

For immediate release
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HIGHLY CRITICAL VERDICT AT INQUEST INTO THE DEATH OF ANNE MARIE BATES

The jury at the inquest into the self-inflicted death at HMP Brockhill of Anne Marie Bates today returned a highly critical narrative verdict. The inquest was held before HM Coroner for Worcestershire Victor Round sitting at Worcester Coroner's Court and lasted five weeks.

Anne Marie Bates was found hanging in her cell at HMP Brockhill on 31 August 2001. She was the mother of three children, the youngest born prematurely just two weeks before Anne Marie was remanded into custody. A judge indicated she should have been placed in a bail hostel, but as no-one found her a place she remained in prison until she died.

Anne Marie had a history of serious drug dependency and she had been identified as being at risk of suicide and self harm, but at the time of her death no care plan was in place despite her vulnerability.

In their verdict, the jury found that Anne Marie died an "Accidental death by applying a ligature to herself while not intending to take her life".

The full narrative of their verdict was:

We the jury find there were a number of contributory factors to Anne Marie Bates' death. The most significant issues were:

- 1) Anne Marie's placement on A Wing was inappropriate due to her vulnerability.*
- 2) There was inadequate support for Anne Marie to deal with the bullying on A Wing between 26/08/01 and 31/08/01. This is with particular reference to the final hour of her life during the sanitation period.*
- 3) There is sufficient evidence that there was an inappropriate relationship between a prison officer and an inmate. We are satisfied this was the driving force behind Anne Marie's inappropriate transfer to A Wing.*
- 4) Ann Marie's withdrawal from drugs may have played a part in her state of mind but we cannot be sure of her psychological state.*
- 5) We feel initial FS2052SH process for Anne Marie was inadequate. She should have been placed back on the FS2052SH at some point after the 12th August 2001.*

6) *We are all agreed that the confusion surrounding Anne Marie's bail application did have an effect on her state of mind. Her overwhelming confusion and the lack of legal cohesion also had an effect.*

7) *We feel Anne Marie's concerns for the care provisions for [her son] had a contributory effect on her state of mind.*

Anne Marie's father Ron Brayson said:

Violet and I are pleased with the jury's verdict and all of the evidence that has been heard over the last five weeks. We always knew Anne Marie should not have died. We have been waiting for five years and the inquest vindicates what we have always believed. We are grateful that some prison officers had the courage and honesty to come forward and tell the truth. We still want to know what will happen to those prison staff who failed Anne Marie. What really matters is Anne Marie did die and nothing will bring her back for us and her three children.

Helen Shaw, Co-director of INQUEST said:

That it has taken nearly five years for this tragic and unnecessary death to be subject to public scrutiny is unacceptable. The evidence heard at the inquest demonstrates clearly that Anne Marie did not receive the care she needed in the final days and hours of her life. Following the highly critical verdict and damning evidence heard at the inquest it is crucial that the Prison Service make a statement about what steps they will be taking to hold to account those staff who failed Anne Marie.

The inquest and investigation system must be reformed urgently to ensure other families do not wait for so long to find out the truth and that action is taken so that more women do not die in similar circumstances.

The family was represented at the inquest by barrister Nick Brown from Doughty Street Chambers instructed by Jane Deighton of Deighton Guedalla solicitors.

Notes to Editors

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.

FS2052SH is the monitoring form used to record notes on the care of prisoners believed to be at risk of suicide and self-harm.

Further Information	
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