INQUEST
Working for truth, justice and accountability

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JURY RETURN CRITICAL VERDICT ON 'DEARTH OF EFFECTIVE ALTERNATIVES' FOR WOMEN IN THE JUSTICE SYSTEM

Today the jury at the inquest into the death of Mandy Pearson before HM Coroner Mr. David Hinchliff sitting at Wakefield Coroner's Court returned a critical verdict into her death.

Mandy Pearson was found hanging in a dormitory cell in the Health Care Centre at HMP New Hall on 11 October 2004. Mandy had a long history of serious self harm and mental health difficulties but despite persistent and regular threats of suicide and self harm, Mandy was never placed on the suicide and self harm monitoring procedure in the weeks before her death.

In their narrative verdict, the jury stated that prison "was not the best option for Mandy and for others in a similar position…there appears to be a dearth of effective alternatives which means they are imprisoned within the justice system."

The jury highlighted shortcomings in the prison's management of Mandy's risk of self harm stating "Mandy was seen by a number of staff who made an assumption that she was under 2052 action [suicide watch]. This highlighted clear inadequacies in the communication systems between healthcare staff and staff of other agencies within New Hall".

They went on to state that "there was a lack of appropriate training and inadequate support of the staff responsible at the time as well as confusion over the interpretation of local instructions [prison's internal procedures]."

Anne Owers, the Chief Inspector of Prisons, giving evidence at inquest said, *"we are too often using our prisons as a default setting for those for whom we do not have the appropriate resources to look after in the community."*

Cynthia Keast, Mandy's mother said,

> *"I would like to thank the jury for the attention and thoroughness in which they examined the circumstances of my daughter's tragic death. Mandy is much missed by family and friends. I hope that lessons will be learnt and changes will be made so that women like Mandy receive appropriate care and support outside prison.*

Deborah Coles, co-director of INQUEST said,

> *"Once again an inquest jury have criticised the prison service for institutional failures and management incompetence. The government urgently needs to address the issue of women with mental health problems being inappropriately placed in prisons which*

can not keep them safe. It is imperative these concerns are taken on board by Baroness Corston's review of vulnerable women in prison."

The family were represented by INQUEST Lawyers Group members Fiona Borrill of Lester Morrill Solicitors, Leeds and barrister Leslie Thomas of Garden Court Chambers.

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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.