

PRESS RELEASE

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JURY DELIVER CRITICAL VERDICT AT INQUEST INTO DEATH OF YOUNG WOMAN IN PRISON

Yet another jury at an inquest into a death of a woman in prison has highlighted the inappropriate use of prison for vulnerable women. The jury at the inquest into the death of 19 year old Petra Blanksby delivered a critical verdict declaring “**prison was not an appropriate place**” for Petra.

Petra Blanksby died on 24 November 2003, following an incident at New Hall prison on 19 November when she was found in her cell having tied a ligature around her neck. The jury found that the following had contributed to her death:

- Traumatic life experiences including mental and physical abuse in early childhood, coupled with an unstable upbringing and a complete lack of emotional support.
- Prison was not an appropriate place in view of Petra’s diagnosis.
- There appears to be no infrastructure in the forensic mental health service for people with her problems.

At the conclusion of the three week inquest HM Coroner David Hinchliff said that he was struck by the comments of the consultant psychiatrist Dr Keith Rix. Dr Rix gave evidence to the inquest that in a civilised society someone as severely mentally disordered as Petra should not be in prison. The coroner announced he would use his power under rule 43 of the Coroners Rules to write to the Prison Service and the Department of Health in the hope of them providing appropriate facilities for women with similar problems. In a statement made after the inquest the family urged the government to implement the recommendations of the Corston Report¹.

Kirsty Blanksby, Petra’s sister said:

“Petra was a wonderful mother and daughter, as well as a brilliant sister who always managed to warm the hearts of everyone around her. It is simply wrong that she was in prison instead of receiving the necessary and proper help for her deep-seated problems. We only hope that lessons will be learnt to prevent a similar tragedy happening again and for the government to realise that it cannot use prison as an NHS dumping ground for vulnerable women with mental health problems.”

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¹ Corston, J. (2007) *The Corston Report: A review of women with particular vulnerabilities in the criminal justice system*, The Home Office.

Deborah Coles, Co-Director of INQUEST said:

“Petra was a vulnerable young woman who was criminalised for her mental health problems. Her death was entirely predictable and therefore preventable, for which someone should be held to account. We await the response of government ministers to the evidence heard at this inquest, and its verdict. They are responsible for criminal justice policies that fail to divert the mentally ill and vulnerable from custody. The failure to implement the recommendations of the Corston Report and invest resources in alternatives to custody for vulnerable women is putting more lives at risk. The sad reality is that despite this death taking place over four years ago the lessons have not been learned and women like Petra are still being sent to prison where they continue to die.”

Notes to editors:

1) Petra died on 24 November 2003 following an incident at HMP New Hall on 19 November when she was found in her cell having tied a ligature around her neck. At the time of her death Petra was on remand having been charged with the offence of arson with intent to endanger life. The evidence revealed that the offence with which Petra was charged was an act of self-harm and the only life endangered was her own.

Petra had an alarmingly long history of serious attempts at self-harm and had been under the care of the mental health services for many years. She had previously been diagnosed with a personality disorder. Throughout her time in New Hall, Petra was subject to an open F2052SH, the form used to record details of those identified as being at risk of suicide and self-harm. During the 130 days Petra spent in New Hall she was involved in at least 90 incidents of serious self harm, some resulting in hospital admission. While Petra was in the prison, her son was placed for adoption. Witnesses gave evidence that there was a “blatantly obvious” increase in Petra’s pattern of self-harm linked to her son’s adoption.

A range of concerns have emerged in the evidence heard at the inquest including:

- The acknowledged unsuitability of prison for someone with Petra’s mental health problems.
- The lack of provision in the community for women who self-harm.
- Concerns about the role of Derbyshire Social Services in relation both to Petra’s own care and the arrangements for the adoption of her son.
- The collective failure of various authorities to understand the impact of adoption proceedings on Petra’s mental health and self-harming.
- Concerns about the care provided by the Pennine Health Care Trust in not admitting Petra to hospital on the day she committed the offence which led to her remand in custody, despite her specific attempts to seek help.
- Procedures, staff training and access to resources at HMP New Hall on 19 November 2003.

2) 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 and conducts policy work on the issues arising.

3) Petra Blanksby’s family were represented at the inquest by barrister Leslie Thomas of Garden Court Chambers, instructed by Jo Kearsley of Farleys Solicitors in Burnley. Both are members of the INQUEST Lawyers Group.

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