

Dying on the Inside

Examining Women's Deaths in Prison

Executive summary



Dying on the Inside provides the first analysis of all self-inflicted deaths of women in prison in England and Wales between 1990 and 2007. It brings into the discussion around these deaths the largely unheard voices of bereaved families.

Between 1990 and 2007, 115 women died in prison of which 88 were self-inflicted deaths. One woman has already taken her own life in 2008. The high level of distress and vulnerability among women prisoners is well documented, and yet the persistent theme running through these deaths is the lamentable failure of the criminal justice system to enforce its own duty of care.

Dying on the Inside identifies trends and patterns, and in doing so paints a picture of preventable tragedy. The report examines both the events that led to the women's imprisonment and the treatment and care of the women once in prison. In considering the failure to implement change, the report draws on expert opinion and makes first-hand observations of the post-death investigation process.

The report's key recommendation is that if women's deaths in prison are to be prevented, prison must be abolished as the central response to women's offending and investment in radical community-based alternatives should be prioritised. Addressing the complex reasons why women enter the criminal justice system - poverty and inequality - should also be a priority.

Chapter 1: Trends, facts and figures

This chapter identifies the trends in women's deaths in prison between 1990 and 2007. There has been an increase in the number of women's deaths in prison during this period and this chapter considers this increase in the context of the overall number of women in prison. The women are not a homogenous group; however, they share a number of common characteristics which are identified and set out in this part of the report.

Women dying in prison are likely to be:

- Young.
- White.
- UK nationals.

- Housed in local prisons.
- Charged with a diverse range of offences, including one third who are charged with non-violent offences.
- Dying in the early stages of their imprisonment.
- On remand or unsentenced.
- If sentenced at the time of death, serving long or life sentences.
- Housed in single cells.
- Hanging themselves.
- Mothers.
- Already at risk of suicide – previous suicide attempts and mental health problems.
- Drug users.

Chapter 2: The decision to imprison

This chapter analyses the decisions that led to the women's imprisonment. In a number of cases prison was used inappropriately as a response to self-harm, suicide attempts and mental illness. This chapter considers the impact of prison on women in these circumstances.

Following one period of imprisonment, women frequently found themselves in cycles of offending and imprisonment that were difficult to break. This chapter considers this cycle, and concludes that despite the ineffectiveness of prison in preventing women's offending, it continues to be the chosen criminal justice response to them and their problems. In this context, the role of the courts, media and other agencies are considered. Recommendations in this chapter focus on preventing women being sentenced to prison in the first place - thus preventing the cycle of imprisonment and offending - as follows:

- Better assessment of the suitability of prison for women appearing before the courts.
- Prioritised resettlement assistance for women following a period in prison.
- Sentencers should be required to make regular visits to women's prisons and to facilities providing alternatives to prison.

Chapter 3: Dying inside

This chapter identifies gross failings in the care provided in prison and how these failings contributed to the women's deaths. Identical failings occurred across a number of the deaths suggesting the presence of systemic problems, including poor management of the women's prison estate; inappropriate policies and practices in place to deal with women identified as at risk of suicide and self-harm; inadequate drug withdrawal and detoxification regimes; and poor staffing levels. Much more could have been done in prison on both a systemic and individual level to keep the women alive and this chapter makes a number of recommendations including:

- A return to separate management of the women's prison estate.
- Provision of women in prison with more purposeful daily activity.
- Counselling and support for women in prison through external agencies independent of the Prison Service.

Chapter 4: The experiences of the bereaved

Following a death, bereaved families often experience difficulties seeking the truth and engaging in the investigations into the women's deaths. This chapter discusses how families are left to negotiate complex and intrusive legal processes with limited financial resources. Institutional defensiveness and indifference also affect a family's ability to participate in the investigation and inquest process.

Bereaved families can provide a unique perspective on women's deaths in prison due to the length and nature of their relationship with the women who died. Their contribution to post-death investigations is potentially highly valuable in preventing further deaths in similar circumstances. Families also have a legal right to know what happened.

In order to facilitate the maximum involvement of the bereaved family in the investigation and inquest process that follows a death in prison, this chapter recommends:

- Automatic provision of good quality, non means-tested, publicly-funded legal representation for bereaved families appearing at inquests.
- Full and timely disclosure of all relevant documents to the bereaved family.
- Access to independent advice and support for bereaved families, including improved access to bereavement counselling.

Chapter 5: After a death – implementing change following a death in custody

This chapter considers why opportunities to learn from previous deaths of women in prison are not maximised and examines the role of delays in post-death investigations, inquest verdicts and rule 43 reports. Currently, concerns raised by juries and coroners into women's deaths in custody do not lead to coherent policy or practical change. Where a series of deaths have occurred at one prison within a short space of time there is limited scope for examining the deaths together.

The effectiveness of post-death investigations in preventing further deaths in prison is entirely dependent on the commitment of those with the power and resources to learn from the deaths and implement the recommendations made at various stages throughout the investigation and inquest process. This chapter makes a number of recommendations to facilitate this including:

- Create a Standing Commission on Custodial Deaths to examine the wider issues around deaths in custody.
- Hold a wide-ranging inquiry into the deaths of women in prison.
- Create mechanisms for public scrutiny of coroner's recommendations, jury findings and investigation report recommendations.
- Amend Prisons & Probation Ombudsman (PPO) reports after the inquest to take into account jury findings, coroners' recommendations or comments, and the response of the authorities.
- Widely disseminate PPO reports and encourage the PPO be more outspoken and critical where failings have been highlighted.

Chapter 6: Conclusions and recommendations

Analysis of the deaths of women in prison custody between 1990 and 2007 reveals a shameful and deplorable picture of preventable tragedy. The issues that were raised after deaths that took place in 1990 are as prevalent and concerning in the deaths that took place in 2007 – 17 years later. This is an abuse of human rights and requires a fundamental rethink of the way women are dealt with by the criminal justice system. As such, the recommendations in this report focus on a departure from current thinking and practice. The key recommendation is the abolition of prison as the main response to women offenders and investment in radical community-based alternatives.

This final chapter of the report sets out how law, government spending and government policy around the criminal justice system can be redirected and reshaped so that the criminal justice response to women offenders can be reformed so that prison is the response of last resort and community-based alternatives are prioritised. Examples of best practice are provided, which urgently need developing and implementing nationally. The report recommends the following occur as matter of urgency:

Gender must be taken into account in the criminal justice system

A criminal justice system that can respond to women offenders in a gender-appropriate manner is crucial to seeing prison abolished as the central response. It requires a system that:

- Is committed to the Gender Equality Duty;
- has a gender-appropriate organisational structure, and
- encourages early diversion away from the criminal justice system.

Gender-appropriate prison alternatives

Introducing alternative responses to women offenders requires the introduction of the following:

- Appropriate responses to women who pose a threat to society, including appropriate mental health facilities.
- Gender-appropriate community service schemes.
- Small community-based therapeutic centres.

Interim measures

Routine use of diversions and prison alternatives will not occur immediately. As long as women remain in prison their lives are at risk. Thus, we offer an interim solution. At the end of each chapter, recommendations have been made and examples of best practice provided for preventing deaths of women held in prison. These should be implemented without delay, along with the recommendations made in other relevant reports.

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