Written evidence from INQUEST

Background

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. INQUEST provides expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. INQUEST's Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody, is a member of the Independent Advisory Panel on Deaths in Custody and sat on the reference group for the Corston report.[1]

2. INQUEST has reported consistently on the scandal of deaths of women in prison. In May 2018, INQUEST published 'Still Dying on the Inside'[2] which highlighted the lack of action from successive governments to prevent the deaths of women in prison. We published an update to this report a year later.[3] In these, we called on the government to take measures to save lives by redirecting resources from the criminal justice system to community-based women's services. This report built on the significant body of work INQUEST has carried out on deaths of women in prison. In 2014 we published 'Preventing the deaths of women in prison: the need for an alternative approach' followed by the launch of 'Dying on the Inside' in the House of Commons in 2008. This evidence has been strengthened by the facilitation of families' legal representation at inquests, allowing for more probing at inquests. It has shone a light on the reality of prison for women and shows how for so many women, prison has been a death sentence.

3. This submission puts before the Committee some of the issues that have come to light from our casework and monitoring which need to be addressed if the number of preventable deaths of women in prison are to end.

Reducing the number of women in custody

4. INQUEST has repeatedly called for urgent action to save the lives of women in custody. The most effective way to do this is to reduce the number of women in prison. As of 4 June 2021 there are 3,170 women in prison. Over the past ten years women have made up an average of 4.6% of the total prison population. That there has

[1] Corston, J (2007) The Corston Report: A review of women with particular vulnerabilities in the criminal justice system. Available from: https://webarchive.nationalarchives.gov.uk/20130206102659/http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf

[2] INQUEST (2018) Still Dying on the Inside. Available from: https://www.inquest.org.uk/still-dying-on-the-inside-report

[3] INQUEST (2019) Still Dying on the Inside: June 2019 Update. Available from: https://www.inquest.org.uk/2019-update-still-dying

been almost no progress on the systemic and structural change needed to reduce the women's prison population 14 years after the publication of the Corston report speaks to the ongoing absence of political will of successive governments to effect meaningful change.

5. Despite the much-needed reduction in the female prison population being a key strategic priority in the Female Offender Strategy, the government has demonstrated little commitment to its own goal. This is clear from the Ministry of Justice's recent decision to introduce 500 extra women's prison places[4] and the overall unwillingness to divert women away from custody into well-funded, radical alternatives.

6. Alternatives to imprisonment highlighted in the Female Offender Strategy include eliminating the use of short sentences that provide little public protection and establishing community-based women's centres. With properly trained staff, these alternatives would reduce the number of women and the potential trauma women experience in prison. However, both options are under-utilised by the courts**.**

7. Imprisonment as a response to women who have broken the law should be abolished, as should the remanding of women for their own protection and safety. For the small number of women whose offence is so serious that they may be considered a danger to others, a network of small, secure, therapeutic units should be created. The government should indicate its intention to move in this long-overdue direction by halting its current programme of prison building and expansion.

8. INQUEST also calls for a meaningful commitment to an immediate reduction in the women's prison population in the context of COVID-19. The pandemic gave the government an opportunity to reduce the number of women in custody to protect lives, in line with public health and human rights guidance[5], [6]. An indicator of the government's often contradictory policy around women in prison is its underuse of the Compassionate Release on Temporary Licence scheme, introduced in April 2020 'to limit the spread and impact of COVID-19 in the prison estate'[7]. The scheme was

[4]Ministry of Justice (2021) Extra funding for organisations that steer women away from crime. Available from: https://www.gov.uk/government/news/extra-funding-for-organisations-that-steer-women-away-from-crime#:~:text=Up%20to%20500%20new%20places,education%20while%20completing%20their%20sentence

[5] Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2020) Advice of the Subcommittee on Prevention of Torture to States Parties and National Preventive Mechanisms relating to the Coronavirus Pandemic. Available from: https://www.ohchr.org/Documents/HRBodies/OPCAT/AdviceStatePartiesCoronavirusPandemic2020.pdf

[6] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2020) Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (Covid-19) pandemic. Available from: https://rm.coe.int/16809cfa4b

[7] Ministry of Justice and HM Prison & Probation Service (2020) Covid-19: Use of Compassionate ROTL.

woefully underused and just 25 women, eight of whom were pregnant, were released[8] before the scheme was paused in August 2020.[9]

9. Alongside this scheme was the End of Custody Temporary Release scheme. In collaboration with Women in Prison, INQUEST campaigned for the government to use this scheme to immediately reduce the number of people in prison and other detention settings. Over 450 organisations and individuals signed a letter[10] to the Prime Minister calling on him to take urgent life-saving steps. However, according to official statistics[11] just 204 prisoners were released on this scheme, up to and including 27 July 2020. While this data is not disaggregated by sex, the low numbers suggest that again, very few women were released as a result.

Deaths and Self-Harm in Women's Prisons

10. In the three years since the publication of the Female Offender Strategy (27 June 2018) there have been 28 deaths in women's prisons, including eight self-inflicted deaths. Of particular concern are the two recent stillbirth deaths of babies in prison in 2019 and 2020 in HMP Bronzefield and HMP Styal respectively. These deaths are indicative of the poor conditions experienced by women in prison, and also speak to the lack of governmental and institutional commitment to the rehabilitative custodial environment outlined in its own Strategy.

11. It is our belief that the majority of deaths in prison are preventable. Inquests and post-death investigations are essential for proper scrutiny of the poor conditions in custody and should be used as an opportunity for learning. However, INQUEST's analysis of inquest jury findings and coroners' reports shows a failure to act on recommendations to keep prisoners safe and well.[12],[13]. Time and again inquests reveal that imprisonment

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Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881060/covid19-use-compassionate-rotl.pdf

[8] Ministry of Justice (2020) Freedom of Information Act Request – 200803026, FOI releases for August 2020. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/954392/FOI_200803026_pregnant_prisoners_with_Covid_and_released_early_under_compassionate_grounds.odt

[9] See INQUEST's submission to the Justice Committee's inquiry on mental health in prisons (2021) for further detail on the government's early release scheme.

[10] INQUEST and Women in Prison (2020) Powerful coalition call on government to immediately reduce number of people in detention settings. Available from: https://www.inquest.org.uk/covid-19-letter

[11] Ministry of Justice (2021) FOI releases for August 2020: Prisoners released under COVID early release scheme by offence (table) (FOI no. 200728017). Available from: https://www.gov.uk/government/publications/foi-releases-for-august-2020

[12] INQUEST (2020) Deaths in prison: A national scandal. Available from: https://www.inquest.org.uk/deaths-in-

was an inappropriate response to women who already face a range of social, health and economic inequalities. In INQUEST'S view, this highlights the state's failure to abide by its own rules in relation to providing a duty of care for prisoners. As noted by INQUEST's Executive Director in 2013: '*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.'*[14]

12. Our casework on deaths in women's prisons continues to identify the following issues that contribute to deaths:
    - **Poor physical and mental health care provision**. Standards of healthcare in prisons are inadequate and often not in line with the service provided in the community.
    - **Failures in communication between healthcare, mental health staff and prison staff.** This includes inadequate recording and sharing of important medical and mental health related information.
    - **Substandard responses to medical emergencies.** Delays in calling for emergency services, and poor training of staff in first aid skills to identify medical emergencies, feature in a number of post-death investigation documents.
    - **Poor drug management processes.** Management of both prescription and illicit drugs is inadequate in prisons. Failures to review prescriptions and an inability to recognise or respond to the risks and warning signs of illicit substance misuse are regularly recorded at inquests.
    - **Inappropriateness of the prison environment.** The harsh environment of prison compounds the trauma and suffering of vulnerable women rather than working to rehabilitate them.

    The fact that these issues remain a constant feature of our work over decades is clear evidence that efforts to improve conditions for women in prison have been inadequate and ineffective.

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prison-a-national-scandal

[13] INQUEST (2008) Dying on the inside: Examining women's deaths in prison. Available from: https://www.inquest.org.uk/dying-on-the-inside

[14] Coles, D. (2013) 'Deaths of women in prison: Human rights issues', in Malloch, M. and McIvor, G. (eds.) Women, Punishment and Social Justice. Routledge

13. As we now know from the accounts of people in prison, inspection reports and other sources, women in prison have experienced extraordinary and unprecedented restrictions in prison as a result of the pandemic, including the suspension of in-person family visits and extreme and indefinite periods spent in solitary confinement. While not underestimating the challenges of the pandemic, this extremely restrictive approach to managing potential virus outbreaks in prison must not be written off as inevitable – as we indicate above, there was a more humane alternative that involved releasing women back into the community.[15] The severe regimes imposed in women's prisons separated families and resulted in worsening physical and mental health for women in prison.[16]

14. Official statistics show that the number of self-harm incidents in the women's estate has increased by 178% (5,642) over the past ten years, with a rise of 13% in the rate of incidents in the 12 months to December 2020[17]. INQUEST welcomes government statistics that indicate a 19% decrease in the number of self-harm incidents among women in the latest quarter. However, these figures should be approached with caution. INQUEST's casework consistently points to women's mental ill health and distress, the inappropriateness of the prison environment and the failure of systems to manage and support women at risk as the causes of self-harm.

15. In our view it is inevitable that with this backdrop, the even harsher restrictions of the past year will have contributed significantly to these figures. It is highly concerning that HMI Prisons continue to identify a failure to "understand" the reasons for high levels of self-harm in women's prisons. It is especially troubling that the reported levelling-off of self-harm during the early stages of the COVID crisis was not properly analysed[18].

16. In order to reduce the level of self-harm in women's prisons, there needs to be a concerted effort from the Ministry of Justice to address the needs of women in prison. There is an urgent need to address the following issues:
    - Low staffing levels in prison, particularly on weekends.

[15] See INQUEST's submission to the Justice Committee's inquiry on mental health in prisons (2021) for further detail on the impact of COVID-19 restrictions on the mental health of prisoners.
[16] HMIP (2021) What happens to prisoners in a pandemic? Available from: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/what-happens-to-prisoners-in-a-pandemic/
[17] Ministry of Justice (2021) Safety in custody quarterly: update to December 2020. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/982115/safety-in-custody-self-harm-dec-20.xlsx
[18] (2020) HM Chief Inspector of Prisons for England and Wales, Annual Report 2019-20. Available from: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf

- The unmet mental health, drug and alcohol treatment needs of women in prison including the lack of understanding of procedures for monitoring Assessment, Care in Custody and Teamwork (ACCT) processes.
- The presence of intimidation and bullying by both prisoners and staff.

Case studies

The following case studies highlight the issues of bullying and intimidation, inadequate ACCT processes and the impact of unmet mental health needs of, and on, women in prison.

Charlotte Nokes died from 'natural causes' in HMP Peterborough in 2016. Charlotte was serving an indefinite Imprisonment for Public Protection (IPP) sentence and was more than seven years over the minimum tariff when she died. Charlotte had been diagnosed with a Personality Disorder and was prescribed a number of antipsychotic drugs as a result. The inquest into her death heard that Charlotte often appeared over-sedated, drowsy, was slurring her speech and that some of her medication was administered for unusually long periods. At the time of her death, Charlotte was placed on an ACCT after attempting to take her own life. Charlotte was on twice hourly observations as part of this process. Despite this and the documented welfare checks throughout the night, the inquest jury heard that she died a number of hours before she was found in the morning of 23 July.

Jessica Whitchurch was 31 years old when she died two days after she ligatured in HMP Eastwood Park in 2016, the year that saw the highest annual number of deaths in women's prisons on record. Jessica was openly bullied by other prisoners – described by a prison mental health worker as a 'campaign' against her. After being found in a state of distress with ligatures around her neck in her cell, staff decided to re-open ACCT procedures and put Jessica on twice hourly observations. The jury at Jessica's inquest heard deeply troubling evidence about bullying directed at Jess during this period, including goading by other prisoners to ligature herself again which went unchallenged by staff. Less than two hours after the first ligature, Jessica was found unconscious. An expert witness told the jury that the last check on Jessica when she was alive had been 'inadequate'. A second expert witness told the court that the lack of mandatory healthcare involvement in Jessica's ACCT 'significantly compromised' the management of her risk to herself. Jessica's death was one of 12 self-inflicted deaths in women's prisons in 2016, one of which took place in the same unit and also featured bullying as a concern.

Emily Hartley was 21 years old when she died a self-inflicted death at HMP New Hall in 2016. 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. On 1 February 2018, an inquest jury 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 the strikingly similar death of Petra Blanksby. 19-year-old Petra was imprisoned for an arson offence, having set fire to her bedroom in an attempt to take her own life. Both women were criminalised for being mentally unwell. At the end of Petra's 2008 inquest, the coroner recommended to the Prison Service and Department of Health they

should deal with the lack of secure therapeutic facilities outside of prison. At the conclusion of Emily's inquest, the same coroner 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.*'

17. INQUEST's casework and monitoring also regularly evidences how prison often re-traumatises women, many of whom have suffered the effects of domestic violence pre-prison. Recent evidence also highlights the high proportion of women in prison with brain damage, with sustained domestic abuse as a likely cause.[19] The very fact that women with such painful histories are placed in prison highlights the absence of a trauma-informed approach.

18. Imprisoned women are amongst the most powerless and disadvantaged in society. The effects of pre-custody life experiences**,** as noted above, follow women into prison, where they are exacerbated by their surroundings and circumstances. These experiences are often characterised by:
    - Sexual and physical abuse
    - Domestic violence and exploitation
    - High rates of trauma related to institutional care
    - High rates of self-harm
    - Educational disadvantage
    - Racism and discrimination
    - Drug and alcohol misuse, and;
    - Physical and mental illness.

19. Women's experiences of such trauma impacts on their response to imprisonment. Rather than examining and addressing the complex needs of women in prison, their inevitable distress is often perceived by both prison and healthcare staff as **r**elating to a lack of discipline, self-control and respect for authority, as well as a pathological desire to harm or kill themselves. Such attitudes draw attention away from the harm-inducing nature of the prison environment. This is particularly pronounced in the cases of Black women.

Case studies

[19] The Guardian (2021) Four in five female prisoners in Scotland found to have history of head injury. Available from: **https://www.theguardian.com/society/2021/may/13/four-in-five-female-prisoners-in-scotland-found-to-have-history-of-head-injury**

The following case studies highlight the issue of Black women's complex needs being met with discipline and control methods.

Sarah Reed died in HMP Holloway in 2016. Sarah was a 32-year-old black woman who was remanded to prison in order for the courts to obtain a fitness to plead assessment in relation to an alleged offence which took place while she was sectioned at a mental health unit. Sarah's 2017 inquest heard that her psychotic illness remained untreated whilst she was in prison due to a failure of prison psychiatrists to manage her medication, and that her behaviour was instead treated as a discipline issue. The inquest jury concluded that Sarah did not receive adequate treatment for her high levels of distress, and the failure of prison psychiatrists to manage her medication contributed to her death as did the failure to complete the fitness to plead assessment in a timely manner.

Annabella Landsberg died in 2017. Her death also highlighted issues with poor provision of physical health care in prison as a result of negative and mistaken staff perceptions. Annabella, who had Type 2 diabetes, was restrained by prison officers in HMP Peterborough on 2 September 2017. From this point on, she was observed lying on the bare floor, not engaging or responding. While she was observed by both prison and healthcare staff throughout a 21-hour period, there was a failure to recognise she was critically ill. Instead, it was considered that she was faking illness. Four days following the episode of restraint, Annabella died in hospital. Annabella's inquest heard evidence that a nurse was called to assess Annabella, but instead of conducting physical observations, threw a cup of water over her as she believed her to be pretending. The inquest found that HMP Peterborough failed to provide healthcare for chronic illnesses equivalent to that in the community and had inadequately trained medical staff.

Conclusion and recommendations

20. INQUEST casework monitoring over four decades shows that many of these deaths raise profound questions about human rights violations – not only in the failure to provide a safe and dignified environment but also in the failures to act on evidence and recommendations from investigations to prevent deaths. Improvements in women's journeys through the criminal justice system are possible only if there is a dramatic reduction in the prison population and a real commitment to long-term action that builds on the learning from past investigations into deaths in women's prisons. As is stands, prison does not work. Reconviction rates show that prisons fail prisoners, victims and communities. For far too many women, prison is not just harmful but deadly.

21. INQUEST urges the Committee to raise the following action points with HMPPS and the government with the goal of improving conditions in prison and dramatically reducing the imprisoned female population.

- **Develop and fund radical alternatives to custody which respond to the specific mental health and other needs of women.** For instance, establish more refuges, rape crisis centres, drug and alcohol services, gender appropriate community-based

schemes and small therapeutic centres to appropriately address women's needs. Revisit and implement recommendations in Corston's seminal review of women's imprisonment – namely the dismantling of the prison system and an expansion of gender-specific support in the community.

- **Instigate a proactive programme of mental health screening** that will direct policy and resources to address the lasting impact of pandemic restrictions on prisoners.
- **A commitment to providing in-depth staff training to respond to the physical and mental health needs of specific groups of women prisoners** including Black, Asian and minoritised women, LGBTQ+ and young women.
- **Family involvement in the ACCT process for vulnerable women in prison.** Families of imprisoned women are often best-placed to speak on the mental health needs and history of their loved one in prison. Involving them in the process would provide valuable insight into the care and support of the women subject to ACCTs.
- **Provide automatic non-means tested funding for families.** This would ensure proper public scrutiny and equality of legal representation with state funded lawyers. We welcome the recommendations made by the Committee in the May 2021 report on the Coroner Service[20]. This would work towards drastically reducing the harmful and traumatising impact of prison on these groups.
- **A new national oversight mechanism for implementing official recommendations.** As recommended by this Committee in the report on the Coroner Service, a new oversight body should be established to 'oversee risks to public safety discovered by coroners and inquest juries and monitor and enforce action to reduce these risks.'[21]
- **A review of sentencing decisions and possible alternatives available to courts should be part of any investigation following a death or serious injury in prison.** This approach would help ensure responsibility and accountability for deaths beyond the prison service.

ENDS

June 2021

[20] Justice Committee (2021) The Coroner Service: First Report of Session 2021-22 Available from: https://committees.parliament.uk/publications/6079/documents/68260/default/

[21] Justice Committee (2021) The Coroner Service: First Report of Session 2021-22. Available from: https://committees.parliament.uk/publications/6079/documents/68260/default/