

**PRESS RELEASE 26 APRIL 2005 - For immediate release**

**VERDICT RETURNED AT INQUEST INTO THE DEATH OF JULIE WALSH IN HMP STYAL – BUT KEY QUESTION REMAINS UNANSWERED**

Today the jury at the inquest into the death of 39-year-old Julie Walsh in HMP Styal returned their verdict. Following two weeks of evidence they decided that: *“Julie died of dothiepin poisoning exacerbated by di-hydrocodeine and her death was an unintentional consequence of her actions. The contributing factor to her death was the failure of the nurse to secure the medication on the trolley. This provided an opportunity for the bottle of dothiepin to be taken.”*

Evidence was heard at the inquest of poor security of medication during its administration to vulnerable prisoners, including the location and accessibility of the medication trolley and low staffing levels of nurses and prison officers.

This was the last inquest to be heard into the deaths of six women at HMP Styal between August 2002 and August 2003, all of whom had histories of mental health and/or drug problems. Having conducted the inquests into these deaths, the coroner said that some of the matters brought to his attention were outside the scope of his powers under Rule 43 of the Coroner’s Rules. However he said most of the recommendations made following the Prison and Probation Ombudsman’s investigation had been implemented, but it was a tragedy that it took six deaths to achieve that. The coroner noted that in 2001 he conducted an inquest into a death at Styal and wrote a Rule 43 letter firmly backing the then governor’s requests for detoxification facilities. He also stated he was particularly concerned about the way Julie Walsh’s family had been treated following her death and would be writing to the Prisons Minister to raise these matters with him.

Following the inquest the family said:

“Julie Walsh was a much loved mother, sister and partner and is very much missed. While this inquest has answered some of the family's questions it cannot relieve our feelings of grief or anger at what happened. With the exception of Nurse Layton, we feel that the system and every individual involved in that system let Julie down in some way. Our only hope is that lessons have been learnt so that nothing like this ever happens again.”

Deborah Coles, co-director of INQUEST, said:

“Julie was one of six women to die in Styal prison and despite the inquests there remains one key unanswered question - why did the Prison Service fail to implement the recommendation in February 2002 of its own watchdog the Prison Inspectorate *“that, as a matter of urgency, a proper detoxification regime should be put in place”*. Inquests into deaths in prison are subject to delay, can only examine individual deaths in isolation and have a limited remit – all of which frustrate the opportunity to learn the lessons. Since Julie's death another 25 women have died in prisons around the country. There needs to be a wide-ranging independent public inquiry that examines the wider issues outside the scope of inquests: sentencing, allocation and whether prison can ever be an appropriate place for vulnerable women. Such an inquiry could make a significant contribution to preventing any further loss of life.”

**Note to editors:**

Juries at previous Styal inquests into the deaths of Anna Baker, Sarah Campbell and Jolene Willis have returned highly critical verdicts and have highlighted serious issues of concern regarding the treatment and care of women withdrawing from drugs, the regime and the conditions in which they were held.

Since Julie's death, 25 women have died in prisons in England and Wales, 17 of which have been self-inflicted deaths, 7 non-self inflicted and 1 remains unclassified.

See [www.inquest.org.uk](http://www.inquest.org.uk) for further details, statistical information and press releases relating to the previous deaths at HMP Styal.

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts.

Deaths of Women in HMP Styal, August 2002 - August 2003						
Name	Classification	Ethnicity	Age	Status	Cause	Date Of Death
Julie Walsh	Self-Inflicted	UK White	39	Remanded	Overdose	12/08/2003
Hayley Williams	Self-Inflicted	UK White	41	Convicted	Hanging	04/06/2003
Jolene Willis	Self-Inflicted	UK White	25	Convicted	Hanging	20/04/2003
Sarah Campbell	Self-Inflicted	UK White	18	Convicted	Overdose	18/01/2003
Anna Baker	Self-Inflicted	UK Black	29	Remanded	Hanging	26/11/2002
Nissa Smith	Self-Inflicted	UK White	20	Remanded	Hanging	10/08/2002

Source: INQUEST Casework and monitoring

Deaths of Women in Prison (England & Wales) 2000-2005							
Classification	2000	2001	2002	2003	2004	2005	Total
Self-Inflicted	8	6	9	14	13	1	51
Non-Self-Inflicted	1	1	2	1	7	0	12
Awaiting Classification	0	0	0	0	0	1	1

Source: INQUEST Casework and monitoring

<b>Further Information</b>	<a href="http://www.inquest.org.uk">www.inquest.org.uk</a>
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