failures in mental health and substance abuse provision, sentencing policies and a lack of investment in alternatives to custody.

58. Decisive action is needed now to completely overhaul the way women in conflict with the law are treated. Coupled with investment in a wide-ranging alternative programme of interventions, this could finally end the catalogue of pain, punishment, self harm and, ultimately, deaths of women that continue to shame our prison system.

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