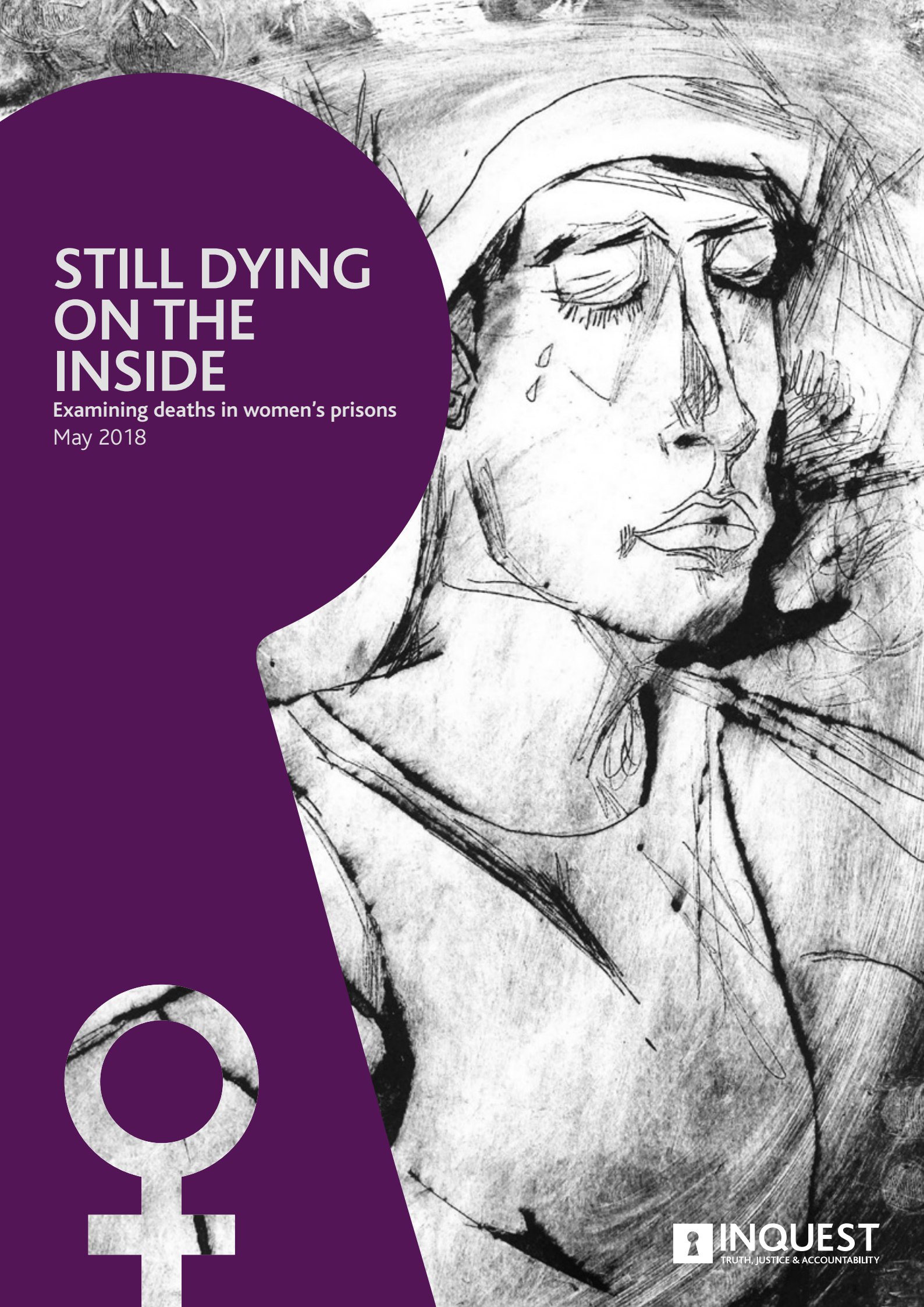

STILL DYING ON THE INSIDE

Examining deaths in women's prisons

May 2018

INQUEST
TRUTH, JUSTICE & ACCOUNTABILITY

ABOUT INQUEST

INQUEST is an independent charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes death in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. This includes work around the Hillsborough football disaster and the Grenfell Tower fire.

ABOUT THIS REPORT

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Artwork: 'Perception' by artist Charlotte Nokes who died in HMP Peterborough in 2016. Charlotte won several Koestler prizes for her art and described herself as 'the artist in residence'. Inside images generously provided by the Koestler Trust, which form part of the exhibition *100 Years On: An Art Trail by Women in Prison*.

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In memory of those who have died in women's prisons, March 2007 to March 2018

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Sarah Jaconelli
Julie Armstrong
Annabella Landsberg
Mangui Fu
Susan Smith
Christine Diskin
Yvonne McCluskie
Nicola Birchall

The names of three women have been omitted at the request of their families.

According to INQUEST records, seven transgender women have died in men's prisons during this period.

FOREWORD

BY DEBORAH COLES

"She had been trying to get help. She knew she was getting ill but unfortunately her only options were to sit in A&E and wait to be assessed by a psychiatrist or be assessed through the police intervention – so getting herself arrested. They were about the only options…. She tried to get help. She tried to tell people and she had not been heard."
Diane Coulson, mother of Emily Hartley.

Emily Hartley, aged 21, was the youngest of 22 women to die in prison in 2016, the year that saw the highest annual number of deaths in women's prisons on record. Emily was imprisoned for arson, having set fire to herself, her bed and curtains. She had a history of serious mental ill-health including self-harm, suicide attempts and drug addiction. This was Emily's first time in prison. A prison that could not keep her safe. A sentence that cost her life.

On 1st February 2018 the inquest investigating Emily's self-inflicted death concluded with deeply critical findings about her care and the failure to transfer her to a therapeutic setting. What made her premature and preventable death all the more shocking is that ten years to the day of Emily's inquest, the same coroner had dealt with a strikingly similar death, that of Petra Blanksby. Nineteen year-old Petra was imprisoned for an arson offence, having set fire to her bedroom in an attempt to take her own life. Two women, ten years apart, criminalised for being mentally unwell.

Petra too, had a history of mental ill health and suicide attempts. At the end of her inquest in 2008, the coroner recommended to the Prison Service and Department of Health they should deal with the lack of secure therapeutic facilities outside prison. At the conclusion of Emily's inquest, the same coroner David Hinchliff wrote: *"I repeat ten years later that the Prison's Department and the Department of Health should conduct a collaborative exercise to achieve the provision of suitable, secure, therapeutic environments in order to treat those with mental health problems"*.

Eleven years after the publication of Baroness Corston's seminal review in 2007 of women in the criminal justice system[1], the situation has never felt so desperate. It is with anger, sadness and deep frustration that we report almost no progress on the necessary systemic and structural change needed. Ninety-three women have died in women's prisons since March 2007. The casework team at INQUEST continue to support families whose daughters, sisters, mothers, aunts and grandmothers have died. The harms of imprisonment follow women back into the community, as demonstrated by the fact that 116 women died after release from prison between 2010 and 2017.

INQUEST's work with bereaved families seeks to make visible the women behind the statistics and the structural issues behind their criminalisation and imprisonment. We seek to show the human face of this pernicious social problem, because so many of these deaths are preventable. They raise profound concerns about human rights violations – not only the failure to provide a safe and dignified environment, but also the failure to act to prevent further deaths, an aspiration that unites all bereaved families.

The women's names memorialised in this report are a stark reminder of the tragic human consequences of the failure of successive governments to take seriously the needs of women experiencing a range of health, economic and social inequalities. They also speak to institutional state violence and how our prisons today systematically generate pain and suffering and how they can lead to death.

This report provides unique insight into deaths in women's prisons. It is empirically grounded in (1) an examination of official data; (2) INQUEST's original research and casework; and (3) an analysis of coroners' 'Prevention of Future Death' reports and narrative jury findings. This evidence has been strengthened by the facilitation of families' legal representation and the more effective participation of the bereaved. This has led to more searching questions at inquests and has shone a light on the shocking reality of women's experiences in the criminal justice system.

INQUEST are calling for urgent action to save lives. We do so by calling for the transformation of services and ending the inappropriate imprisonment of women. What we know from our casework and monitoring of deaths is that this is not just a criminal justice, or prisons, or policing, or sentencing issue. The way women who are in conflict with the law are treated is at the extreme end of institutionalised social and economic inequalities and the gendered imbalances in power that flow from these. This is a social justice and a feminist issue.

Law breaking by women differs markedly from that by men. It is less frequent, and less serious. Women bear the brunt of social, health and economic inequalities; reflected in the fact that 87% of women sentenced to prison are there for non-violent offences, with 40% imprisoned for theft. Women's experience of trauma then impacts on their response to imprisonment. This forms part of a vicious cycle of victimisation and law breaking.

The women who end up in prison are amongst the most powerless and disadvantaged in society largely due to traumatic life experiences of: sexual and physical abuse, domestic violence, exploitation, periods of homelessness, institutional care, self-harm, educational disadvantage, trafficking, racism, drug and alcohol misuse and mental illness, underpinned by poverty and inequality. INQUEST's 2008 book, *Dying on the Inside* included interviews with bereaved families, many of whom had desperately sought help and support for their relatives. Prisons are full of men, women and children who have been unable to access the support and help they need in the community. As a result, serious mental distress in prison is endemic and we know that class, gender, race and disability play a major part in criminalisation and imprisonment.

The death of Sarah Reed, a 32 year-old black woman, in HMP Holloway in 2016 is illustrative. Sarah's death highlights the intersections of race, gender and mental health for women in prison. Sarah was remanded to prison by the courts for the sole purpose of obtaining psychiatric reports to confirm whether she was fit to plead, for an alleged offence which took place while she was sectioned at a mental health unit. Once in prison, staff treated Sarah's acute distress as a matter of discipline and control.

Incarceration forms part of a continuum of coercion, control and violence inflicted against women in the home, in the community and inside prisons. The state's responsibility for the damaging and sometimes fatal consequences of imprisoning women often starts well beyond the prison walls with failures in social, health and educational services, sentencing policies and a lack of investment in alternatives.

It does not have to be like this. Social justice approaches do work. In particular, independent, specialist organisations and services that are run by and for women and that are culturally specific for BAME women and girls. Services that understand the lived experiences of women and girls and offer a holistic approach, can improve well-being and enable them to take control of their lives. Reallocating resources from policing, courts and prisons into refuges and rape crisis centres, drug and alcohol services, gender appropriate community-based schemes and small therapeutic centres, as well as innovative approaches such as theatre and arts projects - will materially improve their lives and impact far more positively on women (and their children).

Austerity measures are impacting disproportionately on women, including cuts to legal advice, housing, benefits and services for victims of domestic violence. This is most sharply felt across the intersections of ethnicity, gender, disability and class. Diversion schemes and existing specialist women's centres and projects are under critical threat because of a lack of sustainable funding.

As the criminologist Pat Carlen[2] 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 prison as being the ultimate panacea for all social, political and penal ills"*.

This report is intended to reenergise and reframe the debate about women's imprisonment as a social justice and feminist issue. Women in the criminal justice system do not need another inquiry or report or more research. Women in prison need actions, not words. We know what needs to be done and what works.

In this report INQUEST is laying down a challenge, to government and parliamentarians, to policy makers, practitioners and to campaigners: Recognise women's imprisonment as a form of structural violence against women. Honour our nation's international treaty obligations to safeguard vulnerable women and girls. And work together towards dismantling and eradicating the outdated and failing women's prisons that blight our criminal justice system and society today.

Deborah Coles, Executive Director, INQUEST

BACKGROUND AND CONTEXT

In 2008, INQUEST published *Dying on the Inside: Examining Women's Deaths in Prison*, providing a detailed analysis of women's deaths and documenting families' experiences, bringing their voices and concerns into the discussion. This was followed by a 2014 report, *Preventing the Deaths of Women in Prison*. This report builds on this previous body of work, exploring both self-inflicted and non self-inflicted deaths.

Working alongside bereaved families for almost four decades, INQUEST has been instrumental in drawing attention to the deaths of women in prison. INQUEST has consistently raised concerns about the ineffectiveness of the state's investigative processes following a death in custody and the need for recommendations to be acted upon to prevent future deaths[3].

THE CORSTON REVIEW

Campaigning by bereaved families and INQUEST around the sharp rise in deaths across the women's estate in early 2000, persuaded the then Labour government to commission Baroness Jean Corston to conduct an independent review of women in the criminal justice system. This was influenced by the evidence that arose from the inquests into the deaths of six vulnerable women with mental health and drug problems in Styal prison in a 13-month period. INQUEST arranged for her to meet bereaved families and submitted evidence to the review.

The publication of Corston's ground-breaking review in March 2007 was a pivotal moment. It offered a blueprint for change. She called for *"a distinct, radically different, visibly led, strategic, proportionate, holistic, woman-centred, integrated approach"*. The review recommended the dismantling of the women's prison estate, the introduction of small custodial units and an expansion of gender-specific support in the community, through a network of women's centres. It was expected that the use of imprisonment for women could be reduced to an 'absolute minimum' and was hoped that women's imprisonment could be almost entirely phased out.

At the time there was great optimism that positive change was imminent. Steps were taken to invest in some community-based provision and a much-needed national network of women's centres. However, funding of many services has now been cut and many are at risk of closing. Liz Hogarth (former women's policy lead at the Ministry of Justice and advisor to Corston) has analysed developments since the review[4]. Reflecting on the current situation, she says that nothing has changed and prison remains a disproportionate and inappropriate response for too many women. She concludes, *"the situation is now much worse, and shockingly so"*.

As Deborah Coles noted back in 2013[5], the Corston report

"offered the Government a real opportunity to embrace a more 'abolitionist' agenda and undertake a fundamental overhaul of the existing system. By rejecting this key recommendation Government squandered a unique opportunity with the inevitability that there would consequently be piecemeal reforms only, thus subverting the key objective of the report."

There has been a lack of progress on Corston's key recommendations to: reduce the women's prison population to an absolute minimum, to support and sustain community-based services, and to build small custodial units for the small number of women who may require some form of secure setting. If they had been followed, custodial places would be required for no more than around 125 women[6]. The refusal of successive governments to act on these crucial recommendations means that reforms have done little to disrupt the operation of a failing, often brutal and lethal system.

The Corston Report[7] *10 Years On* by Women in Prison, evaluates progress on each of the recommendations. While it *"sparked numerous initiatives, reports, strategies, commissions and groups"*, Women in Prison concludes that *"sadly many of these initiatives have not been sustained and it would be fair to say we have seen a stagnation and loss of momentum in fully implementing"* Corston's recommendations. This lack of progress has also been noted by the UN Committee on the Elimination of Discrimination Against Women, who in 2013 called on the government to *"vigorously implement"* the recommendations[8].

RECENT DEVELOPMENTS

In response to a shocking rise in self-inflicted deaths in women's prisons in 2016, the Independent Advisory Panel on Deaths in Custody (IAP) conducted a 'rapid information gathering exercise' to establish the reasons for the sudden increase and identify mechanisms to prevent self-harm and self-inflicted deaths. Published in 2017[9], the review collated expert evidence from more than 100 respondents, including INQUEST, and identified reasons for the sudden rise in deaths.

It highlighted reductions in staffing; unmet mental health, drug and alcohol treatment needs; a discernible increase in the vulnerability and complex needs of women entering prison; an increase in illicit drug use, intimidation, bullying and debt in custody; a decrease in use of release on temporary licence (ROTL); an increased likelihood of homelessness on release and high numbers of recalls; and, the knock-on effect of the hasty closure of HMP Holloway in 2016 including increased distance from home and pressure on other establishments, combined with the widespread closure of women-only support services in the community. The 51 IAP recommendations cover reforms to community-based services, prison reform, mental health, transfer of information, family contact and preparation for release.

The focus of the IAP investigation was on self-inflicted deaths and the prison conditions that may have contributed to the sudden rise. However, they also drew attention to a marked increase in deaths from so called 'natural causes' and the deaths of women following release. Informed by our casework and monitoring, INQUEST has serious concerns about the impact of poor prison healthcare, for both physical and mental health. Conclusions from inquests indicate that poor healthcare provision in prison and the community is a factor in many deaths often registered as 'natural'.

Since the publication of Corston's review, numerous inquests, official government reports, parliamentary inquiries and NGO reports have continued to document the vulnerabilities and challenges faced by women in prison and called for an investment in community-based services and a significant reduction in the use of custody[10]. This substantial body of evidence has highlighted what needs to happen to bring about positive change to meet women's needs, improve safety and save lives. And yet there has been very little decisive action to make the structural change needed.

The government's 2016 White Paper *Prison Safety and Reform* committed to the construction of five new 'community prisons' for women and the publication of a *Women's Justice Strategy* in early 2017. More than a year later, the strategy has not yet emerged and is now expected in Summer 2018.

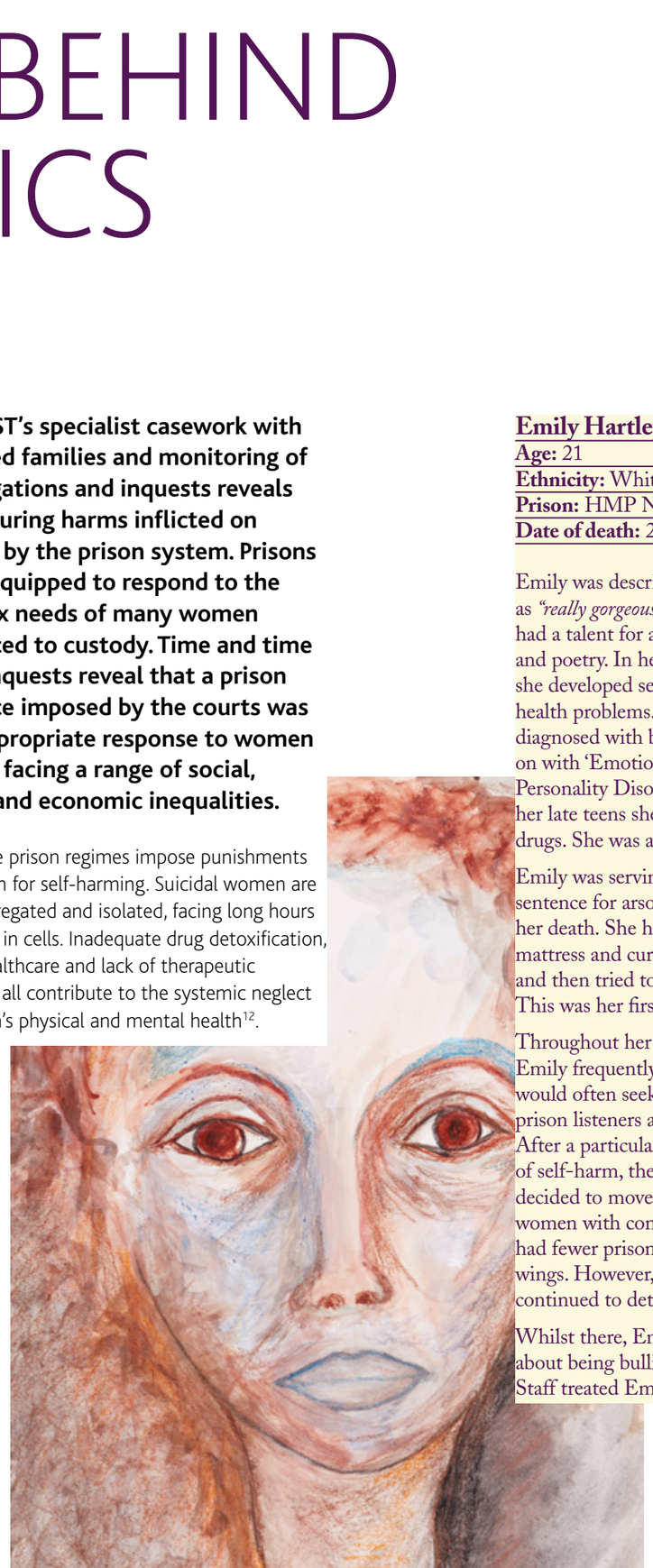
Looking ahead, the direction of travel is unclear but with the right commitment from government, change is possible. The forthcoming *Women's Justice Strategy* represents an important opportunity to implement Corston's recommendations and embed the learning of the last 11 years to radically improve community based services and minimise the use of imprisonment for women.

THE WOMEN BEHIND THE STATISTICS

"Behind the statistics are stories of preventable tragedies; incontrovertible evidence of human rights abuses; the institutional failure of the prison system to exercise its own duty of care. The risks of custody for women are well documented and known to the authorities and yet women continue to be imprisoned"
(Coles, 2013)[11]

INQUEST's specialist casework with bereaved families and monitoring of investigations and inquests reveals the enduring harms inflicted on women by the prison system. Prisons are ill-equipped to respond to the complex needs of many women sentenced to custody. Time and time again inquests reveal that a prison sentence imposed by the courts was an inappropriate response to women already facing a range of social, health and economic inequalities.

Repressive prison regimes impose punishments on women for self-harming. Suicidal women are often segregated and isolated, facing long hours locked up in cells. Inadequate drug detoxification, failing healthcare and lack of therapeutic strategies all contribute to the systemic neglect of women's physical and mental health[12].



***Women Resilience*, HM Prison Peterborough, Portrait, 2017**

Emily Hartley

Age: 21
Ethnicity: White
Prison: HMP New Hall
Date of death: 23 April 2016

Emily was described by her mother as *"really gorgeous and lovely."* She had a talent for acting, music and poetry. In her early teens she developed serious mental health problems. Emily was diagnosed with bi-polar and later on with 'Emotionally Unstable Personality Disorder' (EUPD). In her late teens she started taking drugs. She was also raped.

Emily was serving a 32-month sentence for arson at the time of her death. She had set fire to her mattress and curtain in her flat and then tried to set fire to herself. This was her first time in prison.

Throughout her time in prison Emily frequently self-harmed and would often seek support from prison listeners and Samaritans. After a particularly serious incident of self-harm, the mental health team decided to move Emily to a wing for women with complex needs which had fewer prisoners than the other wings. However, Emily's condition continued to deteriorate there.

Whilst there, Emily complained about being bullied by staff. Staff treated Emily's distress as a discipline issue and she was subject to formal disciplinary proceedings, two of which related to her swearing at officers and apologising afterwards. This behaviour was a feature of her EUPD. A third incident related to her breaking her wardrobe to obtain a nail or staple to self-harm.

Just eight days before her death, Emily's self-harming behaviour dramatically escalated when she not only opened up pre-existing cuts to her arms but also attached a ligature to her neck and showed a nurse what she called a 'suicide file' and a letter for 'who finds me'. This information was insufficiently shared with staff responsible for her care. No review was held into her suicide and self-harm management and no immediate additional support was put in place.

The jury at her inquest in January 2018 concluded that Emily should have been moved to a therapeutic unit after her mental state deteriorated in prison. The jury also made serious criticisms about the management of her risk of suicide and self-harm.

Hours before her death Emily phoned her mother complaining about the lack of care and said no one was checking on her, despite being on two observations per hour. Emily was found hanging behind the house block in an out of bounds area. It took the staff two and a half hours to notice she was missing and find her body. The day before, knowing she had not been checked, she had written,
"I'm lower than any previous time in my life… yet you officers can't even follow a simple ACCT document and commence checks to ensure that I am indeed still alive. This is ridiculous. Life is ridiculous. What's the point? Why live?"

Sarah Reed

Age: 32
Ethnicity: Black
Prison: HMP Holloway
Date of death: 11 January 2016

Sarah was described by her mother as a warm, kind and loving person who loved dressing up in beautiful and unusual clothes. She was someone who was always wanting to include and help others. Throughout her life Sarah struggled with mental ill-health. She had never recovered from the trauma of the death of her baby daughter in 2003. Her mental health problems were exacerbated after she was assaulted by a police officer in a brutal attack in 2012, an offence for which he was found guilty.

Sarah was remanded to prison in October 2015 for the sole purpose

THE WOMEN BEHIND THE STATISTICS

of obtaining two reports on her fitness to plead, for an incident which was alleged to have taken place whilst she was sectioned in a mental health hospital. Due to various delays, Sarah had not been assessed by the date the report was supposed to be ready in December. The final reports were due to be finalised on 11th January, the day she died and 15th January, four days after her death.

In prison, Sarah's mental health deteriorated and her final days were harrowing. She was sleepless, hallucinating, chanting, and without the medication she had relied on for years. Much of her behaviour was interpreted by prison staff as a discipline issue. Sarah was put on a basic regime and denied visits from family and lawyers, despite her right to visits as a remand prisoner. Sarah was put on 'four man unlock' and a screen was placed before her cell door.

Sarah was found lying in her bed with a tight ligature around her neck and could not be resuscitated. The jury at the inquest concluded that unacceptable delays in psychiatric assessment, inadequate treatment for her high levels of distress, and the failure of prison psychiatrists to manage Sarah's medication contributed to her death. Marilyn, Sarah's mother, believed Sarah was a victim of collective failure of those involved in her care. Speaking publicly, she said,

'I sleep at peace at night because I know I fought for my daughter to the very last'.

Natasha Evans

Age: 34
Ethnicity: White
Prison: HMP Eastwood Park
Date of death: 27 November 2013

Natasha was one of five siblings, and part of a close knit and loving family. She was artistic and had always enjoyed calligraphy and painting as a child. Natasha had a history of drug addiction and lived with her partner who was a drug supplier. She was suffering from depression after her cousin died of a drug overdose. Natasha had been sentenced to four months in prison for a drug related offence.

On the day of her death Natasha became seriously unwell and was incoherent. The nurse who assessed her failed to call an ambulance or alert a GP, and instead asked a fellow prisoner to monitor her condition. Later that afternoon Natasha was found collapsed in her cell and then had to wait a further 59 minutes for an ambulance. By the time it arrived it was too late to save Natasha and she died whilst being treated by paramedics. A post mortem revealed that she died of kidney and heart infections which caused her to develop sepsis.

At the inquest, which was heard almost two years after her death, the jury returned a critical narrative conclusion which found that neglect contributed to her death. The expert evidence confirmed that, had Natasha received appropriate care, she would have survived.

Since Natasha's death there have been a further six non self-inflicted deaths at Eastwood Park, five of which were of women under the age of 55.

Following the inquest her mother said,
"Listening to three weeks of evidence about how my daughter was failed repeatedly on the day of her death, by the very people who were meant to look after her, has been incredibly hard. All I can hope now is that lessons will be learnt so that another mother might be spared what I have had to endure".

Diane Waplington

Age: 40
Ethnicity: White
Prison: HMP Peterborough, (privately run by Sodexo)
Date of death: 16 May 2014

Diane had an ordinary childhood and was a bright and fun-loving mother of three. She met her husband at the age of 15 and suffered a break-down when their relationship ended. Diane had a long history of mental ill-health and serious self-harm. She was diagnosed with 'Emotionally Unstable Personality Disorder' and had been hospitalised in mental health units numerous times. The only time she made progress was during a period in the Farndon Unit, a dedicated low secure environment for women. However, when that placement came to an end she did not receive similar care elsewhere.

Diane was remanded to custody after she set fire to her hospital bed whilst a voluntary patient in a mental health unit. She was charged with arson. This was her first time in prison. During her four days in Peterborough prison she self-harmed on five occasions. The day before she died, she threw hot water at a prison officer. Despite the state of her mental health, the response of prison staff was to put her in the segregation unit. This is where Diane died. Just before her death she had asked to speak to a Samaritans listener but was told that the phone had ran out of battery. She was found suffocated and could not be saved.

The jury at the inquest identified serious failures about the care Diane received and how her suicide risk was managed. They also categorically stated that opportunities to divert her away from prison custody were not adequately considered.

Giving evidence to Parliament's Joint Committee on Human Rights in May 2017, Diane's mother Sheila said, *'Prison is no place for mentally ill people, it is a trigger.'*

K.W. (name has been omitted at the family's request)

Age: 26
Ethnicity: White
Prison: HMP Bronzefield, (privately run by Sodexo)
Date of death: 27 September 2015

K was one of three siblings. She enjoyed listening to music and liked to laugh and joke about with her family and friends. K had mental ill-health and was diagnosed with 'Borderline Personality Disorder'. She was known, both to mental health services and the prison, as a prolific self-harmer with a high risk of death.

K had been in prison before for numerous short sentences for minor offences. She spent her 18th birthday in prison, years before. This time she was sentenced for breaching an ASBO and low level theft. During her six months in HMP Bronzefield, prison officers recorded 235 incidents of self-harm, most of them by tying ligatures around her neck. K had also tried to set herself on fire, and the fire brigade had to be called.

The inquest was listed to take place in 2016 but was unexpectedly adjourned twice, it is expected to be heard in Autumn 2018. The main question the family have is, why was K not transferred to a hospital when her self-harming escalated? If K had been sent to a specialist service for women with personality disorders, the family believe she would have almost certainly survived.

Since K's death there have been three further deaths in HMP Bronzefield. Like K, two of the women were in prison for non-violent offences, and the third was there for arson. K's family hope the inquest will ensure measures will be put in place so that no one has to go through the heartache and devastation they have had to suffer.

Caroline Hunt

Age: 53
Ethnicity: White
Prison: HMP Foston Hall
Date of death: 29 September 2015

Caroline's daughter said she was a kind person who cared deeply for her friends and family. She believed her mother had been blighted with various mental health issues throughout her life, which led directly to the circumstances surrounding her offence. This was Caroline's first time in prison.

Caroline was initially remanded in HMP Foston Hall in May 2015. She was released on bail and then returned to prison in September 2015. During the next 20 days in Foston Hall, Caroline was very distressed and feeling hopeless about her future. The day before her death she was found with a bag over her head, and her cellmate alerted prison staff that Caroline had written a suicide note. The staff decided to move her to a cell on her own and increase observations from two to three times an hour. The next morning Caroline was found hanging and died in hospital three days later.

The inquest jury found serious failings in the way Caroline was managed and cared for, including that staff underestimated the risk she posed to herself, that she should have been referred for a formal psychiatric assessment, that it was inappropriate given her risk to move her to a single cell, and that the level of observations set was not appropriate.

Following Caroline's death, the overnight custody manger, who was the most senior officer on duty at the prison the night before she was found hanging, was immediately suspended for his actions surrounding the assessment of risk. At the inquest, more than 18 months later, the coroner found a key member of staff still had a *"lamentable lack of understanding"* of suicide prevention policies.

Caroline was the fourth person to die in HMP Foston Hall in 2015. Since her death there have been two further deaths. After the inquest her daughter said,
"I have learned some very sad truths about life inside prison and just how difficult prison is for the most vulnerable people in society."

WOMEN IN PRISON

"Taking the most hurt people out of society and punishing them in order to teach them how to live within society is, at best, futile. Whatever else a prisoner knows, she knows everything there is to know about punishment because that is exactly what she has grown up with. Whether it is childhood sexual abuse, indifference, neglect; punishment is most familiar to her".

Chris Tchaikovsky, former prisoner and founder of the charity, Women in Prison[13]

The women's prison population has remained fairly static post the Corston review. On 31 December 2017 there were 3,919 women in prison in England and Wales. 8,545 women entered prison in the year to September 2017, either on remand or to serve a sentence[14].

Forty eight percent of women are reconvicted within one year of leaving prison. This rises to 61% for sentences of less than 12 months and to 78% for women who have served more than 11 previous custodial sentences[15].

Many women in the criminal justice system have personal experiences of trauma, abuse and domestic violence. More than half of women in prison in England (53%) report having experienced emotional, physical or sexual abuse as a child compared to 27% of men[16]. The charity, Women in Prison, report that 79% of the women who use their services have experienced domestic and or sexual violence (ibid).

Eighteen percent of the women's prison population are Black, Asian or Minority, Ethnic (BAME). There is disproportionate use of custodial remand and custodial sentencing for black women[17] who, for example, are 2.3 times more likely to receive a custodial sentence for drug offences compared to white women[18]. Once in prison, BAME women report experiencing racial and religious discrimination from other prisoners and staff[19]. Positive relationships with staff are less likely to be reported by BAME women and they are more likely to feel intimidated and threatened by prison staff.

A recent report from Muslim Hands found that 79% of women of Muslim backgrounds in prison reported experiencing domestic violence and abuse prior to imprisonment[20]. This figure is likely to be similar for South Asian women in prison many of whom often have to overcome additional and exceptional challenges and hurdles in the form of rejection, cultural taboos and forced family or community isolation.

In December 2017, 10% of the women's prison population were foreign nationals[21]. It is estimated that around 31% of foreign national women are in prison for drugs offences with many reporting being coerced or committing offences due to poverty and the need to support their families[22]. They are often held beyond the end of their sentence, awaiting a decision on whether they are to be deported (ibid).

Two thirds of women in prison are mothers of dependent children[23], adding to the pains of imprisonment for both mothers and children. Women are more likely than men to be remanded into custody[24] and more women are sent to prison for theft than for violent offences. In the year to September 2017, 6,462 women were sentenced to immediate custody of which 40% (2,579) were imprisoned for theft offences and 9% (603) for violence against the person offences[25]. Sixty two percent of sentences were for six months or less. Such short sentences can result in women losing their homes and children, compounding disadvantage and at huge cost to the public purse.

In his most recent annual report, the Chief Inspector of Prisons[26] describes how women coming into prison are *"increasingly vulnerable"* and that 65% of women, compared with 42% of men, said they had mental ill-health. Growing numbers of women arrive at prison feeling depressed or suicidal. In the year under review, 2016-17, 41% of women reported mental health difficulties compared with 29% at previous inspections. The proportion of women who said they had at some stage felt unsafe in prison had risen to 52% from 39%.

In a 2014 study[27] of prescribing practices in prison it was found that 48% of women in prison were prescribed at least one mental health medicine (compared to 17% of men) and prescribing rates for women in prison are six times higher than among patients in the community.

In 2007 there were 11,224 incidents of self-harm in women's prisons. This gradually came down to 6,019 in 2013 and rose to 8,015 incidents in 2017[28]. In 2017 there were 292 self-harming women per 1,000 prisoners, compared to 124 men per 1,000. There were 183 hospital attendances by women following a self-harming incident in 2017. Since 2007, the only year it was higher was in 2008 when the figure stood at 209 hospital attendances.

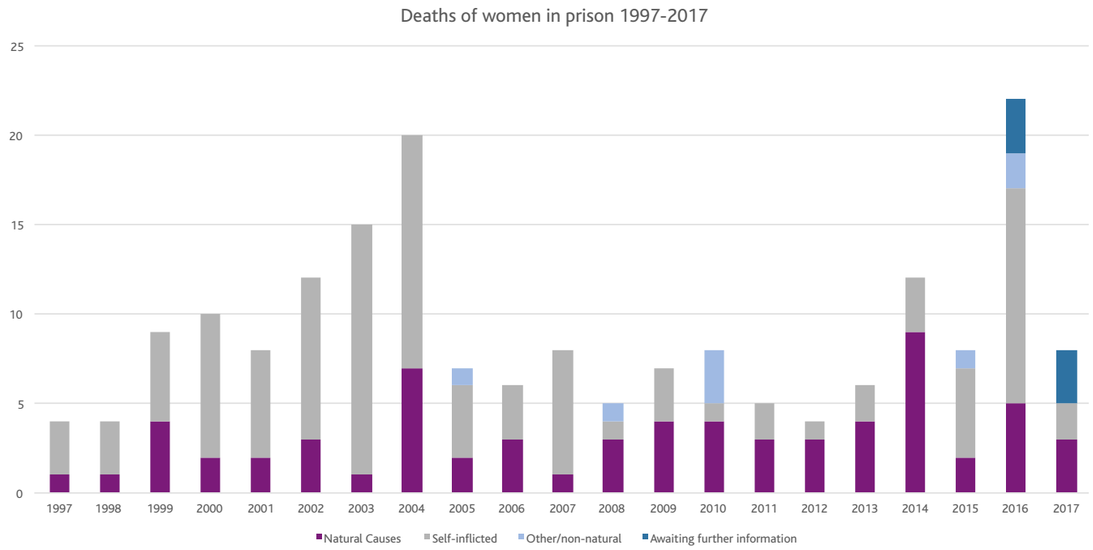
Rehabilitation, HM Prison Peterborough, Silver Award for Painting, 2017

REVIEWING DEATHS

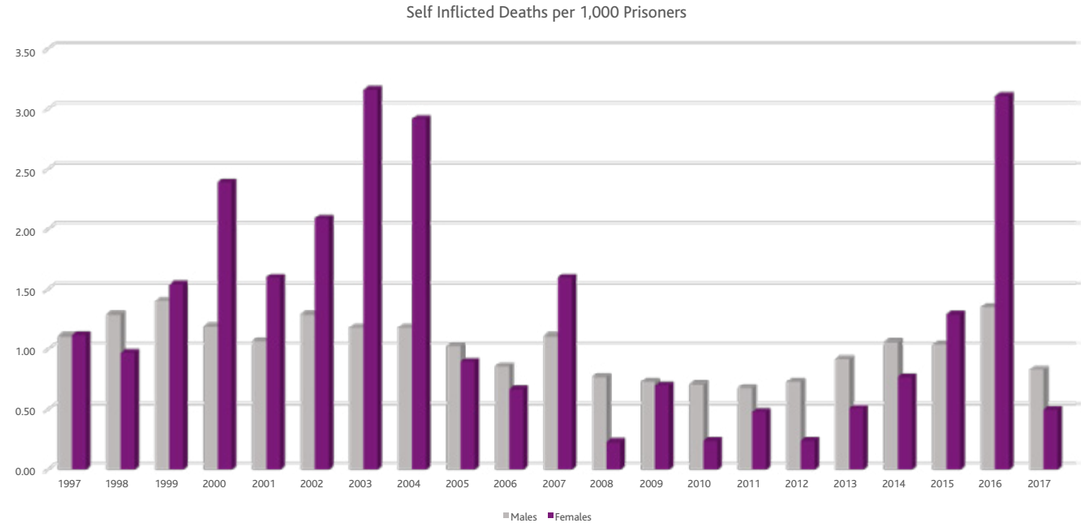
Ninety-three women have died in women's prisons in England and Wales since the publication of Baroness Corston's review in March 2007[29]. The figure below, produced from Ministry of Justice statistics, gives a longer-term view of women's deaths to highlight the trends over time, broken down by cause of death according to MoJ classifications. 2016 was the deadliest year on record for both male and female prisoners with a total of 346 people dying. Twenty-two women died, 12 of which were self-inflicted, 7 non self-inflicted and three are awaiting classification[30].

While this report focuses on deaths in women's prisons, it is important to acknowledge that women are also dying in other forms of detention including police cells, mental health settings and immigration detention. Furthermore, since March 2007, seven transgender women have died in men's prisons, five of which were self-inflicted and two, non self-inflicted.

In 2014 there was a sharp rise in non self-inflicted deaths in prison (classified by the Ministry of Justice as 'natural causes'). According to INQUEST case monitoring, of the nine women who died, six were either in a privately run prison or were in a prison with non-NHS healthcare providers such as Care UK, Cimarron and Spectrum.



Source: Ministry of Justice (2018) 'Deaths in prison custody 1978 to 2017' *Safety in Custody quarterly: update to September 2017*



Source: Ministry of Justice (2018) 'Deaths in prison custody 1978 to 2017' *Safety in Custody quarterly: update to September 2017*

INQUEST collects information on deaths in prison based on our specialist casework database, Ministry of Justice notifications of deaths, and safety in custody statistics. Of the 93 deaths in women's prisons between March 2007 and March 2018, 37 were self-inflicted, 48 were non self-inflicted and 8 await classification. Of the 37 self-inflicted deaths, 31 were by hanging.

Of 93 women, we know that 12 were BAME, 5 were white Irish and 76 were white. A breakdown of the 93 deaths by age is below:

AGE	DEATHS
19-29	13
30-39	30
40-49	26
50-59	18
60-69	5
70-79	0
80-89	1

DEATHS AFTER PRISON

The transition from custody to the community can often be very difficult for women who are likely to be facing a series of challenges including housing, health, addictions, poverty, mental ill-health and family relationships.

Between 2010/11 and 2016/17, 116 women died while under probation supervision following release from prison. The apparent cause of death recorded by the Ministry of Justice are as follows:

- 31 self-inflicted
- 40 natural causes
- 4 homicides
- 8 accidents
- 3 other
- 30 unclassified

That such large numbers of women are dying after release is particularly concerning and even more so given that these are underestimates as two Community Rehabilitation Companies did not return their figures.

REVIEWING DEATHS

Very little is known about these 116 women and the circumstances of their deaths. Recent annual reports from the Chief Inspector of Probation have made no mention of such deaths and the Prison and Probation Ombudsman do not routinely investigate or produce reports on deaths of people on probation.

CORONERS' RECOMMENDATIONS AND JURY FINDINGS

Properly conducted inquests which expose the truth, culminate in a finding about what went wrong and make recommendations for change, can help families in their bereavement process. They can play an important preventative role. A robust, wide-ranging inquest at which families are legally represented is an opportunity to ensure proper scrutiny and uncover unsafe systems or practices and action needed to prevent future deaths.

Access to legal aid funding for families was a key recommendation from the Corston Review but was rejected by government. The current system is heavily stacked against families with unequal access to funding and resources. At present there is an anomalous situation where the state has automatic access to public funding for legal representation. This is in contrast to families who have to go through a protracted and intrusive process to access funding. This 'inequality of arms' has been exacerbated by the outsourcing of prison services, such as healthcare. Families frequently find themselves up against well-funded legal teams representing multiple state and non-state agencies at inquests. The agenda of a majority of state lawyers at inquests is to conduct a defensive and damage limitation exercise, and seek to deflect criticism.

There is an accountability gap following the investigation and inquest system. Narrative jury findings that often provide a good overview of systemic failings are not collated anywhere except by INQUEST. Coroners' 'Prevention of Future Death' (PFD) reports are sent to relevant authorities (for example, prisons, private service providers and government ministers), and comment on action that should be taken to 'eliminate or reduce the risk of death'. Whilst these go on the judiciary website, they are not searchable.

Analysing both narrative findings and PFDs is helpful in uncovering emerging trends and patterns of deaths. They can act as a valuable learning tool for state agencies to implement policy and practice to prevent future deaths. However, no one is charged with the follow up and audit of what action has been taken and whether this has impacted on sustained local and national level learning. The cases of Emily Hartley and Petra Blanksby illustrate this and it was INQUEST who drew the coroner's attention to his previous recommendation.

INQUEST collates narrative findings and PFDs as part of our casework and monitoring. Within the time period of March 2007 to March 2018, INQUEST identified 33 reports which included 18 jury narrative conclusions and 15 coroners' 'Prevention of Future Death' reports relating to the deaths of 25 women.

Our analysis, presented in the following table, identify a series of systemic failures around self-harm and suicide management and inadequate healthcare. Other contributory factors include a lack of staff training, poor communication and poor record keeping.

The themes highlighted are similar to those identified in the latest Annual Report from the Chief Coroner, 2016-2017, including failure to pass on information and the need for additional or improved training for staff[32]. Such findings are consistent with those of official investigations, inspections and Independent Monitoring Board reports. The Prison and Probation Ombudsman's[33] *Learning Lessons Bulletin* on self-inflicted deaths of women in prison identifies a number of areas of learning including improving suicide and self-harm prevention procedures, assessment and management of risk, addressing mental health issues, combating bullying and ensuring timely emergency responses.

ISSUES RAISED IN CORONERS' REPORTS TO PREVENT FUTURE DEATHS AND JURY NARRATIVE FINDINGS

ISSUE RAISED	JURY NARRATIVE FINDINGS (total of 18)	'PREVENTION OF FUTURE DEATH' REPORTS (total of 15)
Self-harm and suicide management	11 (61%)	11 (73%)
Communication failures	12 (67%)	8 (53%)
Poor record keeping	10 (56%)	5 (33%)
Insufficient staff training	6 (33%)	4 (27%)
Inadequate health care	6 (33%)	5 (33%)
Poor mental health assessments	10 (56%)	6 (40%)
Drugs including prescribed medication	6 (33%)	4 (27%)
Procedural failures and delays	11 (61%)	9 (60%)

The jury at the inquest of **Lisa Marley**, who died in 2008 at HMP Styal, found "failure to ensure awareness of, accurately report and act on all events which could be significant for a prisoner at high risk of self-harm" and "inadequate implementation and monitoring of observations and interactions regime".

Natasha Evans' death in 2013 at HMP Eastwood Park was classified as 'natural causes' contributed to by neglect. The jury found that "there was a serious failure on the part of the nurse who attended Natasha…. to adequately assess her, to alert a GP or call an ambulance, to stay with and continue to monitor Natasha or to document this attendance in a timely fashion".

The jury at the inquest of **Sarah Reed**, who died in HMP Holloway in January 2016 after being found with a ligature around her neck, said that "the decision to reduce the frequency of observations on Sarah Reed…. was inappropriate given the clear evidence of the deterioration of her mental state". The jury concluded that had a timely fitness to plead assessment taken place, which was the purpose of her remand sentence, "then Sarah Reed would not still have been incarcerated in HMP Holloway at the time of her subsequent mental deterioration but in the hands of her community mental health team".

At the inquest of **Samantha Dainty,** who died in 2009 at HMP Foston Hall, the coroner raised serious concerns about a healthcare assistant, rather than a qualified nurse being sent to the wing. "On arrival there were pieces of equipment in the bag that she had taken from healthcare that she was unqualified and untrained to use. I can find no logic in sending an unqualified person to an incident of which that person has no knowledge of the nature of the incident that they are going to and, furthermore has at their disposal potentially lifesaving equipment which they are unqualified and untrained to use".

The jury concluded at **Margaret Atkinson**'s inquest that there was an inappropriate assessment of risk, which led to a delay in staff at HMP Low Newton entering her cell in 2016. "Two senior prison officers and an experienced nurse saw her in her single cell with an article of clothing around her neck. They talked to the deceased and asked her to remove the item of clothing from around her neck but she declined to do so. None of the three members of staff thought this to be a high-risk situation and none thought it appropriate to enter the cell on an emergency basis. After staff had observed her in this position on at least three occasions over quite an extended period of time, staff decided to enter the cell to remove the article of clothing, but still not believing the situation to be serious".

CONCLUSION AND PROPOSALS

The persistence and repetition of the same key issues over an 11-year period reveals nothing less than a glaring failure of government to act upon recommendations to prevent future deaths of women in prison. By doing so, they are reneging on their obligation under Article 2 of the European Convention on Human Rights to protect the right to life. Immediate action is needed to implement the repeated recommendations from official reports, NGOs and coroners to save lives.

In 2017, three major reports were published by Women in Prison, Agenda and the Centre for Crime and Justice Studies, all containing coherent and evidence-based recommendations, many of which build upon the Corston Review;

- Women in Prison's *The Corston Report 10 Year On*[34], evaluates progress on each of Corston's recommendations and outlines five priority areas for government to bring about change within and outside the prison system.
- Liz Hogarth's *Trapped in the Justice Loop*[35] report for the Centre for Crime and Justice Studies similarly puts forward seven recommendations to prevent the criminalisation of women and develop a sustainable model of women-centred services.
- Agenda's *Mapping the Maze*[36] report highlights the gaps in provision that exist and proposes a model for good practice in services for women facing multiple disadvantage.

The consistent theme across these reports is the overwhelming need to focus on addressing the needs of women in the community and avoiding punitive, criminal justice interventions. This is something INQUEST wholeheartedly supports.

Reforms are urgently needed to improve safety in the existing prison system. However, reform alone will not be enough. Deaths in custody cannot be looked at in isolation from issues of poverty and inequality. It is time to end the inappropriate imprisonment of women. Systemic change is required to improve women's safety, equality and power in society and subsequently their life chances both inside and outside the prison system. By doing so it is possible to imagine a world where women's prisons are unnecessary and obsolete.

IMPRISONMENT OF WOMEN IS A FORM OF STATE-SANCTIONED VIOLENCE

Prison is an ineffective and expensive intervention that does not work, as demonstrated by high reconviction rates. It fails prisoners, victims and communities. For far too many women a prison sentence is a death sentence. Women in the criminal justice system are among the most powerless, marginalised and disadvantaged women in society. In the absence of community-based services and a social infrastructure that supports their needs, women experience a criminal justice system that is ill-equipped to tackle what are often deep-seated social inequalities.

The Declaration of Elimination of Violence Against Women (UN, 1993) defines violence against women (VAW) as *"an act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"*. The declaration locates VAW as occurring within the family, general community or educational institutions and includes violence *"perpetrated or condoned by the State, wherever it occurs"*.

In reconceptualising our work on deaths of women in prison we are looking at violence against women and girls as a human rights issue and as a cause and consequence of gender inequality. This includes violence perpetuated by or condoned by the state which includes the incarceration of women and girls in prisons and immigration centres.

Many women in prison have experienced sexual and physical abuse, violence and trauma and have been failed by multiple agencies. There is no clear demarcating line between women as defendants and women as victims or complainants. Self-harm, violence and death experienced by women in custody forms part of a continuum of violence that usually starts in the community and follows them into, and back out of, prison.

Within this framework, INQUEST perceives imprisonment as a form of state sanctioned violence against women, and part of a cycle of harm that too often leads to trauma, injury and death.

The use of punishment and imprisonment is the result of a lack of political will to take seriously violence against women across society. The imprisonment of women is a matter for everyone - feminists and social justice campaigners alike. Those fighting for gender equality and justice must take seriously the plight of women in prison.

MAKING PRISONS OBSOLETE

INQUEST's work has led us to the conclusion that prison should be abolished as a response to women who break the law, save for a minute and wholly unrepresentative micro-minority of women, who even then need a dramatically new form of intensive disposal and treatment: see Recommendation 3 below. Instead, investment should be made in community-based alternatives to criminalisation and punishment. What is crucial is that such services are distinctly separate from the criminal justice apparatus and all efforts are made to divert women from the criminal justice system all together.

> **'… imagine a constellation of alternative strategies and institutions with the ultimate aim of removing the prison from the social and ideological landscapes of our society. In other words, we would not be looking for prisonlike substitutes for the prison, such as house arrest safeguarded by electronic bracelets. Rather, positing decarceration as overarching strategy, we would try to envision a continuum of alternatives to imprisonment – demilitarization of schools, revitalization of education at all levels, a health system that provides free physical and mental care to all, and a justice system based on reparation and reconciliation rather than retribution and vengeance'**[37]
>
> **Angela Y Davis, Are Prisons Obsolete?**

CONCLUSION AND PROPOSALS

KEY RECOMMENDATIONS

1. **Redirect resources from criminal justice to welfare, health, housing and social care.** Reallocated criminal justice resources should be invested in refuges and rape crisis centres, drug and alcohol support services, gender appropriate community services and small community based therapeutic centres. They should be independent, specialist and dedicated services run by and for women and include culturally specific provision for BAME girls and women.

2. **Divert women away from the criminal justice system**. Diversion from criminal justice towards treatment and support must be the preferred option. Strategies and holistic 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. Part of the former Holloway women's prison site could be developed as a women's building to deliver these gender specific services.

3. **Halt prison building and commit to an immediate reduction in the prison population.** Imprisonment should be abolished as a response to women who have broken the law. For the 100 women or so whose offence is so serious that they may be considered a danger to others, a network of small therapeutic secure units should be created.

4. **Review sentencing decisions and policy.** A meaningful review of sentencing decisions and alternatives available to courts should be part of any investigation following a death or serious injury in prison. Such a focus would help ensure responsibility and accountability for deaths beyond just the prison service.

5. **An urgent review of the deaths of women following release from prison.** Deaths of women following release from prison are largely ignored, hidden from view and do not receive the same level of scrutiny, concern or investigation currently received by deaths in custody. A review should explore current arrangements for monitoring deaths, the circumstances surrounding these deaths and identify measures that relevant agencies can take to protect women upon release.

6. **Ensure access to justice and learning for bereaved families.** To ensure fairness and equality where there is a death, families should be allowed access to justice through non-means tested public funding for representation at inquests as recommended by two Chief Coroners and in two recent reviews by Dame Elish Angiolini and Bishop James Jones. This would ensure proper public scrutiny, equality of legal resources with state funded or corporate lawyers and would help to maximise the preventative potential of coroners' inquests.

7. **Build a national oversight mechanism for implementing official recommendations.** The lack of statutory enforcement and oversight of safety recommendations is putting lives at risk. There is an overwhelming case for the creation of a national oversight mechanism on deaths in custody. This body would be tasked with monitoring, auditing and reporting on the accumulated learning from post death investigations by the Prison and Probation Ombudsman, inquest outcomes and recommendations from HM Inspectorate of Prisons and Independent Monitoring Boards. This would ensure greater transparency in terms of tracking whether action has been taken to rectify dangerous practices and systemic failings. Parliamentary oversight (possibly through a select committee) should annually review and monitor prison inquest findings and Prevention of Future Death reports to track issues and trends. The Ministry of Justice and NHS England should provide a response to the review to ensure a high level of political focus and accountability. There should also be an annual Ministerial statement to parliament.

Labels, HM Prison Send, Portrait, 2017

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Still Dying on the Inside provides unique insight into deaths in women's prisons based on an examination of official data, INQUEST's research, casework and an analysis of coroners' reports and jury findings. The report reveals the enduring harms inflicted on women in the prison system and includes the stories of women who have died. *Still Dying on the Inside* calls for urgent action to save lives and puts forward a series of recommendations to transform services and end the inappropriate imprisonment of women.

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