

For immediate release 6 December 2007

**JURY CONDEMNS PRISON SERVICE MANAGEMENT FOLLOWING
DEATH OF MENTALLY ILL WOMAN IN HMP DURHAM -
GOVERNMENT RESPONSE TO CORSTON REVIEW INADEQUATE TO
PREVENT FURTHER DEATHS**

Before HM Coroner for County Durham Andrew Tweddle
Sitting at Chester-le-street Magistrates Court, Newcastle Road, Chester-le-street,
Co. Durham DH3 3UA

The inquest into the death of 20 year old Louise Giles concluded today with the jury returning a highly critical narrative verdict saying she died an accidental death and that the cause of death was strangulation by ligature. They then said:

She died at 0010 hours on 21st August 2005 at I Wing at HMP Durham. Having deliberated over the evidence presented in court we the jury have unanimously agreed to the following concerns:

- *Prison conditions on I Wing were unsuitable for Louise Giles this includes inadequate mental health care provision.*
- *There was insufficient guidance and organisational input throughout the management system.*
- *There was insufficient representation from I Wing and healthcare professionals at health and risk management meetings.*
- *The judgement of wing staff who were inadequately trained in mental health issues was heavily relied upon, resulting in inappropriate care for Louise.*
- *The management and implementation of the 2052SH cases reviews was inadequate and support plans unclear for staff to follow.*
- *There was a delayed reaction to the urgent recommendations from various bodies to close I Wing.*
- *We believe that on the nights leading up to and including the night of Louise's death she was not appropriately cared for. Signs of emotional distress were overlooked.*

The coroner said that he would be considering whether he would make any rule 43 report. He also agreed at the request of the family's barrister to consider writing to the Director General of the Prison Service about the suppression of documents which became apparent during the inquest.

continues...

The family of Louise Giles stated in response to the jury verdict:

Having heard the evidence, we are appalled that Louise was ever sent to 'I' Wing when the Women's Team at Prison Service Headquarters had produced a damning report into the conditions on the wing in March 2005. We are angry that the inquest did not consider policy issues concerning the placement of young mentally ill female offenders. We hope the evidence that has been heard regarding the conditions women were kept in at HMP Durham, which we have given evidence about to the Corston review, will influence the government in its response to the recommendations of the Corston Review and that mentally ill women are diverted from custody. We thank the jury for their careful consideration of the evidence and their obvious concern about the plight of women like Louise in the criminal justice system.

Deborah Coles, co-director of INQUEST said:

Louise Giles died as a direct result of the failure of Prison Service officials and Ministers to act on the clear warnings that there was a real risk of suicide unless action was taken. Their complacency and inaction is a clear case of corporate manslaughter for which the Prison Service should be brought to account. Punishing women with severe mental problems by incarcerating them in such alienating conditions was cruel, inhuman and degrading treatment. Already this year seven women have taken their own lives in prison. The government's response to the Corston review is characterised by delaying tactics: more reviews and no resources when the evidence is abundantly clear that without urgent action more women will die.

Background to the case

Louise Giles was one of only six women held in high security conditions pending the wing's closure in September 2005.

Evidence was heard at the inquest that the consultant psychiatrist treating Louise firmly believed that her mental illness (paranoid schizophrenia) was such that she should have been admitted to a secure psychiatric unit. She was a prolific self harmer and during her time at Durham there were 23 reported incidents of self harm. In the last week of Louise's life she had been downgraded to 'basic' regime, staff having removed her television and radio despite knowing that these had been a major distraction from the voices telling her to harm herself.

Evidence from the psychiatrist, RMN and health care was that her mental illness meant that she was not in control of her own behaviour and therefore incapable of complying with instructions. Prison staff appeared ignorant of her condition and interpreted her as being "lazy, dirty and idle". To downgrade her to basic regime was in effect to punish her for behaviour she couldn't help.

continues...

Reports warn of risk of suicide

In 2004, following a highly critical report by Her Majesty's Chief Inspector of Prisons (HMCIP) the Prison Service announced it would close HMP Durham women's prison and the majority of the 120 women previously located at Durham were moved to other women's prisons.

A report from the Women's Policy Team of the Prison Service in March 2005 following its visit to Durham concluded that: *"...women's distress level was very high and that it has the potential to increase so significantly in the short term future that suicide will be a real risk unless some significant changes are made very quickly"*.

However, in June 2005 HMCIP carried out a further inspection of I Wing and their report gave a stark warning about the increased risk of suicide and noted: *"The Prison Service itself was well aware that the situation was having a seriously damaging effect on the few remaining prisoners."* The report criticised many aspects of the regime: staff often waking prisoners with hourly night-time checks; unnecessary strip searches; bullying by staff; a lack of policies on drugs, race or suicide prevention; and a mainly male staff contingent. The report also stated that incidents of self-harm involving women were not properly discussed at the suicide prevention meeting of the whole prison.

The wing was described by both prisoners and staff as a tense, claustrophobic and oppressive environment in which both groups felt they had been abandoned *"out of the line of sight of the overall management of the prison"*.

The inquest jury heard that not a single significant change was made in response to either reports and that I Wing remained open although expected to be closed in September. All prison staff conceded that I Wing for much of its existence suffered from a lack of management at both a local and national level and was an inappropriate environment for mentally vulnerable young women like Louise.

The family were represented by barrister Nick Stanage from Garden Court North Chambers instructed by Fiona Borrill of Lester Morrill Solicitors, both members of the INQUEST Lawyers Group.

Further Information	
INQUEST website	www.inquest.org.uk
Deborah Coles, Co-Director, INQUEST	office 020 7263 1111
Fiona Borrill, Lester Morrill Solicitors	office 0113 391 6015

Notes to Editors

Deborah Coles was an independent member of the Corston Review Group.

continues...

The government did not accept Baroness Corston's Recommendation 6 that:

"Public funding must be provided for bereaved families for proper legal representation at inquests relating to deaths in state custody that engage the state's obligations under article 2 of the European Convention on Human Rights. Funding should not be means tested and any financial eligibility test should be removed whenever article 2 is engaged. Funding should also cover reasonable travel, accommodation and subsistence costs of families' attendance at inquests."

The state has unlimited access to public funding and is represented at every death in prison custody inquest. Given the fact that it was family legal representation at the inquests into the six deaths at HMP Styal that prompted this review it is disgraceful the government has not accepted this recommendation. Bereaved families do not willingly find themselves in this position and should be treated with equality at inquests and provided with non means tested public funding for their legal representation in the same way as the Prison Service. We will be raising this with relevant ministers as a matter of urgency.

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody to provide an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts. It is consulted widely, by government ministers and departments, MPs, lawyers, academics, policy makers, the media and the wider public.

Louise was the seventh woman to take her own life at the Women's Unit in Durham between August 2002 and 2005. In September 2005, following Louise's death and a call from HM Chief Inspector of Prisons Anne Owers for all the remaining women to be moved as a matter of urgency, the unit was closed and all remaining prisoners in the unit were transferred to HMP Bronzefield.

Deaths of women in HMP Durham 1990-2005

Name	Date of Death	Ethnicity	Age	Cause of death
Louise Giles	21/08/2005	UK White	20	Strangulation by ligature
Sharon Miller	08/05/2004	UK White	45	Hanging
Wendy Booth	12/11/2003	UK White	35	Hanging
Jayne Buck	01/05/2003	UK White	28	Hanging
Sue Stevens	21/02/2003	White	48	Hanging
Beverly Fowler	02/10/2002	Black Caribbean	32	Hanging
Diana Schooling	19/08/2002	UK White	52	Hanging
Linda Tandy	04/06/1990	UK White	35	Hanging

Source: INQUEST Casework and monitoring