

# Written Evidence from INQUEST

## About INQUEST

1. INQUEST is the only charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians.
2. INQUEST's specialist casework focuses on deaths in prison and other forms of detention, and mental health settings, as well as deaths where wider issues of state and corporate accountability are in question, such as Hillsborough and Grenfell Tower. Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people.

## Executive Summary: *Still Dying on the Inside*: Examining deaths in women's prisons – May 2018

### Overview

3. *Still Dying on the Inside*<sup>1</sup> provides unique insight into deaths in women's prisons based on an examination of official data, INQUEST's research, casework and an analysis of coroners' reports and jury findings. It calls for urgent action to save lives and puts forward a series of bold recommendations to transform services, provide gender specific support in the community and end the inappropriate imprisonment of women.

4. *Still Dying on the Inside* highlights the lack of progress on implementing recommendations from Baroness Corston's seminal review of women in the criminal justice system published in March 2007. Ninety-three women died in women's prison between March 2007 and March 2018.

5. Featuring the stories of women who have died, the report reveals the enduring harms inflicted on women in the prison system. It is intended to reenergise and reframe the debate about women's imprisonment and deaths in custody as a social justice and feminist issue. INQUEST describes imprisonment as a form of state sanctioned violence against women, and part of a cycle of harm that too often leads to trauma, injury and death.

6. INQUEST's work has led us to the conclusion that prison should be abolished as a response to women who break the law, save for a wholly unrepresentative micro-minority of women, who even then need a new form of intensive intervention.

7. INQUEST is calling on government and parliamentarians, policy makers, practitioners and campaigners to;

- recognise women's imprisonment as a form of structural violence against women.
- honour international treaty obligations to safeguard vulnerable women and girls.
- work together towards dismantling and eradicating outdated and failing women's prisons.

### Deaths in women's prisons

8. There were 93 deaths in women's prisons between March 2007 and March 2018, of which, 37 were self-inflicted, 48 were non self-inflicted and 8 await classification. Of the 37 self-inflicted deaths, 31 were by hanging. 2016 was the deadliest year on record when 22 women died, of which 12 were self-inflicted, seven were non self-inflicted and three await classification. Between 2010/11 and 2016/17, 116 women died while under probation supervision following release from prison.

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<sup>1</sup> INQUEST (2018) *Still Dying on the Inside*: Examining deaths in women's prisons can be viewed online here <https://inquest.rit.org.uk/still-dying-on-the-inside-report>

9. INQUEST's analysis of jury findings and coroners' reports reveals a series of systemic failures around self-harm and suicide management and inadequate healthcare. Other contributory factors include a lack of staff training, poor communication and poor record keeping.

10. Many women in the criminal justice system have personal experiences of trauma, abuse and domestic violence. More than half (53%) of women in prison report having experienced emotional, physical or sexual abuse as a child compared to 27% of men. Law breaking by women differs markedly from that by men. It is less frequent, and less serious. Women bear the brunt of social, health and economic inequalities; reflected in the fact that 87% of women sentenced to prison are there for non-violent offences, with 40% imprisoned for theft.

11. Prisons are ill-equipped to respond to the complex needs of many women sentenced to custody. Time and time again inquests reveal that a prison sentence imposed by the courts was an inappropriate response to women already facing a range of social, health and economic inequalities.

12. Long running problems in service provision have now been made worse by austerity measures and have impacted disproportionately on women, including cuts to legal advice, housing, benefits and services for victims of domestic violence. This is most sharply felt across the intersections of ethnicity, gender, disability and class. Diversion schemes and existing specialist women's centres and projects are under critical threat because of a lack of sustainable funding.

## Key recommendations

- a. **Redirect resources from criminal justice to welfare, health, housing and social care.** Reallocated criminal justice resources should be invested in refuges and rape crisis centres, drug and alcohol support services, gender appropriate community services and small community based therapeutic centres. They should be independent, specialist and dedicated services run by and for women and include culturally specific provision for BAME girls and women.
- b. **Divert women away from the criminal justice system.** Diversion from criminal justice towards treatment and support must be the preferred option. Strategies and holistic interventions that address the many complex reasons why women enter the criminal justice system— sexual and physical abuse, poverty, homelessness, addiction, and mental and physical ill health – offer the best option for tackling the issues that underlie the deaths of women in prison. Part of the former Holloway women's prison site could be developed as a women's building to deliver these gender specific services.
- c. **Halt prison building and commit to an immediate reduction in the prison population.** Imprisonment should be abolished as a response to women who have broken the law. For the 100 women or so whose offence is so serious that they may be considered a danger to others, a network of small therapeutic secure units should be created.
- d. **Review sentencing decisions and policy.** A meaningful review of sentencing decisions and alternatives available to courts should be part of any investigation following a death or serious injury in prison. Such a focus would help ensure responsibility and accountability for deaths beyond just the prison service.
- e. **An urgent review of the deaths of women following release from prison.** Deaths of women following release from prison are largely ignored, hidden from view and do not receive the same level of scrutiny, concern or investigation currently received by deaths in custody. A review should explore current arrangements for monitoring deaths, the circumstances surrounding these deaths and identify measures that relevant agencies can take to protect women upon release.
- f. **Ensure access to justice and learning for bereaved families.** To ensure fairness and equality where there is a death, families should be allowed access to justice through non-means tested public funding for representation at inquests as recommended by two Chief Coroners and in two recent reviews by Dame Elish Angiolini and Bishop James Jones. This would ensure proper public scrutiny, equality of legal resources with

state funded or corporate lawyers and would help to maximise the preventative potential of coroners' inquests.

- g. **Build a national oversight mechanism for implementing official recommendations.** The lack of statutory enforcement and oversight of safety recommendations is putting lives at risk. There is an overwhelming case for the creation of a national oversight mechanism on deaths in custody. This body would be tasked with monitoring, auditing and reporting on the accumulated learning from post death investigations by the Prison and Probation Ombudsman, inquest outcomes and recommendations from HM Inspectorate of Prisons and Independent Monitoring Boards. This would ensure greater transparency in terms of tracking whether action has been taken to rectify dangerous practices and systemic failings.

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