INQUEST

Truth Justice Accountability

BUILT TO HARM

HOW WOMEN'S PRISONS TAKE LIVES

Acknowledgements

This report was written by Jessica Pandian. Thank you to Deborah Coles, Rosanna Ellul, Leila Hagmann and Mo Mansfield for their insightful contributions along the way and to the casework team for their assistance.

Thank you to Indianna Purcell for proofreading, Richard Fontenoy for assisting with the data analysis, and to Naomi Oppenheim for collating INQUEST's archival materials which are featured throughout the report. We would also like to thank Rachel Carr for designing this report with such care.

We extend our gratitude to the bereaved families who we worked with throughout the process.

ISBN 978 0 946858 323

Charitable Trust Registered Charity No.1046650 | Registered Company No. 03054853

www.inquest.org.uk 89-93 Fonthill Road, London N4 3JH 020 7263 1111

Contents

Foreword

DEBORAH COLES
Executive Director of INQUEST

Over decades, INQUEST has documented needless deaths in women's prisons. The stories reveal women repeatedly harmed, failed and dehumanised.

Deaths in women's prisons have been a long-standing focus of INQUEST's work, and this report builds upon INQUEST's previous analysis published in our trilogy of reports on the matter, 'Dying on the Inside'.

'Built to Harm: how women's prisons take lives' is grounded in evidence from INQUEST's casework, official data, and coroner's inquests. It adds to the overwhelming evidence that condemns the use of women's prisons.

While the state often minimises the harm experienced in prison, inquests have consistently exposed the dark reality. Those who are sent to women's prisons are confronted with neglect of their mental and physical health, use of force, strip-searches and, more broadly, dehumanisation, racism and indifference. Deaths occur at the sharp end of violence.

Despite endless reforms, the question of who is sent to prison and why has remained largely unchanged. The reforms, whether dressed up as 'gender responsiveness' or 'trauma informed practice', have failed to safeguard lives and have instead reinforced the legitimacy of prison. Prisons, by their very design, are built to harm. Radical decarceration is the only path forward.

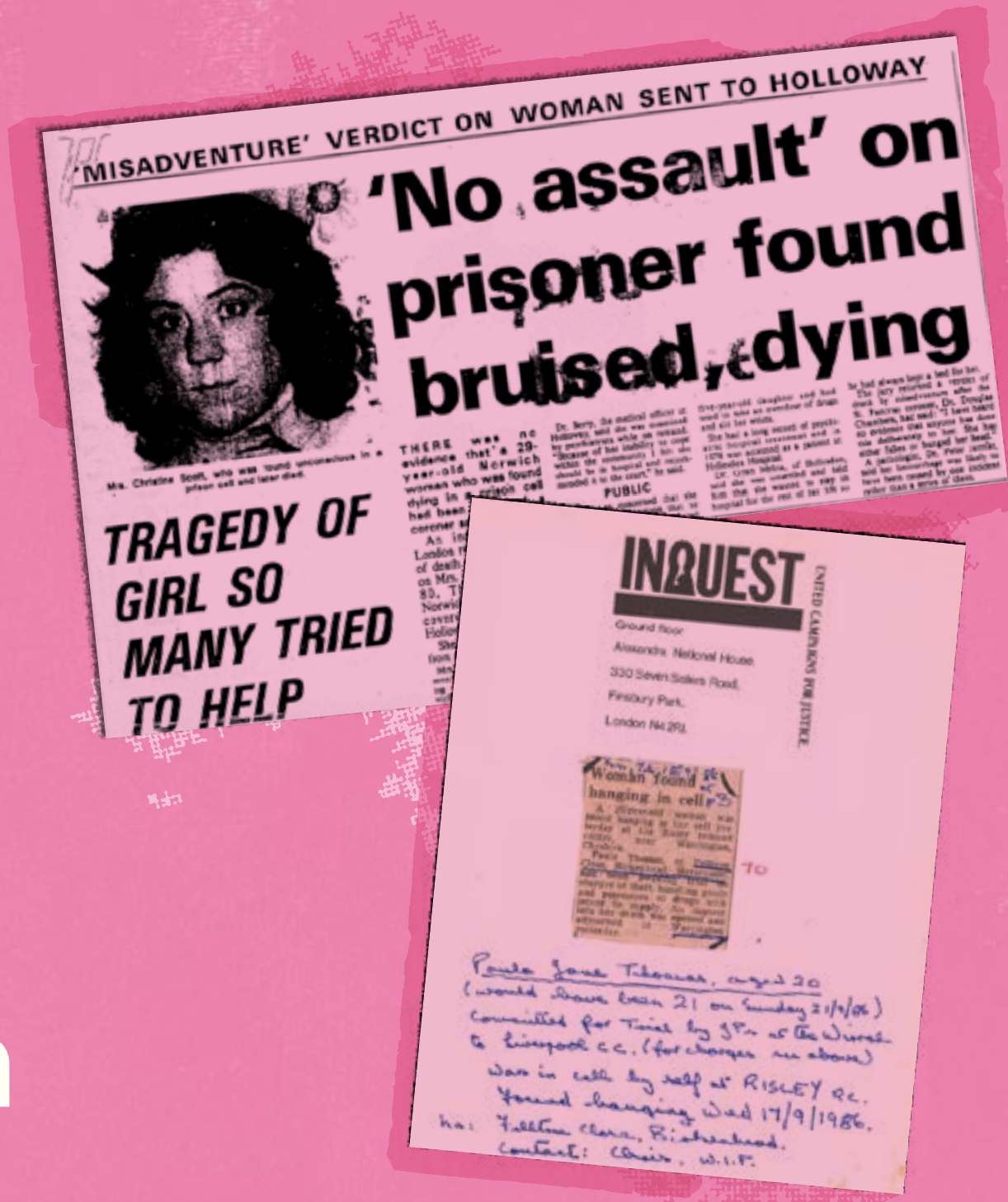
The criminal justice system disproportionately polices, prosecutes and imprisons marginalised people by criminalising poverty, homelessness, mental ill heath, and drug dependency. While one arm of the state punishes, the other offers meagre support when it comes to housing, mental ill health and gender-based violence. Those who are excluded from and failed by multiple agencies are gathered up in its carceral net.

Public funding is channelled into prisons rather than vital community-based services which could address the root causes of social issues. Why is a prison place always available, but not accommodation, mental health care or space in a refuge?

This report reasserts our call to end women's imprisonment; we must dismantle an institution endlessly exposed for its abject failure, one so resistant to reform. Prisons disappear people, not problems. The stories of those who died are all the evidence needed to underscore that prisons are not and will never be solutions to social ills. The only certainty is that more deaths will follow unless the government radically changes direction. Rather than more rhetoric, now is the time for political bravery and implementation of tangible steps towards ending women's prisons.

01

Introduction



'MISADVENTURE' VERDICT ON WOMAN SENT TO HOLLOWAY

'No assault' on prisoner found bruised, dying

Ms. Christine Scott, who was found unconscious in a prison cell and later died.

TRAGEDY OF GIRL SO MANY TRIED TO HELP

INQUEST

UNITED CAMPAIGNS FOR JUSTICE

Ground floor
Alexandra National House
330 Seven Sisters Road,
Finsbury Park,
London N4 2PJ

Woman found hanging in cell

Paula Jane Thomas, aged 20
(would have been 21 on Sunday 21/9/86)
committed for Trial by JPs at the Wirral
to Liverpool C.C. (for charges see above)
Was in cell by self at RISLEY RC.
Found hanging Wed 17/9/1986.
HA: Fulton Close, Rickerstead.
Counsel: Clair, W.I.P.

Introduction

This report exposes the successive failures of reforms, strategies and frameworks introduced in the policy around women's prisons in England and Wales since the launch of the Ministry of Justice's Female Offender Strategy in 2018.[1]

The strategy's intended purpose was to improve lived conditions in women's prisons and reduce the women's prison population. 2018 also marks the year in which INQUEST published 'Still Dying on the Inside',[2] the third INQUEST publication providing unique insight into deaths in women's prisons.

Through foregrounding the circumstances of seven deaths in women's prisons and highlighting issues which have persisted for decades, this report provides further evidence that the women's prison estate is – and for decades has been – incapable of adequate reform.

An analysis of the deaths reveals the key thematic issues, which fall under three categories:

1. not believing prisoners in crisis and at risk,
2. failings in prison processes, and
3. imprisonment as the default to social inequality.

Lastly, the report provides a statistical analysis of deaths and self-harm in women's prison from 2018 - 2024.

If we do not address the current prison crisis and reflect on its harmful impact, it is inevitable that more people will be exposed to the harms of the prison environment and die.

This report is a blunt reminder to the Government to act now by committing to dismantle the women's estate and halt all prison building.

Background and context

Prison campaigners and activists in the UK have long called for the abolition of prisons, dating as far back as 1970, when the campaign group 'Radical Alternatives to Prison' came together.[3]

In 1972, Radical Alternatives to Prison published a leaflet opposing the rebuilding of a women's prison in Holloway, North London.[4] They clearly stated, 'Imprisonment does nothing about outside conditions in which even the strongest would find tolerable survival difficult. It often destroys what little there is. **No prison, however humane and progressive can do otherwise.**'

The publication of the independent Corston Review in 2007 marked a watershed moment in the criminal justice sector.[5] It was the first time an official report had put forward the recommendation that women's prisons in England should be dismantled. The Corston Review recognised the harm prison inflicts on people as well as on their families and wider communities.[6] It was the first time that the demands of grassroots campaigners were, to a certain extent, reflected in an official report.

Following the publication, there was great anticipation that the government would take steps towards drastically reducing the prison population.

The Corston Review offered the government an opportunity to contribute towards transformative societal change by recommending the dismantling of women's prisons. However, by not agreeing to the key recommendation of the review,[7] the government ultimately defaulted to committing to piecemeal reforms that left larger structural issues untouched and that largely depended on an underfunded voluntary sector working with probation services, all while the judiciary continued to imprison women.

Therefore, in spite of a landmark review, backed up by a wealth of evidence from government, NGO's, and inspection and monitoring bodies on the destructive impact of prison, the government has continued to inject funding into scaling up the prison estate in England and Wales while simultaneously increasing the length of custodial sentences.

As a result, the prison population has doubled over the last 30 years, despite crime rates having fallen substantially.[8]

As of December 2024, almost 3,500 women were imprisoned and by September 2028 it could surpass 4,000.[9]

This demonstrates the lack of structural change since the Corston Review. This is contextualisd by the UK possessing the highest prison population and imprisonment rate in Western Europe since the early 2000's,[10] with it set to balloon to over 100,0000 by 2029, a direct symptom of increasing the amount of legislation passed that criminalises poverty and inequality.[11]

Between 2014 - 2024, 109 people have died in women's prisons according to Ministry of Justice data,[12] laying bare the failures of consecutive governments to safeguard the lives of some of the most marginalised people in society.

02

Women in prison: a profile

(page 1 of 2)

Coroner's list of fears over women's jail

■ Nissa Smith: Found hanged

BY NICOLA BOWLING

NOTE (for information): para 4 - Sarah Elizabeth Campbell was the 3rd of the 6 women to die.

Manchester Evening News

COMMENT

Just what is wrong at Styal Prison

Women in prison: a profile

This report refers to 'women' where it is known the people identify as women. When referring to external research, we use their terminology, i.e. women. In other circumstances, the report refers to 'people', in recognition of the fact that not everyone in women's prisons identifies as a woman, and to include the deaths of babies.

Women make up only 4% of the prison population in England and Wales.[13] While the number of women in prison on a given day hovers around 3,500, the number of times people were admitted to women's prisons in the year to June 2024 was 6,000.[14]

The use of community sentences for women has halved since 2011,[15] while the use of very short sentences has slightly declined. 4% of people in women's prison identify as Gypsy, Roma or Traveller compared to 1% of the general population,[16] and racialised people are disproportionately represented.[17]

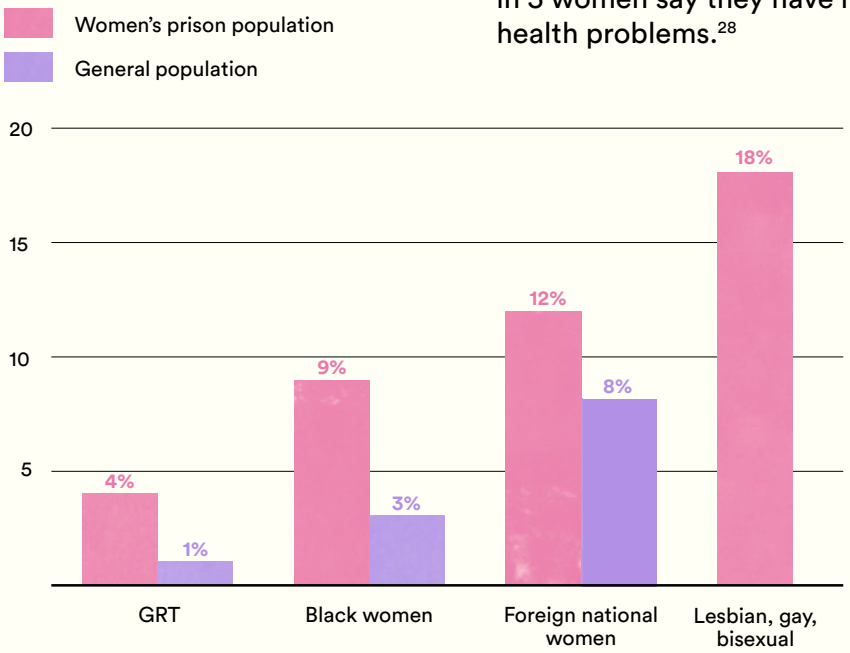
Data broken down by both ethnicity and gender is limited, but in 2017, Black women made up 9% of the prison population compared to 3% of the general population.[18] A 2018 report highlighted how foreign national women represent 8% of the general population in England and Wales, but 12% of all women in prison and nearly a fifth of those on remand.[19]

Almost one in five women in prison identify as gay/lesbian or bisexual, and 49 people have self-reported as transgender men, with 5 or fewer people having self-reported as transgender women in the women's estate.[20]

LGBTI people are recognised by the United Nations as a particularly at-risk group in prison to violence and ill-treatment.[21]

The impacts of imprisonment on individuals, families and whole communities are extremely detrimental. More than half of women in prison have children under 18[22] and 17,500 children have been separated from their mothers due to imprisonment.[23] 44% of women in prison report having a disability.[24]

People in women's prisons have complex needs, as many have experiences of mental ill health, drug and alcohol dependency, domestic violence and precarious housing. 3 in 10 women in prison said they had been in local authority care or had a social worker as a child.[25] More than two-thirds of women in prison serving less than 12 months said they needed support with previous or ongoing trauma, including domestic violence.[26] More than half of women in prison reported experiencing emotional, physical and sexual abuse as a child[27] and more than 3 in 5 women say they have mental health problems.[28]



A timeline of policy reform of women's prisons since 2018

2018

The Ministry of Justice (MoJ) launches the Female Offender Strategy[29]

With the supposed aim of reducing the women's prison population, the MoJ invests £3.5 million into community-based provision and domestic abuse support for women over two years.

For context, the annual MoJ departmental expenditure limit for 2018-19 was £4 billion.[30]

By 2021, the government had delivered on less than half of the 65 commitments.[31]

The National Audit's Office (NAO) found that the MoJ had failed to set targets for its main objectives, including the proportion of women to be diverted from the criminal justice system. [32]

2019

The Farmer Review

Commissioned to support the Female Offender Strategy, the review finds that family ties were 'utterly indispensable' to the rehabilitation of women in prison.[33]

By January 2023,[34] six of the 33 recommendations had not been completed.[35]

2021

MoJ announces 500 more prison places for women

In addition, the MoJ promises £2 million additional funding for organisations supporting marginalised women.[36]

For context, HMPPS committed gross resource expenditure for the year 2021/22 was £4.5 billion.[37]

The move is quickly met with resistance from the NGO sector. The organisation Women in Prison write to the then Secretary of State to say that the proposal undermines the government's own evidence and criminal justice strategy.[38]

2023

The MoJ releases the Female Offender Strategy Delivery Plan 2022 - 2025

It aims to reduce the number of women entering the criminal justice system, reduce short sentences, self-harm and self-inflicted death in prison, and improve outcomes on release by piloting residential women's centres in at least five sites.[39]

The delivery plan includes a £9.5 million investment in women's community centres, £46 million in charities, and £14 million in women's centres.

By 2024, only 20 of the 51 commitments had been completed. Only one approval of a women's centre in Swansea is referenced as opposed to the promised five centres.[40]

The failure to meet their own commitments highlights a complacency to meaningfully work towards reducing the population in women's prisons.

2024

Experts warn that funding pressures for women's centres will result in more women being imprisoned[41]

New data shows that 77% of the 26 women's organisations that make up the National Women's Justice Coalition had not received sufficient funding to cover their 2025/26 expenditure. The average funding shortfall is more than £750,000.[42]

The government announces a pause to their 2021 plans to build 500 more prison places for women citing fiscal challenges. They commit to continue the building in the future, much to the disappointment of INQUEST and other NGOs.[43]

2025

The government launches the Women's Justice Board

Chaired by Lord Timpson, its focus is on **diverting women from the criminal justice system**, residential alternatives to custody and **improving outcomes for women** across the criminal justice system.[44]

2025

The Independent Sentencing Review publishes its final report

It recommends **long-term funding for women's centres** and the use of problem-solving courts which **prioritise treatment from support services** as opposed to custody.[45]

However, the review's ultimate focus is to **push for extending punishment beyond prison walls** and into the community, through the use of **intrusive technology-centred community supervision.**

The review fails to address the structural reasons for which people enter prison, such as poverty and inequality. This means routes into the criminal justice system remain unchallenged.

2025

The Sentencing Guidelines Act becomes law

The law blocks new guidelines on pre-sentence reports that would consider factors like age, race, and pregnancy in sentencing. However, **these reports can still be requested individually.[46]**

Feminist and anti-racist groups supported pre-sentence reports, believing they could **help reduce imprisonment rates for marginalised people.**

2025

The Sentencing Bill is introduced to Parliament[47]

This includes measures to **mostly abolish short sentences** and expand the use of electronic tagging and punishment in the community more broadly.[48]

03

The Stories

MUM'S PRISON DEATH PROTEST

Daughter died in cell

By LYNN BROWN

THE mother of a teenager who was found hanging in prison after being convicted of killing a pensioner has taken her fight to end custody deaths to 10 Downing Street.

Sarah Elizabeth Campbell, 18, who was born in Wrexham, was convicted of manslaughter at Mold Crown Court in January after harassing a pensioner in Chester city centre, causing him to have a heart attack.

But just a day after being sent down she was found dead in her cell at Styal Prison, Cheshire.

Since then, her mother, Pauline Campbell, who is a retired NEWI lecturer, has fought for an independent inquiry into the six deaths at the prison since August, 2002 and August, 2003.

The determined mother travelled to London on Saturday to take part in the National Demonstration against Deaths in Custody.

And the 56-year-old even walked up to the doors of 10 Downing Street to present Government officials with a letter from family and friends of dead prisoners.

Pauline, who lives near Malpas, Cheshire, says she will not give up until there is an overhaul of the prison service.

She said: "The demonstration went really well and a highlight of the day was when I addressed the crowd at Trafalgar Square using a microphone.

Dismay

"I spoke of my dismay at the continuing chaos in the Prison Service and the inability of the Home Office to do anything about it.

"Over the past year the number of prison deaths has increased, and in Styal Prison these have been three women who have died since Sarah.

"Many of these women shouldn't even be in prison because they are not a threat to the community.

"It was a very moving experience to be part of the demonstration, but it is saddening it had to take place at all."

SARAH CAMPBELL
DIED 18 JAN
STYAL PRISON
AGED
WHY?

FORMER NEWI lecturer Pauline Campbell protesting in London to end deaths in custody. Inset: Sarah Campbell, who died at Styal Prison earlier this year

ANN-MARIE ROBERTS

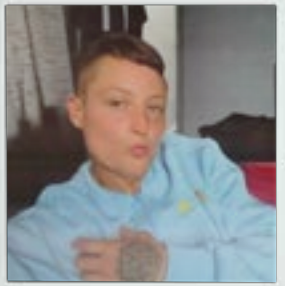
Ann-Marie enjoyed going on walks and was a talented artist. Her family describe her as a sociable person who loved going out, meeting and talking to new people.

Died in HMP Eastwood Park in July 2021

Inquest conclusion:
Natural causes

Died aged 51 years old

SARIA HART

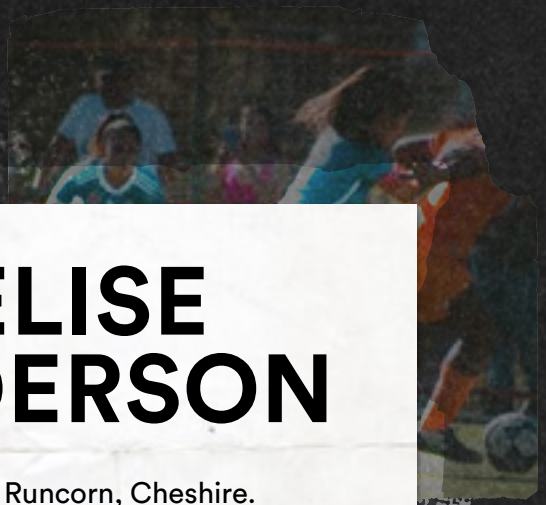


Saria was born in Tamworth, the third of seven children. Her family describe her as a sociable person with a big heart who loved being around people.

Died in HMP Foston Hall in 2019

Inquest conclusion:
Narrative, serious failings

Died aged 26



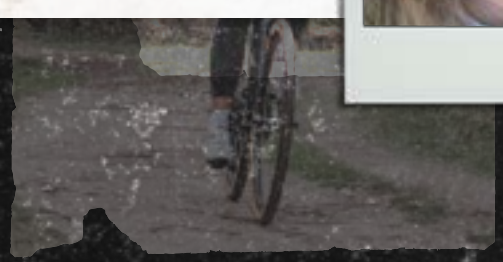
ANNELISE SANDERSON

Annelise grew up in Runcorn, Cheshire. A tomboy from an early age, Annelise was interested in biking and playing football. A passionate, loving and forgiving person, her family said she cherished the relationships of those to whom she was closest.

Died in HMP Styal in 2020

Inquest conclusion:
Narrative, serious failings

Died aged 18



LUISA BOULTBEE

Died in HMP Foston Hall in 2020

Inquest conclusion:
Narrative, serious failings

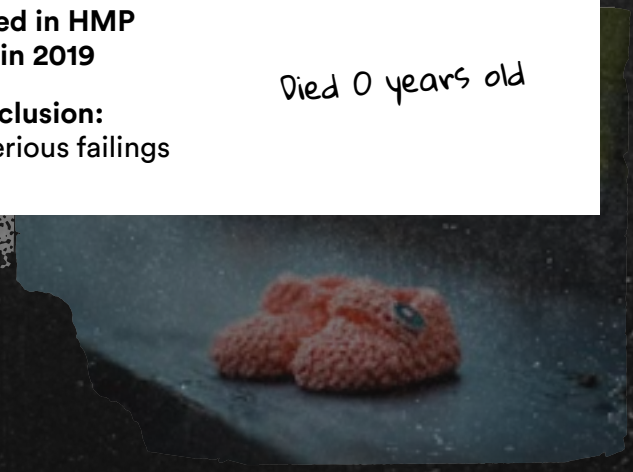
Died at 49 years old

AISHA CLEARY

Born and died in HMP Bronzefield in 2019

Inquest conclusion:
Narrative, serious failings

Died 0 years old



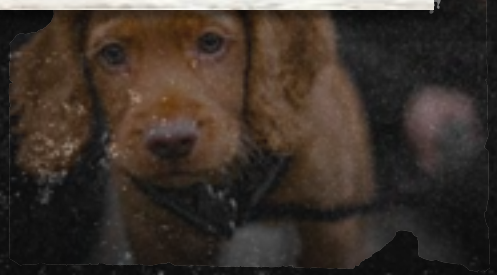
KAY MELHUISH

Kay held qualifications in canine psychology and was an avid breeder of cocker spaniels. She loved Nike Air Max trainers. Those who loved her describe her as having a strong character, who lived for her children, and as being a loyal friend and sister.

Died in HMP Eastwood Park in July 2022

Inquest conclusion:
Neglect, serious failings

Died aged 36



CHRISTINE MCDONALD

Christine was a mother of four. She was kind, loving, and had a good sense of humour. She was someone who always put others before herself. She was loved and is missed immensely by her family.

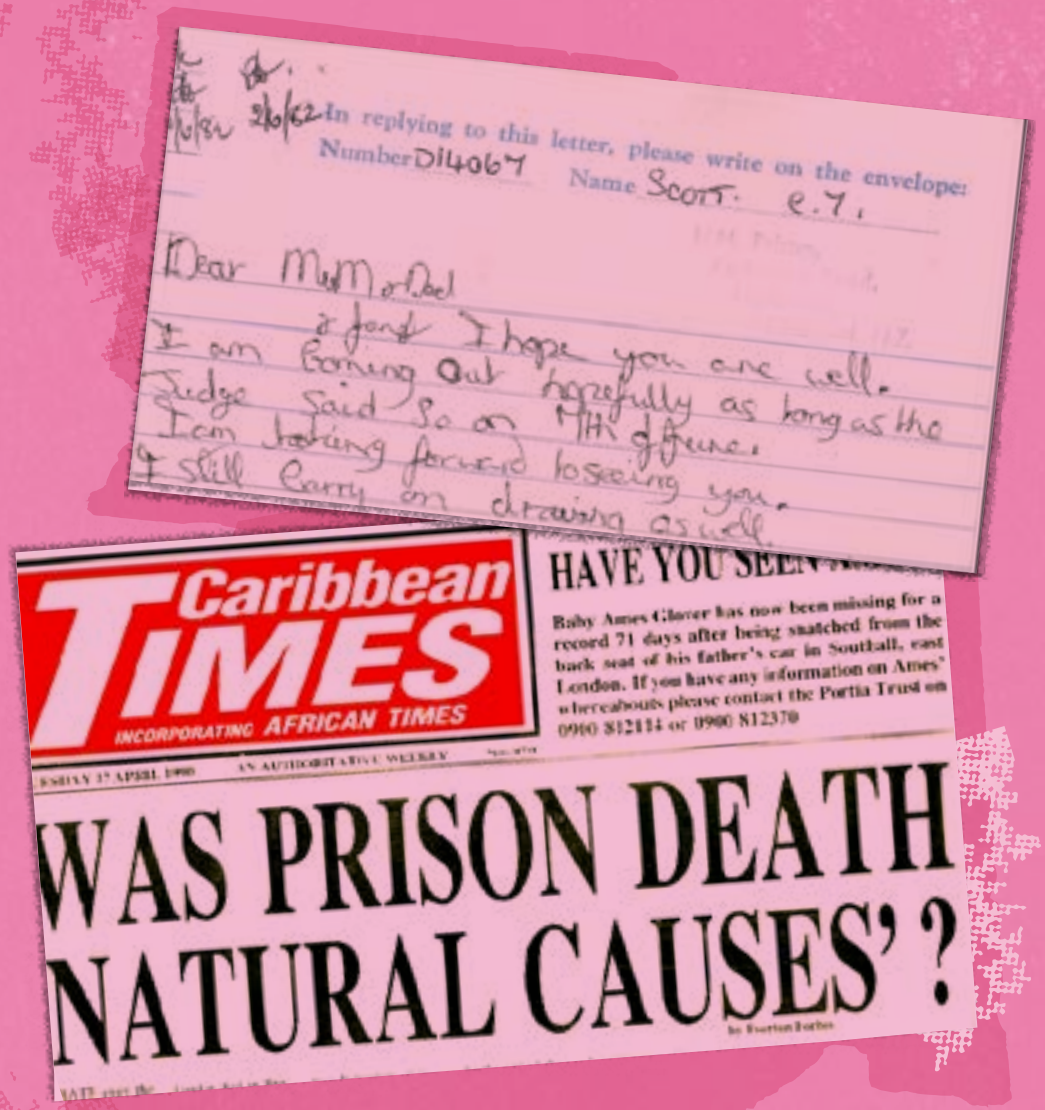
Died in HMP Styal in 2019

Inquest conclusion:
Narrative, serious failings

Died aged 55

04

Analysis


In replying to this letter, please write on the envelope:
Number D14067
Name Scott. E.T.
Dear Mum and Dad
I hope you are well.
I am coming out hopefully as long as the Judge said so on 7th of June.
I am looking forward to seeing you.
I still carry on drawing as well.
Caribbean TIMES
INCORPORATING AFRICAN TIMES
HAVE YOU SEEN
Baby Ames Glover has now been missing for a record 71 days after being snatched from the back seat of his father's car in Southall, east London. If you have any information on Ames' whereabouts please contact the Portia Trust on 0900 812414 or 0900 812370
WAS PRISON DEATH NATURAL CAUSES'?

Analysis

1. Not believing prisoners in crisis and at risk

Many of the deaths of women in prison that INQUEST have worked on expose how the concerns of prisoners or their support network were **routinely ignored**. This includes instances where prisoners' mental health was at risk of worsening. The 2024 Independent Monitoring Board annual report highlighted that prisoners with severe mental illness often did not receive appropriate care and support.[49]

For example, the death of **Annelise Sanderson**, an 18 year old care leaver who had previously attempted suicide, highlights the prison's failure to escalate matters despite repeated signs that her mental health was worsening. Annelise was sentenced to a year in prison after assaulting emergency workers who had intervened when she tried to either drink or pour petrol on herself. It was her first time in prison, a time of recognised heightened risk. When she arrived, her behaviour was described as volatile, but it took three days for an ACCT to be opened. Assessment, Care in Custody and Teamwork, commonly known as ACCT, is the self-harm and suicide prevention guidance in prison. At the inquest, the nurse said that if they had seen Annelise's medical history, they would have opened an ACCT on arrival. Despite Annelise attending ACCT reviews with a ligature around her neck and telling staff she had swallowed a battery, the ACCT was closed after eight days. Months later, she was found ligatured.

> "CONCERNS OF PRISONERS OR THEIR SUPPORT NETWORK WERE ROUTINELY IGNORED

The death of another young woman with mental ill health, 26 year old **Saria Hart**, reinforces how the prison consistently ignored her risk of self-harm and signs she would take her own life. Like Annelise, the moment of her arrest was extremely distressing, and she threatened to self-harm and take her own life. Although the prison was informed of a self-harm alert for Saria, it did not open an ACCT. Despite segregation being known to increase the risk of self-harm and suicide, Saria was segregated after an incident in which she was allegedly abusive towards staff. The Custodial Manager said at the inquest that 'there was absolutely no need to segregate Saria'. Saria was also suspended from her cleaning job as wing manager. Saria passed a note to an officer detailing her intent to take her own life if she lost her job. Although the prison opened an ACCT, in an ACCT assessment the next day, the prison took no action when Saria disclosed plans to end her life and refused to hand over razor blades. The prison again took no action when that afternoon Saria passed a second note to staff expressing intent to take her own life. Two hours later she was found ligatured in her cell.

Whilst the aforementioned deaths expose the prison's routine neglect of women's cries for help, the death of **Kay Melhuish** shines a light on how the prison also ignores the advice and

requests of a woman's support network. Kay was 36 years old with ADHD, autism, complex post-traumatic stress disorder and noise sensitivity, and had previously made attempts on her life. Kay's family, psychologist and solicitors wrote to the prison to warn staff of Kay's suicide risk when she was remanded. It would be her first time in prison. Almost no staff read the prison's neurodiversity plan recommending that Kay phoned family, and the need to reduce noise and to investigate any bullying.

> “
> **ALMOST NO STAFF READ THE PRISON'S NEURODIVERSITY PLAN**

During her first 10 days in prison, Kay only made two short calls to family. She was also only left with one pair of knickers during this time, highlighting the many ways in which her needs and dignity were overlooked. Sometime after, she made two ligatures within 24 hours and told staff she was struggling with noise, medication and phone issues and that she felt bullied. Later, officers found Kay hiding under a table in a quiet room. Rather than treating her with care, six officers restrained her for 13 minutes during which she said she did not want to breathe and that she could self-harm in her cell. Despite saying this, the officers left her alone in her cell. After checking on her, to which there was no response, the officer was told to enter her cell where she was found ligatured. The inquest jury found that neglect contributed to her death and that it was 'incomprehensible' that her basic needs were not met.

2. Failing prison processes

All seven of the deaths featured in the report highlight multiple systemic issues embedded within the prison. These issues are far from new and have been cited widely in post-death investigations over decades and in INQUEST's research.[50]

Substandard response to emergency cell bells

Prison policy states that each cell must have an emergency cell bell installed for prisoners to communicate with staff and that 'staff should acknowledge all requests for assistance by having personal contact with the person'.[51] The expectation is that staff must respond to any emergency cell bell calls within a five-minute period. HM Inspectorate of Prisons has repeatedly noted how emergency cell bells have not been answered in the five-minute window across different prisons.

The death of baby **Aisha Cleary** not only exposes how failing to respond to a cell bell can irreversibly impact chances of survival, but also brings to the fore the inhumanity of not attending to someone requesting support in an emergency crisis.[52]

Baby Aisha was born and died in prison on 26 September 2019. Her mother, Rianna Cleary, an 18 year old Black care leaver, was remanded to prison in August 2019 at six months pregnant. Five days later she was notified that social services would seek a court order to remove her child at birth. Rianna told prison staff that she would kill herself if that happened. Despite this, an ACCT was not opened. On 26 September, Rianna went into labour. She used the cell bell at 8.07pm to request a nurse or ambulance. The prison officer who answered took no action. She called again at 8.32pm. This time, the cell bell was not answered.

Rianna gave birth alone, despite being checked on twice, losing blood and passing out in the early morning. Rianna awoke to her baby Aisha on the bed not breathing. Only after prisoners alerted staff, a prison officer discovered that Rianna had given birth. Nurses attempted to resuscitate Aisha, but paramedics declared her dead 12 hours after Rianna had requested medical assistance.

The death of **Christine McDonald** also exemplifies the fatal consequences of failing to respond to an emergency cell bell, as well as the failure to follow clinical guidance. Christine was 55 years old and dependent on opiates. She witnessed her daughter fall from a third floor window during her arrest. Upon arrival at prison, Christine was suffering from opiate withdrawal. There should be additional observations for those experiencing opiate withdrawal according to prison policy,[53] but the prison failed to enact this.

The following day, Christine was taken to hospital following concerns about her withdrawal symptoms, but the prison failed to conduct a full medical assessment upon her return. That evening the prison did not pass information on to Christine that her daughter was in a stable condition. Other prisoners heard Christine screaming, expressing concern about her daughter. That night, Christine used the cell bell to request a nurse, but no one came. She was found hanging at around 11pm and died the next day.

The inquest jury concluded that not responding to Christine's cell bell and the failure by healthcare to follow clinical guidance about the treatment of her drug dependency contributed to her death.

Poor oversight of health conditions

Healthcare guidance not being adhered to was revealed during the investigations into the deaths of several of the women featured in this report. More broadly relating to the inadequacy of healthcare provision in prison, the All Party Parliamentary Group on Women in the Penal System noted in 2022 that 'the unhealthy prison environment does not meet women's needs and exacerbates ill-health, giving women few opportunities to take control of their own health and well-being.'[54]

Luisa Boultbee was 49 years old with complex needs. She was remanded to prison following a mental health crisis. Her Person Escort Record had noted she had epilepsy. She was only prescribed all the medications she received in the community

the day after her arrival at prison, and the prison did not escalate the issue when she did not take her medication immediately.

When Luisa complained of abdominal pain, a nurse conducted a medical examination through a cell door after which they were satisfied Luisa had no abdominal condition. When Luisa complained of a bitten tongue, a strong indicator of epileptic seizures, a nurse gave her paracetamol. During the night, two mandatory checks were missed. The next morning Luisa was discovered unresponsive in her cell and pronounced dead half an hour later. The inquest found that Luisa died by Sudden Unexpected Death in an Epileptic Patient (SUDEP).

Ann-Marie Roberts was 51 years old with bipolar disorder and diabetes. She was remanded following an incident that occurred during a mental health crisis. It was her first time in prison. At an initial health screening, a prison nurse noted Ann-Marie had Type 2 diabetes but did not create a care plan.

Ann-Marie disclosed she felt depressed and suicidal. Days later, the prison decided Ann-Marie required additional mental health support, but evidence suggests this did not occur. Ann-Marie reported an inability to keep medication down and stomach pain, for which she was only offered paracetamol. An expert endocrinologist at the inquest into her death noted Ann-Marie was likely experiencing worsening diabetic ketoacidosis and that had she been hospitalised between midnight and 3am, she likely would have survived.

During the night of her death, the majority of checks on Ann-Marie were a cursory glance. A prison officer did not take any action when he found her unresponsive. At 7am, it was noted that she was potentially not breathing, but no one checked on her until after 9am. Prison staff found her unresponsive but did not immediately radio an emergency code. Evidence suggests she had been dead since 7 - 8am.

Poor signalling of medical emergencies

The failure to immediately radio an emergency code in the death of Ann-Marie resulted in a delay of emergency medical assistance, which was also an issue in the death of Annelise Sanderson. When Annelise was found ligatured in her cell, the prison officer did not radio an emergency code which caused a delay in requesting an ambulance. This is despite the fact that the prison policy framework states that 'it is the responsibility of all staff to be aware that the preservation of life is the first priority.'[55]

Lack of adherence to self-harm and suicide prevention guidance

Across many of the deaths mentioned in this report, prisons failed to follow self-harm and suicide prevention guidance, known as the Assessment, Care in Custody and Teamwork (ACCT) process.

Prison policy states that 'a member of staff must open an ACCT when a prisoner has self-harmed or where there are concerns regarding a prisoner's risk of suicide or self-harm'.[56] However, the deaths clearly demonstrate how this policy is repeatedly disregarded.

An ACCT was not opened when Rianna Cleary told prison staff she would kill herself if social services took her newborn baby away at birth.

Despite the prison being informed of a self-harm alert for Saria, and her threats to self-harm and take her own life during her arrest, an ACCT was not opened. Similarly, for Annelise, who was arrested while trying to take her own life, and whose behaviour was described as volatile on arrival at prison, an ACCT was not opened immediately, but delayed by three days. Though an ACCT was opened for Kay Melhuish, and she had 11 ACCT reviews within 3 weeks, a mandatory care plan was never put in place.

The 2024 Independent Monitoring Board annual report highlighted enduring concerns about the ACCT process, with several boards noting that ACCT observations, reviews or notes were carried out inadequately, leading them to believe the process was not fit for purpose.[57]

3. Imprisonment as the default

The circumstances surrounding the imprisonment of the women featured in this report casts serious doubt over the decision to imprison the women in the first place.

Many of the women were extremely distressed at the point of arrest, and rather than being met with care and compassion, they were punished. In spite of knowing their high risk to self-harm and suicide, the women were still sent to prison, where people are ten times more likely to take their own life.[58] When Annelise was trying to take her own life, she was arrested and sentenced to a year in prison. Saria, too, was in extreme distress at the point of arrest, threatening to self-harm and take her own life. The arrests were violent and the women were forcibly removed from their communities, exacerbating the distress they already felt. The way in which Annelise and Saria were arrested raises serious questions about why criminal justice diversion schemes were not implemented in these cases, and about why neither the police nor the courts recognised the distress of both women.

> "RATHER THAN BEING MET WITH CARE AND COMPASSION, THEY WERE PUNISHED

Rather than Saria's risk of self-harm being taken into consideration about how prison would affect her, she was sent to prison regardless with a self-harm alert. Both women ended up taking their own life in prison.

Both Ann-Marie and Luisa Boultbee were arrested and imprisoned whilst experiencing mental health crises, despite the fact that prison has been shown to repeatedly induce and exacerbate mental ill health, including to the point of death.[59] Similarly, in spite of Kay Melhuish being neurodiverse with highly complex needs and a history of suicide attempts, she too was sent to prison. Knowing that the prison environment would increase the likelihood that she would take her own life, her family, psychologist and legal representation wrote to the prison to warn them.

The deaths of baby Aisha Cleary and Christine McDonald also expose how women with highly complex needs are sent to prison, where their needs are much less likely to be met and the risk of their health deteriorating is much higher.

Though she was six months pregnant, Rianna Cleary was imprisoned. Italy and Portugal have both implemented laws that prevent pregnant women from being sent to prison, whilst eleven other countries with a total population of about 6.5 million prohibit the imprisonment of pregnant women, or severely curtail it. They include the Russian Federation, Ukraine, Georgia, Brazil, Mexico and Colombia. The feminist organisation, Level Up,[60] is currently campaigning to end the imprisonment of pregnant women in the UK. In England, between April 2023 - March 2024, there were 215 pregnant people in prison and 52 births.[61]

Christine McDonald was dependent on opiates, and prison is known to be an environment where drugs are highly available, yet where treatments for drug dependencies are ineffective. In the HM Inspectorate of Prisons annual report 2024 - 2025,[62] 19% of women reported having developed a problem with drugs, alcohol or medication not prescribed to them since being imprisoned. This underscores how imprisonment itself is a key driver of drug use. Prisons often take a zero-tolerance approach to drug-taking, with great emphasis on drug-testing, which can lead to people experiencing severe withdrawal symptoms and a rapid decrease in drug tolerance, which increases the likelihood of drug overdose on release. INQUEST has argued for a reduction in the prison population, the implementation of harm reduction in prison, and the decriminalisation of drugs more broadly to end drug-related deaths and harm in prison.[63] 30 countries have already implemented, of some form, the decriminalisation of drug possession offences.[64]

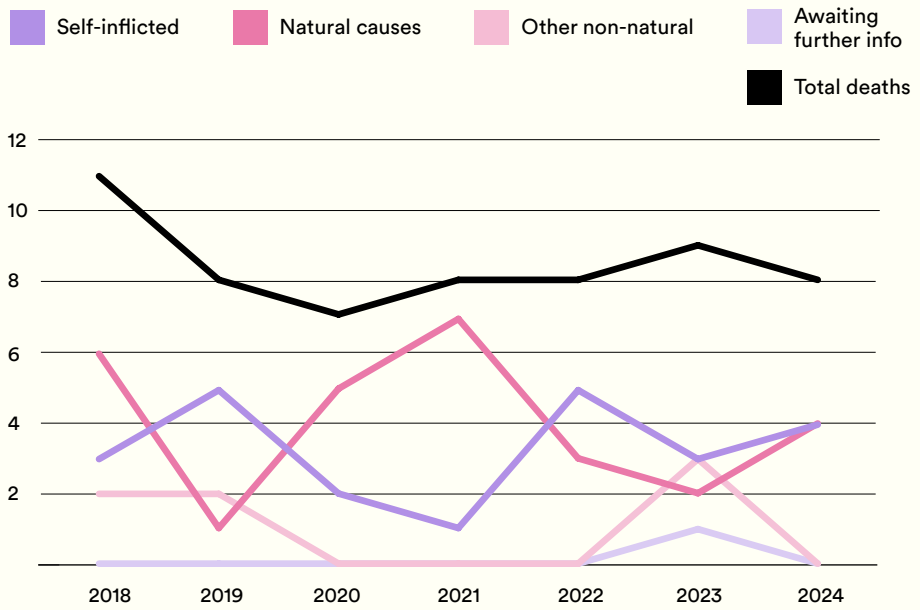
Data analysis

The data presented in this report comes from data published by the Ministry of Justice annually. INQUEST separated the raw data into men's and women's prisons, and here we present our analysis.

In total, from 2018 - 2024, 59 people died in women's prisons. Almost a quarter of these deaths, 14, occurred at HMP Styal, more than any other prison. Deaths in this prison prompted the 2007 Corston Report.

The prison where both Kay Melhuish and Ann-Marie Roberts died, HMP Eastwood Park, reported 9 deaths.

Graph 1 Number of deaths from 2018 to 2024

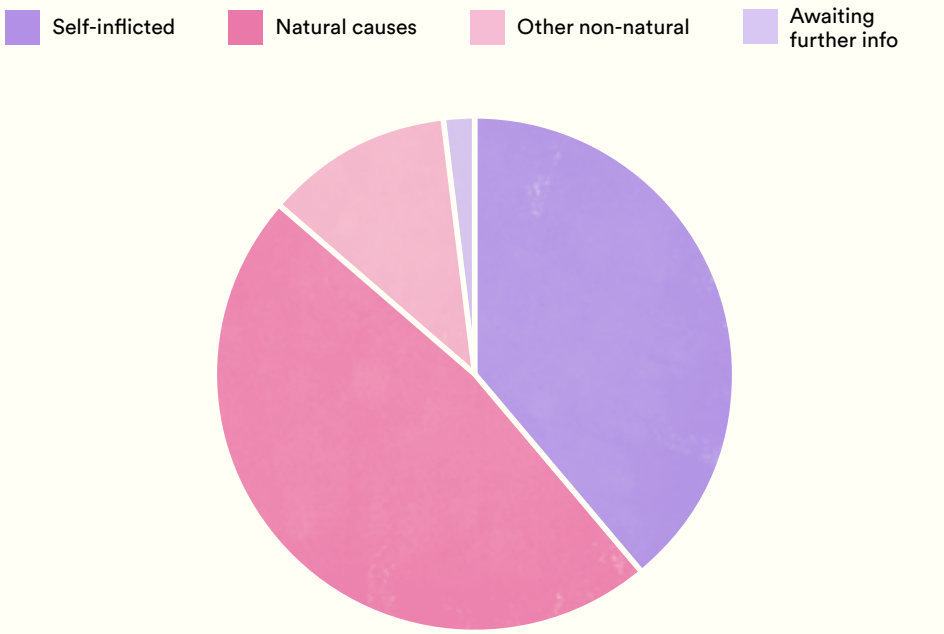


Graph 1 shows the number of deaths from 2018 to 2024, with the total number of deaths per year ranging from 7 in 2020 to 11 in 2018.

Self-inflicted deaths have ranged from 1 to 5 per year, with peaks in 2019 and 2022 of 5 deaths. Natural causes deaths peaked in 2021, with 7 deaths categorised as such. Other non-natural deaths peaked in 2023, with 3 deaths. It is important to note that deaths categorised as 'natural causes' by the Ministry of Justice often reflect failures in healthcare and the prison system.

There has only been one death categorised as awaiting further information, and other non-natural deaths have remained below 3 every year.

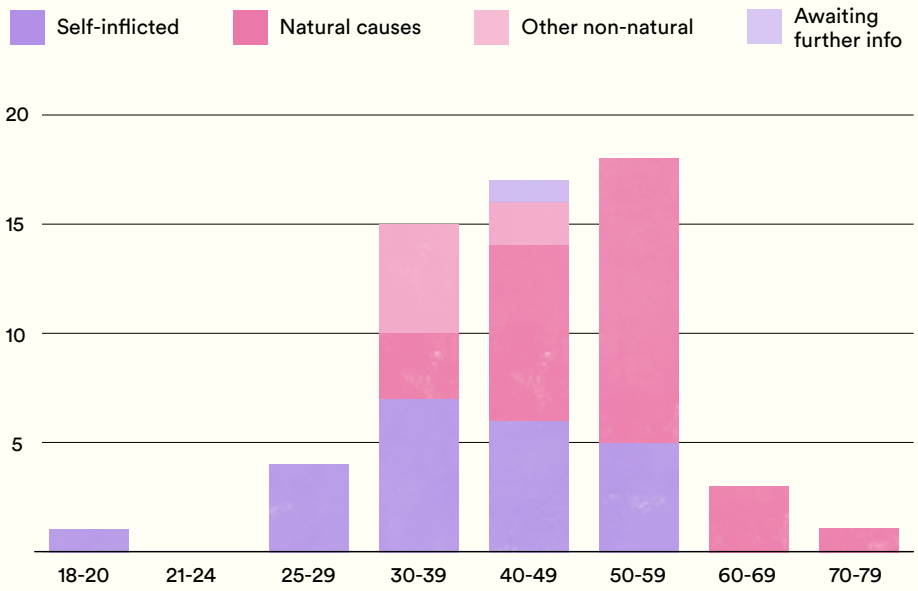
Graph 2 Proportion of self-inflicted deaths, 2018 to 2024



Graph 2 highlights the high proportion of self-inflicted deaths.

At 39%, more than a third of all deaths in prison were caused by someone taking their own life. Almost half of all deaths were classified as natural causes, but as INQUEST notes, deaths classified as natural causes often reflect failures in the prison system and healthcare provision. That 12% of deaths were categorised as other non-natural causes is also concerning, as other non-natural deaths include accidents arising from external causes, accidental overdose/ poisoning and deaths where taking a drug contributed to a death but not in fatal amounts. 47% of the deaths were classified as natural causes and 2% of the deaths as awaiting futher information.

Graph 3 Deaths by age and death category, 2018 to 2024



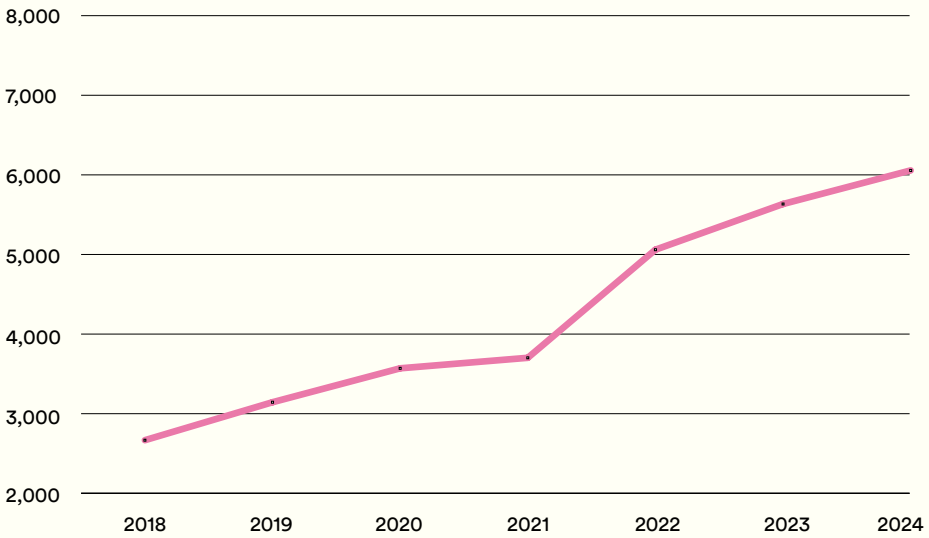
Graph 3 disaggregates the deaths by age and death category, showing how all 5 people under the age of 29 died self-inflicted deaths.

Of note, the 30 - 39 age group had the highest number of self-inflicted deaths and other non-natural deaths. Natural causes deaths were highest among the 50 - 59 age group, and the highest number of deaths occurred within this age category.

More broadly, the graph highlights how the majority of people who died were between 30 and 59 years old, which is a significantly lower age to die compared to the general population.

A Prison and Probation Ombudsman report from 2012 highlighted that the life expectancy of a person in prison was 56 years old,[65] whereas the life expectancy at birth between 2010 - 2012 was 79 for boys and 83 for girls.[66]

Graph 4 Rate of self-harm incidents from 2018 to 2024



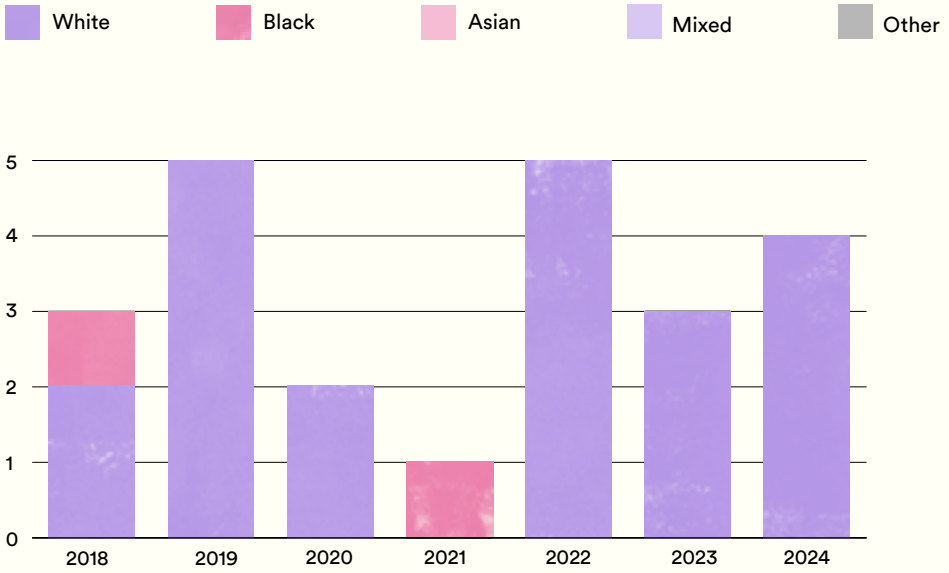
Graph 4 highlights the rapid rise in the rate of self-harm incidents, measured as the number of incidents per 1,000 prisoners, in women's prisons from 2018 to 2024.[67]

The rate of self-harm has now reached an all-time peak since records began in 2004. From 2018 to 2024, self-harm incidents rose from over 2,500 incidents to more than 6,000 incidents per 1,000 prisoners.

The Independent Monitoring Board's 2024 annual report reported that there was a contingent of women who repeatedly self-harmed.[68]

HMPPS noted in their analysis of use of force from 2018 to 2023 that self-harm appears to be the pre-cursor to force being used on young women.[69] 5% of women who experienced force did so more than 10 times.[70]

Graph 5 Ethnicity of self-inflicted deaths in prison, 2018 to 2024



The Ministry of Justice only provides data on the ethnicity of those who died self-inflicted deaths in prison.

The graph shows that since 2018, the vast majority of those who have taken their own life in prison are White. One Black person took their own life in 2018 and another Black person took their life in 2021.

05

Conclusion

Jail death of city woman

A Norwich woman ... unconscious and ... vered in bruises on a ... olloway prison cell ... or had made repeated ... tempts to kill herself, ... inquest heard yester- ... y.

... Christine Scott, aged ... died later in hospital ... m a subdural hemorrage ... the St. Pancras ... roner, Dr. Douglas ... ambers, said there was ... evidence that she had ... n hit.

... Scott was serving a ... nths prison sentence for ... window, ... by ... magistrates.

... inquest was told by Dr. ... Berry that the magistrates ... ignored a call by psychiatrists ... Mrs. Scott to be given hospital ... ment.

PUBLIC

... Berry, the medical officer at ... lowav, said she was examined ... psychiatrists while on remand, ... cause of her inability to cope ... the community. I felt she ... uld be in hospital and recom- ... ended it to the court," he said. ... was so concerned that she ... been sent to prison that he ... ptioned the court to find out ... and was told that the magis- ... es felt the public should be ... cted.

... he saw her during her ... nd remand in custody she was ... aming, agitated and disturbed ... she had apparently tried to ... ng herself in the bath. He ... ght she was schizophrenic.

Mrs. Christine Scott, who was ... prison cell and ...

"I felt Mrs. Scott had reacted ... disproportionately to this sentence," he added.

Prison officers told how after the sentence Mrs. Scott, of 89, Thetford Road, reacted violently, shouting, screaming and kicking ... and banging the walls of her cell.

Prison officer Susan Beddowes said that at Whittington Hospital there was not a single part of her body without a bruise.

RECORD

Mrs. Scott had made many attempts to kill herself. She was separated from her husband and five-year-old daughter and had tried to take an overdose of drugs and slit her wrists.

Prison deaths

YET another Cheshire jail – HMP Risley, Warrington – is experiencing operational difficulties (*Daily Post*, September 12).

The Chief Inspector of Prisons has criticised Risley for failing to protect sex offenders who have been subjected to physical and verbal abuse. The Inspector reported that the establishment was not monitoring or analysing to what extent, where, and why this abuse of "vulnerable prisoners" was taking place.

All prisons have a duty of care towards their inmates and a responsibility for their welfare.

My daughter, Sarah Elizabeth Campbell, aged 18, was a "vulnerable prisoner" (but for different reasons to the Risley prisoners). She went to Styal Prison, Cheshire, on January 17, 2003, and, even though she was known to be "vulnerable", she was dead by 8 o'clock the following evening.

Styal has an appalling record of six deaths (including that of my daughter) during the 12 month period August, 2002-August, 2003.

Mrs Pauline Campbell,
Malpas, Cheshire

Conclusion

The government is making a concerted effort to continue expanding the prison estate.

In June 2025, the government announced in the Spending Review that they would apportion £7 billion to the Ministry of Justice to build 14,000 additional prison places.[71] Expanding the prison estate to house more people will inevitably lead to a rise in deaths, as statistical analysis shows. The prison population is predicted to rise by 15% from 87,000 (as of November 2025)[72] to more than 100,000 by 2029,[73] while self-inflicted deaths in the same period are predicted to rise by 21%.[74]

This report evidences that despite wide-ranging and numerous reforms, deaths in women's prisons have persisted as have the issues underpinning the deaths.

This report evidences that reform is not an effective strategy to curb harm and deaths in prison. Deaths have persisted, as have the issues that underpin them. Poor responses to cell bells, deficient mental and physical healthcare provision, ineffective self-harm and suicide prevention practices and inadequate observation checks are issues that have consistently featured in deaths in women's prisons with no signs of being eradicated.

The repetition of deaths in similar circumstances across women's prisons reinforces the limitations of reform to fundamentally change prisons and improve the outcomes and lives of those inside. The fact that many of the reforms implemented since 2018 were under resourced and poorly managed only compounded their inefficacy. As our timeline showed, evaluations of reforms years later highlight that successive governments simply failed to commit or act on many of the measures. Other reforms, such as the proposal to build 500 more women's prison spaces in 2021, directly contradicted the government's stated aim of reducing the prison population.

It is clear that reform is not the answer. In order to put an end to harm and deaths in prison, a bolder approach is needed. If the government does not act now and demonstrate political will, deaths will continue to mount. Lives are at stake. Lives are in the hands of the government.

Recommendations

1. Reducing the prison population

This report adds to the already extensive evidence that demonstrates how the prison estate is an intrinsically harmful environment where people are more likely to die than if they were in the community.

To end the vicious cycle of harm, the government must commit to dismantling women's prisons and halting all prison building and expansion of existing prisons.

2. Departing from punishment

Many of the women featured in the report were experiencing severe mental health crises in the community, with some trying or threatening to take their own life, at the point at which they came into contact with the police. They should not have been punished. INQUEST is concerned about government plans[75] to expand punishment and surveillance of women in the community, such as through electronic tagging. These measures will do nothing to address womens' acute needs and risk extending some of the known harms of imprisonment into the community.[76] [77]

INQUEST recommends the government reconsiders its plan to extend the punishment of women in the community in recognition of the harm it could cause.

3. Towards care and dignity

If the people included in this report had in the first instance been met with care, treated with dignity, provided appropriate treatment for their mental and physical ill health, it is unlikely they would have come into contact with the criminal justice system. Prison compounded their existing issues, dehumanised them and contributed to their deaths. Had this not been the case, they may still be alive.

In order to reduce imprisonment, the government must ensure that people's material needs are met through investing in community-based services such as welfare, housing, specialist drug and alcohol services, and education, alongside gender-specific services such as women's centres and refuges.

Endnotes

1 https://assets.publishing.service.gov.uk/media/5b3349c4e5274a55d7a54abe/female-offender-strategy.pdf

2 https://www.inquest.org.uk/still-dying-on-the-inside-report

3 https://abolitionistfutures.com/history-of-uk-prison-abolition#:~:text=Time%20has%20come%20for%20abolitionist,the%20UK%20since%20the%201970's

4 https://abolitionistfutures.com/latest-news/alternatives-to-holloway

5 https://prisonreformtrust.org.uk/wp-content/uploads/2022/08/The-Corston-Report.pdf

6 https://workingchance.org/latest/corston-report-whats-changed-since-it-was-commissioned-15-years-ago/

7 https://www.inquest.org.uk/still-dying-on-the-inside-report

8 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingseptember2024

9 https://www.womeninprison.org.uk/news/womens-prison-population-rise-projected-up-to-4100-by-september-2028-by-ministry-of-justice/

10 https://www.eastsuffolk-libdems.org.uk/news/article/uk-has-the-highest-prison-population-in-the-eu#:~:text=Lead%20researcher%20Professor%20Marcelo%20Aebi,80%2C000%20mark%20in%20recent%20years

11 https://www.libertyhumanrights.org.uk/issue/the-governments-plans-to-criminalise-poverty/

12 https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2025

13 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

14 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

15 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

16 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

17 https://www.womeninprison.org.uk/news/double-disdvantage/

18 https://www.womeninprison.org.uk/news/double-disdvantage/

19 https://prisonreformtrust.org.uk/wp-content/uploads/old_files/Documents/Still%20No%20Way%20Out%20summary%20report.pdf

20 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

21 https://news.un.org/en/story/2016/06/532932

22 https://www.gov.uk/government/statistics/estimates-of-children-with-a-parent-in-prison/official-statistics-in-development-estimates-of-children-with-a-parent-in-prison

23 https://prisonreformtrust.org.uk/wp-content/uploads/2024/02/Winter-2024-factfile.pdf

24 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

25 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

26 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

27 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

28 https://prisonreformtrust.org.uk/wp-content/uploads/2025/02/Winter-2025-factfile.pdf

29 https://assets.publishing.service.gov.uk/media/5b3349c4e5274a55d7a54abe/female-offender-strategy.pdf

30 https://assets.publishing.service.gov.uk/media/5d308fd6ed915d2feaf5f887/HMPPS_Annual_Report_and_Accounts_2018-19__web_.pdf

31 https://prisonreformtrust.org.uk/the-government-has-met-less-than-half-of-female-offender-strategy-commitments-almost-three-years-on/

32 https://www.nao.org.uk/wp-content/uploads/2022/01/Improving-outcomes-for-women-in-the-criminal-justice-system.pdf

33 https://assets.publishing.service.gov.uk/media/63d8d9b78fa8f51884b98716/farmer-review-women-progress-update.pdf

34 https://assets.publishing.service.gov.uk/media/63d8d9b78fa8f51884b98716/farmer-review-women-progress-update.pdf

35 https://assets.publishing.service.gov.uk/media/63d8d9b78fa8f51884b98716/farmer-

review-women-progress-update.pdf

36 https://www.gov.uk/government/news/extra-funding-for-organisations-that-steer-women-away-from-crime

37 https://assets.publishing.service.gov.uk/media/657038559462260705c569a7/15.35_HMPPS_Annual_Report_and_Accounts_2021-22_WEB_4_.pdf

38 https://www.womeninprison.org.uk/news/joint-letter-to-the-justice-secretary-on-the-planned-500-prison-places-for-women/

39 https://assets.publishing.service.gov.uk/media/63d78f63e90e0773e01f8960/female-offender-strategy-delivery-plan-2022-25.pdf

40 https://www.gov.uk/government/publications/female-offender-strategy-delivery-plan-progress-report/female-offender-strategy-delivery-plan-one-year-on-progress-report

41 https://www.theguardian.com/society/2024/dec/22/womens-centres-england-and-wales-funding-gap-more-prison-sentences-experts-warn

42 https://www.wbg.org.uk/article/womens-organisations-delivering-the-womens-centre-model-are-struggling-to-survive/

43 https://committees.parliament.uk/publications/44543/documents/221337/default/

44 https://www.gov.uk/government/groups/womens-justice-board

45 https://assets.publishing.service.gov.uk/media/682d8d995ba51be7c0f45371/independent-sentencing-review-report-part_2.pdf

46 https://www.gov.uk/government/news/new-law-to-ensure-fairness-for-all-in-court

47 https://bills.parliament.uk/bills/4012

48 https://www.thejusticegap.com/complex-sentencing-bill-aims-for-ambitious-reforms-but-fails-to-curb-sentence-inflation/

49 https://imb.org.uk/document/independent-monitoring-board-2024-national-annual-report/

50 https://www.inquest.org.uk/deaths-in-prison-a-national-scandal

51 https://prisonreformtrust.org.uk/adviceguide/accommodation-and-living-conditions-in-prison/#:~:text=replaced%20as%20necessary%27-,Cell%20call%20system,of%20the%20cell%20certification%20process.

52 Natasha Chin, a Black woman with drug and alcohol dependencies, died in the same prison, HMP Bronzefield, after her cell bell was not answered to in 2016.

53 https://webarchive.nationalarchives.gov.uk/ukgwa/20240415095405/https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/changing-patterns-of-substance-misuse-in-adult-prisons-and-service-responses/

54 https://howardleague.org/wp-content/uploads/2022/04/APPG-womens-health-and-well-being-FINAL.pdf

55 https://assets.publishing.service.gov.uk/media/6720ae033758e4604742a838/prison-safety-policy-framework.pdf

56 https://assets.publishing.service.gov.uk/media/6720ae033758e4604742a838/prison-safety-policy-framework.pdf

57 https://imb.org.uk/document/independent-monitoring-board-2024-national-annual-report/

58 https://www.theguardian.com/society/2016/nov/28/one-prison-suicide-every-three-days-england-and-wales-say-reformers

59 https://www.inquest.org.uk/news-cjs-mental-health#:~:text=Imprisonment%20can%20also%20induce%20and%20exacerbate%20existing,report%20Fergus%20articulated%20their%20experience%20of%20prison:

60 https://welevelup.org/active-campaigns/pregnancy-in-prison/

61 https://www.gov.uk/government/statistics/hmpps-annual-digest-april-2023-to-march-2024/hmpps-annual-digest-2023-to-2024#mother-and-baby-units-mbus-pregnant-prisoners-and-births

62 https://hmiprisons.justiceinspectorates.gov.uk/hmipris_reports/annual-report-2024-25/

63 https://www.thejusticegap.com/joint-submission-to-prison-drugs-inquiry-highlights-systemic-issues-in-current-regime/

64 https://decriminalisation-map.talkingdrugs.org/

65 https://business.senedd.wales/documents/s90473/HSP15%20-%20Older%20Peoples%20Commissioner%20for%20Wales.pdf

66 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/interimlifetables/englandandwales20102012

67 https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2025

68 https://imb.org.uk/document/independent-monitoring-board-2024-national-annual-report/

69 https://assets.publishing.service.gov.uk/media/68093394e4d2b76ccfb527a0/Use_of_Force_Evaluation_Report.pdf

70 https://assets.publishing.service.gov.uk/media/68093394e4d2b76ccfb527a0/Use_of_Force_Evaluation_Report.pdf

71 https://www.gov.uk/government/publications/spending-review-2025-document/spending-review-2025-html

72 https://www.gov.uk/government/publications/prison-population-weekly-estate-figures-2025

73 https://www.gov.uk/government/statistics/prison-population-projections-2024-to-2029/prison-population-projections-2024-to-2029#:~:text=Table_title:%201.%20Total%20prison%20population%20projection%20and,%7C%20Total:%2099%2C800%20%7C%20Recall:%2013%2C900%20%7C

74 https://iapdeathsincustody.independent.gov.uk/news/urgent-action-needed-to-address-rising-deaths-in-custody-says-iapdc-in-new-report/

75 https://bills.parliament.uk/bills/4012

76 https://www.womeninprison.org.uk/news/weve-graded-the-uk-governments-sentencing-bill-efforts-to-transform-the-justice-system-for-women/

77 https://www.familiesoutside.org.uk/content/uploads/2019/04/In-Brief-14-digital.pdf

INQUEST

Truth Justice Accountability

Charitable Trust Registered Charity No.1046650 | Registered Company No. 03054853