INQUEST
Working for truth, justice and accountability

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FUNERAL OF YOUNG BLACK WOMAN FOUND DEAD IN HOLLOWAY PRISON

Cortege leaves at 12.30 (approx), Thursday 29th June
The Wellesly Community Centre
North Acton Road (opposite Wellesly Road)
Park Royal NW10

On Thursday 29 June the funeral takes place into the death of Cheryl Simone Hartman, a young black woman who was found hanging in her cell at Holloway prison on Sunday 18 June. She was 20 years old. She had a history of mental health problems and had asked to go to prison to get some medical help. She was initially remanded to Holloway for psychiatric reports before being given a nine-month sentence for affray.

The family's grief at her death has been exacerbated by the way in which they found out about her death. Cheryl's mother a diabetic was alone in the house when she was informed by telephone by the prison that her daughter was dead. Other members of the family heard of her death over the radio. Prison staff have given the family conflicting information as to how she died. The family has still not received a personal home visit or a letter of condolence from the prison.

Her death once again raises serious concerns about the use of prison for those with mental health problems. Holloway prison has a disturbing history of women taking their own lives the majority of whom had mental health problems
Since 1993 there have been nine self-inflicted deaths in Holloway, two deaths taking place in 1999.

Holloway has long been at the centre of strong criticism from MPs, campaigners and the government's own watchdog the Chief Inspector of Prisons over the treatment of its women prisoners. For over ten years INQUEST and Women in Prison have called for the windows to be altered in Holloway to make it impossible to attach a ligature. Particularly strong concerns were raised about the care of suicidal or at risk prisoners following the verdict of suicide contributed to by neglect at the inquest into the death of Claire Boseley (`Holloway staff criticised over woman prisoner's suicide' Guardian 19.4.96). In December 1995 the Prison Inspectorate team was pulled out of Holloway as the Chief Inspector concluded that it had sunk into a `stultifying mess'. By the next inspection in December 1997 he still found many inadequacies. Of particular concern was the implementation of the suicide awareness strategy. The team found that self-harm documents were `inconsistently completed throughout' and that the care of prisoners with mental health problems was not always carried out under the direction of a doctor with appropriate psychiatric training. A week before Ms Hartman's tragic death the Chief Inspector of Prison said that ministerial inaction on suicide prevention was costing lives in British prisons.

Deborah Coles Co-Director of INQUEST the advice and campaign group that is assisting Ms Hartman's family said:

"Already this year five woman have taken their lives in prison – equal to the total last year. This is an indictment of the treatment of women in prison – many of whom had mental health problems and should not have been there in the first place. INQUEST's monitoring of previous deaths in Holloway has highlighted a clear link between prison deaths and lack of appropriate medical

treatment and care. I am writing to the Prisons Minister and Director of the Prison Service about my concerns over this death and the insensitive way in which the family have been treated."

Yvonne Hartman, Cheryl's mother said:

"I am devastated by Cheryl's death. She begged for medical help. I trusted the Prison to look after her. I can't understand how she was able to die like this."