

Human
Rights

The Hurt Inside

The imprisonment of women and girls in Northern Ireland



NORTHERN
IRELAND
HUMAN
RIGHTS
COMMISSION

Revised edition

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The imprisonment of women and girls in Northern Ireland Revised Edition

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NORTHERN
IRELAND
HUMAN
RIGHTS
COMMISSION

June 2005
ISBN 1 903681 55 3

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FOREWORD

Following the publication of this report in October 2004 there have been several developments of significance regarding the imprisonment of women and girls in Northern Ireland. As this report notes, in June 2004 women prisoners were transferred from Mourne House Women's Unit at Maghaberry Prison to Ash House, a unit within Hydebank Wood, a male young offenders' facility. In November 2004 the Criminal Justice Inspectorate for Northern Ireland, assisted by Her Majesty's Inspectorate for England and Wales (the Prisons Inspectorate) carried out an unannounced inspection of Ash House. The report on this inspection was published, together with the Northern Ireland Prison Service response at the end of May 2005. The inspection was heavily critical of the regime in Ash House and recommended the development of a discrete women's custody facility for Northern Ireland. It is the intention of the Human Rights Commission to respond fully to the inspection report. That response will include further primary research conducted with women prisoners and former prisoners following the transfer.

This edition of the October 2004 report includes an updated account of the Annie Kelly case, the inquest into her death held in Belfast in November 2004 and the Secretary of State's response to concerns raised by the jury and the Belfast Coroner, Mr John Leckey. The researchers gave evidence to the inquest and the Human Rights Commission observed its progress. Given the seriousness of the issues raised by the jury in its narrative verdict, it was considered important to include this sequence of events in this revised edition.

Finally, the first edition of this report recommended that the powers of the Human Rights Commission be increased to enable it to carry out investigations thoroughly and effectively. The Human Rights Commission welcomes the December 2004 announcement by the Secretary of State that the Commission is to be granted powers of access to places of detention in Northern Ireland, although we still await details of the proposed amendments.

Ms Paddy Sloan
Chief Executive

June 2005



THE AUTHORS

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Phil Scraton is Professor of Criminology in the Institute of Criminology and Criminal Justice, School of Law at Queen's University, Belfast. His doctorate focused on police powers and the politics of accountability and his main research interests are: the criminalisation of children and young people; deaths in custody and other controversial circumstances; public inquiries, inquests and the experiences of the bereaved; imprisonment.

He has written widely in academic journals and in texts on critical criminology, social justice and human rights. His books include: *In the Arms of the Law: Coroners' Inquests and Deaths in Custody* (Pluto Press, 1987), (with Kathryn Chadwick); *Law, Order and the Authoritarian State* (Open University Press, 1987), (ed); *Prisons Under Protest* (Open University Press, 1991), (with Joe Sim and Paula Skidmore); *'Childhood' in 'Crisis?'* (UCL Press, 1997), (ed); and *Hillsborough: The Truth*, (Mainstream Publishing, 1999, revised 2000).

He was a principal researcher within a team researching the welfare and rights of children for the Northern Ireland Commissioner for Children and Young People, *Children's Rights in Northern Ireland* (NICCY, 2005) and was recently awarded a visiting professorship to Monash University, Australia researching the deaths of women in custody.

Linda Moore

Dr Linda Moore has been investigations worker with the Northern Ireland Human Rights Commission since January 2000. Previously she worked with NIACRO's youth justice unit and as lecturer in criminology at the Centre for Studies in Crime and Social Justice, Edge Hill University College.

Linda co-authored (with Dr Ursula Kilkelly and Dr Una Convery) *In Our Care*, the report of the Commission's investigation into the care of children in juvenile justice centres in Northern Ireland. She has also published on policing issues including *Human Rights on Duty: Principles for Better Policing: International Lessons for Northern Ireland* (CAJ, 1997) (with Mary O'Rawe). She was a principal researcher on a team based at QUB researching the welfare and rights of children for the Northern Ireland Commissioner for Children and Young People, *Children's Rights in Northern Ireland* (NICCY, 2005). Linda recently acted as Guest Inspector on the Criminal Justice Inspectorate inspection of the Juvenile Justice Centre at Rathgael.



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FOREWORD TO 1ST EDITION

People held in detention, whether in prison or otherwise, are particularly vulnerable to breaches of their human rights. The 'closed' nature of prison regimes makes it very important that they are open to inspection and investigation by a range of bodies concerned with the care and human rights of those inside. This is all the more crucial because many people who are in prison, especially women prisoners, were vulnerable prior to their detention, through factors such as mental health problems, educational difficulties, drug and alcohol related issues and sexual abuse.

Because of the special vulnerability of people in detention, the Northern Ireland Human Rights Commission decided to make the human rights of prisoners one of its strategic priorities. Several particular factors led to the Commission's decision to carry out research into the care of women prisoners in Maghaberry Prison. In September 2002 the death of 19-year-old Annie Kelly in the Mourne House women's unit at Maghaberry prison concerned the Commission greatly. Early in 2003 the Prisons Inspectorate published a highly critical report based on its May 2002 inspection of Mourne House. In April 2003 several Human Rights Commissioners visited Mourne House and were deeply concerned at aspects of the treatment of women that they witnessed. The Commission consequently decided to conduct research into the care of women in prison in Northern Ireland and commissioned Professor Phil Scraton of Queen's University to work alongside Commission staff in carrying out the research.

The findings of the research are alarming and a number of important recommendations are made. The Commission is keen that a wide range of bodies be involved in discussing these recommendations, since they have the potential to impact very significantly on the future of women's imprisonment in Northern Ireland. We believe that there must also be accountability for the breaches of the rights of women prisoners which occurred between the time of the 2002 inspection and the closure of Mourne House in June 2004. The women have now been moved to Hydebank Wood, the site of a male Young Offenders Centre. The Commission views this move as an entirely inappropriate location for imprisoning women.

I would like to thank Professor Scraton for his dedication in conducting this research – he worked tremendously hard and his commitment to the rights of the women and girls was always evident. The Commission would also like to thank the Northern Ireland Prison Service for its co-operation with the research. This



had been positive until its disappointing refusal on 15 June 2004 to grant the researchers further access. The researchers have asked me to thank the staff at Mourne House – discipline officers and professional staff – for their generosity and openness in talking to and assisting the researchers, the Prison Officers’ Association at Mourne House, who were extremely helpful, as were the Maghaberry Board of Visitors. Most of all we extend our appreciation to the women in Mourne House. It is clear from the research that they gave both of their time and of themselves in being so open in interviews which were undoubtedly extremely painful for some. We hope that when they see the report they will feel that their efforts were worthwhile. The point of producing informed research reports like this is to try to prevent breaches of human rights in the future and to promote a human rights culture. It is in this spirit that we publish this research. We hope that those in authority will listen.

Brice Dickson
Chief Commissioner

October 2004



EXECUTIVE SUMMARY

1. In July 2003 the Northern Ireland Human Rights Commission decided to conduct research into the human rights of women in prison in Northern Ireland.
2. The research remit was to examine 'the extent to which the treatment of women and girls in custody in Maghaberry Prison is compliant with international human rights law and standards, and in particular with Articles 2 and 3 of the European Convention on Human Rights'.
3. The final report of the research makes recommendations to the Northern Ireland Prison Service and to other bodies with statutory responsibility for prison issues. As is standard practice following any major piece of work, the Commission will monitor the extent to which its recommendations are accepted and will report accordingly.
4. Factors contributing to the decision to conduct the research included: the particular interest of the Commission in the rights of detained people; the death of 19-year-old Annie Kelly in Mourne House, Maghaberry in September 2002; the publication of a highly critical Prisons Inspectorate report on Mourne House (the inspection was conducted in May 2002 and the report was published in February 2003); and a visit by members of the Commission to Mourne House in April 2003.
5. The research fieldwork was carried out in Mourne House during March and April 2004, with further visits to the prison in May. Access granted by the Prison Service to the researchers was excellent. Interviews were held with: women prisoners; prison officers; professionals working in the prison including education, probation, healthcare staff and clergy; the Mourne House branch of the Prison Officers' Association; the Maghaberry Board of Visitors. The researchers also observed the Mourne House regime and routines.
6. Using semi-structured interviews, the research focused on: reception and induction; prison routine; education; activities and programmes; physical and mental healthcare; discipline; contact with families; relationships between prisoners and prison officers; and preparation for release.
7. Inevitably, the proposed transfer of women prisoners to a refurbished house at Hydebank Wood, a male young offenders'

centre, became a significant and pressing focus of the research. On 23 April 2004, the Commission recommended that the Prison Service abandon the proposed move and consult with interested parties to consider the development of a long term strategy for holding women in prison. On 18 June 2004, the *Report on the Transfer of Women from the Mourne House Unit, Maghaberry Prison to Hydebank Wood Young Offenders' Unit* was published by the Commission based on this research. The transfer took place on 21 June 2004.

8. During the research a series of significant and troubling events took place. These included: the proposed transfer to Hydebank Wood; the death of Roseanne Irvine in her cell in Mourne House during the first days of the fieldwork; two serious suicide attempts; the involvement of the authors in legal proceedings relating to a 17-year-old child held in isolation; a hunger strike involving a Republican woman prisoner; the suspension and eventual dismissal of prison officers allegedly engaged in 'inappropriate relationships' with women prisoners.
9. On 15 June 2004 the researchers were refused access to enter Mourne House to assess the conditions under which a 17-year-old child, who had spent four weeks isolated in strip conditions in the punishment block, was being held. The researchers had no option but to agree to a governor's instruction to interview the child in the visiting area of Mourne House.
10. A subsequent request by the Chief Commissioner to grant access to the researchers to visit Hydebank Wood YOC and in particular, to assess the conditions in which the 17-year-old girl was being held, was refused. The Prison Service imposed a ban on access which subsequently was extended to other research.
11. The problem regarding access demonstrates the inadequacy of the Commission's powers and the negative impact this can have on the work of the Commission. A key recommendation of this report is that the investigatory powers of the Commission be increased to ensure its effectiveness in investigating alleged breaches of human rights.
12. Between June 2003 and May 2004, 167 women were sentenced and 137 remanded. Total receptions, therefore, numbered 304. A third of all admissions were for fine default and the majority of those sentenced (109) received tariffs less than three months. This statistical 'snapshot' raises the

question of the appropriateness of a prison sentence for women whose offending behaviour is minimal. Given that four admissions were children aged 14 to 17 and a further undisclosed number aged 17, a further issue is the sentencing of children to an adult prison. Month by month the average population was 25, with 17 in July 2003 as the lowest and 34 in February 2004 as the highest.

13. Given the severity of the Chief Inspector's criticisms following the inspection visit in 2002, and the revelation that the Northern Ireland Prison Service had no dedicated policy or strategic plan for the treatment of women in custody, it was reasonable to expect that addressing the Inspectorate's recommendations would have been a priority.
14. On the contrary, the research found that far from responding to the Inspectorate's concerns, the overall regime in Mourne House had deteriorated significantly. There was no Prison Service policy statement or strategy documentation addressing the particular needs of women and girls in prison, there was no dedicated governor responsible solely for the management of women in prison and no gender specific training for prison management or officers. Approximately 80 per cent of prison officers allocated to Mourne House were men and it was not uncommon for the night guard duty to be all male.
15. The research found that serious policy matters with profound implications for the health and welfare of women and girl prisoners were decided on an *ad hoc* basis. For example, there was no policy regarding the separation of politically affiliated prisoners, no policy regarding the admission of sex offenders to a community of women - some of whom had histories of enduring abuse, and no policy for the accommodation and protection of child prisoners.
16. The research found a regime in operation that neglected the identified needs of women and girl prisoners, lacked creative or constructive programmes to assist their personal or social development, compromised their physical and mental health and that failed to meet minimum standards of a 'duty of care'.
17. While accepting that the Northern Ireland Prison Service, and Maghaberry in particular, is emerging from a prolonged period of poor industrial relations, the stagnation of the regime and the systemic complacency within its operation, has caused considerable and persistent suffering for the women and girls held in Mourne House. It also caused intense and openly

voiced frustration for those prison officers and professional workers committed to change and progress.

18. The research found a regime in which women were regularly locked in cells for 17 hours a day, workshops were permanently closed and education classes rarely held. The only regular organised activity was horticulture which was offered to sentenced women only. For many women the regime consisted of being locked alone in their cells with a television for extended periods of time.
19. The high level of security, dating back to the operation of a regime for political prisoners, was inappropriate. For example, women were not permitted to attend education classes a short distance from their cells, unless escorted by prison officers.
20. Women received little or no support on reception and there was no structured induction programme or adequate information provision. Structured sentence management or resettlement programmes recommended by the Inspectorate had not been addressed.
21. The right of women in prison and their children to a meaningful family life was not respected. Women were restricted to brief periods of unlock during which they could make telephone calls to their children. For nine consecutive days over Christmas women had no evening unlock or association. There was an absence of appropriate arrangements for special or enhanced family visits. The restrictive regime caused unnecessary suffering for women, their children and their families.
22. The research found that Mourne House was an unsuitable environment for the imprisonment of child prisoners. There were no age-appropriate programmes and prison staff had no training in the management of child, or young, prisoners. There was no child protection policy available. It is recommended that children under 18 years of age should not be held in Prison Service custody.
23. The punishment and segregation 'block', or special supervision unit, was an inappropriate environment for the location of distressed and self-harming women and girls. Strip conditions comprised a plinth with no mattress and no pillow, an indestructible gown and blanket and a potty for a toilet, without access to a sink. There was no other prison furniture and no 'humanising features' in the cells. These conditions

were degrading and inhumane and, possibly, in breach of Article 3 of the European Convention on Human Rights (ECHR). Certainly, for those under 18, these conditions constitute a serious breach of international standards on the rights of the child.

24. The research found that healthcare for women prisoners was dire. Other than to provide basic day support, the purpose-built Mourne House healthcare centre was closed. Women attended the male prison hospital for treatment, including accommodation in cells alongside male prisoners and shared association. Mental health provision, particularly on the residential landings, was inadequate and prison officers had received no training in offering appropriate care. The recommended provision of healthcare plans for women was routinely ignored on the landings, including for those women considered at risk of self-harm and suicide.
25. The research found that there was, and remains, a lack of adequate residential, therapeutic mental health facilities in Northern Ireland for women and girls suffering from mental health problems or diagnosed as 'behaviour disordered'. It is essential that this issue is addressed as an alternative to prison.
26. The research found that women prisoners coming into contact with male prisoners, using shared transport or in the prison hospital were routinely subjected to verbal abuse and sexual threats.
27. Since the last inspection, two women, Annie Kelly (in September 2002) and Roseanne Irvine (in March 2004) have died in Mourne House. The research raises serious concerns regarding the events leading to their deaths. It suggests that the Prison Service failed to address the profound concerns conveyed by the Belfast Coroner following the inquest into the 1996 death of Janet Holmes in Mourne House.
28. The research finds that the transfer of women prisoners from Mourne House to the Hydebank Wood YOC does not meet the recommendations made by the Inspectorate. The research concludes that Hydebank Wood, which was designed for young male prisoners, is an unsuitable environment for women and girl prisoners.

29. The research recommends that the Prison Service should declare the transfer to Hydebank Wood a temporary measure and initiate full consultation with all interested parties to develop an informed long-term strategy, appropriate operational policies and establish 'best practice' for women's imprisonment in Northern Ireland.
30. It also recommends that a discrete women's custody unit should be developed, either on the site of Mourne House or at another appropriate location. It should be managed separately and be self-contained. It should offer a regime based on an inclusive assessment of women prisoners' needs, met by gender-specific programmes and administered by trained managers and staff.
31. Given the seriousness of the research findings regarding the endemic failures of Mourne House and the need for accountability, it is essential that a further independent and public inquiry is held. Its broad focus should be the deterioration in the regime and the conditions in which women and girls were held in Mourne House, following the 2002 inspection by the Chief Inspector of Prisons and her subsequent criticisms. Its terms of reference should include:
 - the failure by the Director General and the Governor of Maghaberry to implement the Inspectorate's recommendations and the consequences for women and girl prisoners held at Mourne House from 2002 to 2004
 - the circumstances surrounding the deaths in custody of Annie Kelly in September 2002 and of Roseanne Irvine in March 2004
 - the use of the punishment and segregation unit as a location for the cellular confinement of self-harming and suicidal women, including girls, and
 - the circumstances in which prison officers were suspended and dismissed following allegations of inappropriate conduct.

Chapter 1

INTRODUCTION

Background to the report

In July 2003, the Human Rights Commission decided to conduct research into the human rights of women in prison in Northern Ireland.¹ The remit was to examine 'the extent to which the treatment of women and girls in custody in Maghaberry Prison is compliant with international human rights law and standards, and in particular with Articles 2 and 3 of the European Convention on Human Rights'.²

Chapters 1 to 3 describe the rationale for commissioning the research, its remit and the process involved in setting up the fieldwork. They then review the relevant international human rights standards and literature on the imprisonment of girls and women and provide a brief overview of the context of imprisonment of girls and women in Northern Ireland. Chapters 4 to 9 present the primary research on the Mourne House regime at Maghaberry. This includes: women's experiences of the regime; the Young Offenders' Centre in Mourne House; mental health, self-harm and suicide; the separation of paramilitary prisoners; and the transfer of women and girl prisoners from the Mourne House Unit, Maghaberry to Hydebank Wood Young Offenders' Centre. Chapter 10 summarises the research findings and brings together the range of recommendations set out at the end of each of the preceding chapters.

Recommendations are made to the Northern Ireland Prison Service and to other bodies with statutory responsibility for prison issues. As is normal practice following any major piece of work, the Commission will monitor the extent to which its recommendations are accepted and will report on this in due course.

Early in the research it became clear that the proposed transfer of women prisoners would be a significant focus of the work. This proved to be the case and, in June 2004, the Commission published a separate report, *Report on the Transfer of Women from the Mourne House Unit, Maghaberry Prison to Hydebank Wood Young Offenders' Unit*. The transfer took place on 21 June 2004.

¹ The Commission has a power to conduct research under section 69(6) of the Northern Ireland Act 1998 and to carry out investigations under section 69(8).

² Article 2 protects the right to life and Article 3 protects the right to be free from torture, inhuman and degrading treatment.

Decision to conduct the research

Separate, but interrelated, factors contributed to the Commission's decision to carry out this research. The issue of human rights for detained people has been a legitimate area of concern for the Commission since its inception in 1999. Detention, particularly in a closed institution, renders individuals especially vulnerable to human rights abuses. Further, prisoners often share backgrounds and characteristics which accentuate vulnerability. The Chief Inspector of Prisons, Anne Owers, describes this dialectic:

'It is particularly the marginalised who need the protection of human rights: by definition, they may not be able to look for that protection to the democratic process, or the common consensus. And most of those in our prisons were on the margins long before they reached prison (look at the high levels of school exclusion, illiteracy, mental disorder, substance and other abuse); and may be even more so afterwards (with difficulty in securing jobs, homes, continued treatment, and even more fractured family and community ties). Prisons exclude literally: but they hold those who already were and will be excluded in practice.'³

Because of the vulnerability of detained people, the Commission took an early decision to establish this area as a priority, taking a particular interest in children and women in custody,⁴ as well as the rights of people detained under mental health legislation.⁵

The issue of women prisoners in Northern Ireland came to the Commission's attention from a variety of sources including a recent report by the Prisons Inspectorate, Her Majesty's Chief Inspector of Prisons (HMCIP). Its inspection of the Mourne House Unit, in 2002 as part of a full inspection of Maghaberry Prison, was highly critical of the regime for women and girls held in custody.

In fulfilment of their commitment to the human rights of incarcerated people, members of the Northern Ireland Human Rights Commission periodically visit places of detention. On 28 April 2003, three Commissioners accompanied by Commission staff, visited the Mourne House Unit. They spoke with prisoners and staff.

³ Owers A (2004) 'Prison inspection and the protection of human rights' Issue 2 *European Human Rights Law Review* p 108.

⁴ The first formal investigation conducted by the Commission was into the care of children in custody. See: Kilkelly U, Moore L and Convery U (2002) *In Our Care: Promoting the Rights of Children in Custody* NIHR, Belfast.

⁵ Davidson G, McCallion M and Potter M (2003) *Connecting Mental Health and Human Rights* NIHR, Belfast.

The Commissioners were alarmed by conditions in the Unit and the Chief Commissioner, Brice Dickson, subsequently wrote to the then Director General of the Northern Ireland Prison Service expressing the most serious of these concerns.⁶ In his letter the Chief Commissioner stated:

'Generally, our view is that the facilities at Maghaberry are not appropriate for the women who are imprisoned there. We acknowledge that the relatively small number of female prisoners makes it difficult to provide facilities which are *fully* appropriate, but we nevertheless want to draw attention to a number of drawbacks with the current arrangements.'

Among Commissioners' concerns were:

- the inappropriate atmosphere in the Unit
- the lack of empathy for women prisoners displayed by officers
- the lack of privacy for women prisoners
- the high ratio of male staff, especially on night duty
- the amount of time women were locked in their cells
- the use of the punishment block where women were locked up for 23 hours per day, without access to any diversionary activity except reading the Bible
- limited access to the gym and other leisure activities, and
- difficulties regarding mail and telephone calls.

In addition to documenting concern about conditions, the Chief Commissioner's letter also referred to a 'fairly high level of frustration among prison staff regarding the difficulties associated with appropriately punishing prisoners for assaulting prison staff'.

Reference was also made to the case of Annie Kelly, a 19-year-old who died in Mourne House in September 2002: 'from what we gathered on the day of our visit, Ms Kelly was in such a disturbed state of mind for some time prior to her death that it seems incredible that she continued to be detained in a prison at all'.

The Chief Commissioner informed the Director General that it was likely that the Commission would want to conduct an investigation into the treatment of female prisoners in Northern Ireland.

⁶ Letter from the Chief Commissioner to the Director General, Northern Ireland Prison Service, 4 June 2003. In December 2004 Robin Masefield CBE took over from Peter Russell as Director General of the Northern Ireland Prison Service.

In response, the Director General strongly defended the Mourne House regime.⁷ He expressed surprise at the criticism that staff appeared to have little empathy with the prisoners: 'as we have often been complimented on the work being done with the women. Indeed, the most recent inspection by the Chief Inspector of Prisons last year reflected on the relaxed day to day interaction and the helpful and constructive approach adopted by staff'. The Director General stated that a number of the Inspectorate's 49 recommendations regarding Mourne House had already been implemented. He stated that others were 'on hold pending the outcome of a feasibility study into the possibility of accommodating women prisoners at Hydebank Wood instead of Maghaberry'.

Regarding the Commission's specific concerns, the Director General's response is summarised as follows:

- the right to privacy must be offset against a duty of care and the need for control but 'there is certainly no question of staff being unnecessarily intrusive'
- male officers are appointed to Mourne House reflecting the view that 'cross gender postings are often beneficial' (but there is a minimum requirement for a number of female staff on duty at particular times)
- evening association Monday to Saturday is provided to prisoners on standard and enhanced regimes and while this can be affected by staff deployment, 'this is no different to any other establishment'
- the gymnasium is offered three times a week
- while there had been 'teething' problems related to the new telephone system the situation had improved, and
- the system for censorship of mail had 'improved significantly'.

On the serious concern of conditions in the punishment block (or, as it is formally known, the Special Supervision Unit), the Director General reassured the Commission that the decision to place a woman there 'may only be applied following adjudication and is a decision not to be taken lightly'. Such a decision was subject to Prison Rule 32, 'if it is deemed necessary for the maintenance of good order and discipline, or is in the interests of their own safety'. Women were placed in the Special Supervision Unit for no longer than absolutely necessary. He concluded, 'it should be emphasised that whilst in the Special Supervision Unit an inmate is only removed from association with other inmates; all other privileges, appropriate to their regime level, are retained'.

⁷ Letter from the Director General, Northern Ireland Prison Service, 27 June 2003.

Regarding the potential move to Hydebank Wood, the Director General noted that, should the Prison Service's feasibility study prove favourable, the timing of the move would be affected by operational considerations, 'not least the growing total prison population, which may add pressure to accelerate the transfer'.

The Director General's reply did not acknowledge the substance of the Commissioners' concerns. Dissatisfied by this response, which failed to allay its anxieties, the Commission decided to conduct more detailed research into Mourne House.

The initial research remit specifically referred to Articles 2 and 3 of the European Convention on Human Rights (ECHR). These protect the right to life (Article 2) and the right to freedom from torture and inhuman and degrading treatment (Article 3). These principles were enacted into domestic law through the Human Rights Act 1998. The focus on Articles 2 and 3 reflects the Commission's particular interest in this area and is documented in its most recent strategic plan.⁸ It also reflects the Commission's continuing concern regarding the death of Annie Kelly in the Mourne House punishment block in 2002. The Commission is carrying out a range of work on Articles 2 and 3 and its research on prisons forms part of this larger project. The death of Roseanne Irvine in Mourne House on 3 March 2004, during the course of the fieldwork for this report, tragically underscored the significance of protecting the right to life of prisoners.

Other human rights principles are also central to the research, particularly those relating to the concerns identified by the Inspectorate. For example, consideration is required of the right to a private and family life (Article 8, ECHR), the anti-discrimination right (Article 14, ECHR) and children's rights (United Nations' Convention on the Rights of the Child) and other international conventions or rules.

Setting up the research

The Commission carried out a competitive tender for an established researcher to carry out the work in conjunction with Commission staff.⁹ Professor Phil Scraton, Professor of Criminology at the Queen's University of Belfast, was subsequently contracted in this role.

⁸ Northern Ireland Human Rights Commission *Strategic Plan 2003-2006* NIHRC, Belfast.

⁹ Tendering was carried out through the Commission's research register.

An initial meeting was held with the Director General and the Director of Operations of the Northern Ireland Prison Service in October 2003. At this meeting the Director General suggested that, as it was likely that women prisoners would shortly be moving to Hydebank Wood, it would be appropriate to postpone the research until the move was complete. He had put this view previously to the Commission in correspondence.¹⁰ Given the Commission's concerns, the researchers suggested it was vital that the regime and its operation at Mourne House be investigated *prior* to the proposed move. This would provide a baseline against which conditions for women prisoners in Northern Ireland could be evaluated, wherever their location. Further, it was anticipated that the research findings would be significant in responding to the needs of women and girls in prison and in developing a long-term strategy.

Following a constructive discussion, the Director General offered full co-operation with the research and suggested that the researchers write to the Governor of Maghaberry and to the Governor with responsibility for the Mourne House Unit explaining the remit and the proposed research methodology. This was done and a meeting with both governors took place on 11 February 2004.

Again, the meeting was constructive and full co-operation was given to the research. It was agreed that the researchers should prepare individual letters for prisoners and prison officers explaining the research and that fieldwork would begin on 1 March (see *Appendix 2*).

The main fieldwork was carried out in March and April 2004, with further visits to the prison in May. Interviews were held with: women prisoners; prison officers at different levels; professionals working in the prison including teaching, probation, healthcare staff and clergy; the Mourne House branch of the Prison Officers' Association; and the Maghaberry Board of Visitors. A full methodology is attached (see *Appendix 1*). Research questions covered all aspects of women's lives: the daily routine of the prison; education provision; activities; healthcare; discipline; contact with families; and relationships between prisoners and prison officers.

Inevitably the proposed move to Hydebank Wood became a significant and pressing focus of the research. On 23 April 2004, in response to the Prison Service's official announcement that women

¹⁰ Letter from the Director General, Northern Ireland Prison Service, 17 September 2003. While making this point, the Director General stressed that, 'we will, of course, cooperate with your investigation so far as permitted by law and reasonably practical given the other pressures we face'.

were to be transferred, the Commission issued a press statement calling on the Prison Service to abandon the proposed move. The Commission was disappointed that the Prison Service made its announcement having previously cancelled a meeting with the researchers at which concerns about the move were to be raised. Subsequently, on 18 June 2004, the Commission published its interim report on the transfer based on the initial research findings.

Early in the research it was apparent that the project would be considerably more extensive than initially envisaged. The proposed transfer to Hydebank Wood; the death of Roseanne Irvine during the first days of the fieldwork and two other serious suicide attempts; the involvement of the authors in judicial review proceedings and a bail hearing regarding the treatment of a 17-year-old girl on 23-hour lock-up in the punishment block; and a hunger strike involving a Republican woman prisoner – each of these contributed to an already complex project. Together, they delayed completion within the agreed research schedule. As several of these important issues are yet to be resolved, the research has continued through to the publication of the report.

The access to Mourne House, granted by the Prison Service to the researchers, was excellent throughout the course of the research. They were provided with passes to the Unit on a daily basis, were well accommodated and were given unrestricted access to interview staff and prisoners. However, interviews with prisoners were not permitted during the lengthy lock-down periods. The relatively short periods of unlock extended the planned research schedule as only a few interviews could be completed each day.

On Tuesday 15 June 2004, the researchers visited Mourne House to assess the conditions under which the 17-year-old child, who had spent four weeks on the punishment block, was being held. This visit was made following a request from the child's solicitor prior to her imminent bail hearing. In keeping with established practice throughout the research, Dr Moore telephoned the Unit's principal officer to notify her of the intention to visit. The visit was agreed but on arrival, and after the usual security checks, the researchers were refused access to meet the child in her accommodation. The Governor insisted that she could be interviewed only in the visiting area. Given the Commission's lack of investigative powers, the researchers had no option but to agree to the Governor's decision and the meeting went ahead in the visiting area of Mourne House.

A subsequent request by the Chief Commissioner for access for the researchers to visit Hydebank Wood YOC and, in particular, to assess the conditions in which the 17-year-old girl was being held, was

refused. The Director General wrote to the Chief Commissioner stating, 'I think a settling in period of 6 months is reasonable and if you would like to approach us again in the New Year we will carefully consider your request [for access to Hydebank Wood]'.¹¹ Dr Moore was invited to a case conference regarding the 17-year-old girl, which was to be held in Hydebank Wood, but the Prison Service informed the child's social worker that Dr Moore would be refused access to the meeting.¹²

In 2001, the Commission recommended to the Government that its powers be increased so that it may effectively carry out investigations.¹³ The current research demonstrates the inadequacy of the Commission's powers and the negative impact this has on the work of the Commission. A key recommendation of this report is that the investigatory powers of the Commission be increased to ensure that it can effectively investigate alleged breaches of human rights, to bring the Commission in to line with the UN Paris Principles. (Recommendation 1)

¹¹ Letter from the Director General, 8 September 2004.

¹² Following the appointment of Robin Masefield as Director General of the Prison Service in December 2004, the Commission was granted access to visit individual prisoners in the visiting area of Ash House and, in special circumstances, access to the 17-year-old girl (now 18) in her cell. The Commission is still refused a more general right of access to assess conditions in the prison. However, it has negotiated access to conduct follow-up research in autumn 2005.

¹³ See: Northern Ireland Human Rights Commission (2001) *Report to the Secretary of State Required By Section 69(2) of the Northern Ireland Act 1998* NIHRC, Belfast; and (2002) *Response to the UK Government's Consultation Paper on the Review of the Powers of the Northern Ireland Human Rights Commission* NIHRC, Belfast.

Chapter 2

GIRLS AND WOMEN IN PRISON

Human rights and the criminal justice system

While the research remit specifically refers to Articles 2 and 3 of the European Convention on Human Rights, the work is underpinned by a broad range of international human rights standards and law.

The Prisons Inspectorate also relies heavily on international human rights standards in setting its 'expectations' against which it measures conditions for prisoners.¹⁴ The Chief Inspector, Anne Owers, has noted:

'Each expectation is ... mapped against domestic and international human rights standards, as set out in various instruments. It is noteworthy that 96 expectations can be derived directly from binding human rights obligations.'¹⁵

There are many human rights principles which set minimum standards for the treatment of people in prison. The United Kingdom has signed up to most standards, which should be seen as laying a floor (that is, the minimum an individual should expect) rather than establishing a ceiling (that is, aspirational).

Taken as a body of principles, international standards cover every aspect of life in prison from the moment of transportation and reception, including the first days in custody, healthcare, prisoners' legal rights, education and protection from harm. They also extend to the need to seek alternatives to custody, through preventative measures, and the reintegration of prisoners into society. Most principles apply to all prisoners; some are gender or age specific and others relate to the issue of racism or other forms of discrimination in prison.

A fundamental concept, adopted by the Inspectorate, is the 'healthy prison'. It is a concept that has been developed and promoted by the World Health Organisation. In determining whether or not an establishment is 'healthy', four tests are applied:

¹⁴ See: Her Majesty's Inspectorate of Prisons (2004) *Expectations: Criteria for assessing the conditions in prisons and the treatment of prisoners* Her Majesty's Stationery Office, London.

¹⁵ Above, p 5.

1. Are prisoners held in safety?
2. Are they treated with respect and dignity as human beings?
3. Are they able to engage in purposeful activity?
4. Are they prepared for resettlement?

While the 'healthy prison' concept appears to be an oxymoron, the tests provide a framework for assessing a prison's compliance with baseline human rights standards. A prison regime which does not satisfy each test would breach baseline standards and, therefore, violate prisoners' human rights.

Taken together, the international standards constitute a significant volume of material. Some standards apply to the rights of prisoners and others to the behaviour expected of prison staff.¹⁶ There is only space here for a brief summary of the principles and, where appropriate, they are referenced throughout the report. The most fundamental principle is that detainees or prisoners should be treated humanely 'and with respect for the inherent dignity of the human person'.¹⁷

The right to life¹⁸ is fundamental as without this right other rights cannot be protected (although the right is not absolute, there being certain restrictions to its application). When a person is in the custody of the state, the state has a particular duty to safeguard their right to life.¹⁹

There have been several recent landmark cases concerning deaths in prison. The *Amin* case related to the death of teenager Zahid Mubarek who, in March 2000, was beaten to death by a racist prisoner sharing his cell in Feltham Young Offenders Institution.²⁰ Zahid Mubarek's family lawyers argued that Article 2 of the ECHR entitled the family to a public hearing and the House of Lords ruled in October 2003 that there should be a public inquiry into the death.

¹⁶ For example, UN *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*, 1990; UN *Code of Conduct for Law Enforcement Officials*, 1979.

¹⁷ UN *Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment*, 1988, Principle 1.

¹⁸ For example, *Convention for the Protection of Human Rights and Fundamental Freedoms*, 1950 (ECHR), Article 2; *Universal Declaration of Human Rights*, 1948, Article 3.

¹⁹ See: Kelly M (2005) *The Right to Life: A Practical Guide to the European Convention on Human Rights* NIHR, Belfast; Kelly M (2005) *The Right not to be Ill-treated: A Practical Guide to the European Convention on Human Rights* NIHR, Belfast.

²⁰ *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51.

The *Middleton* case concerns the suicide in prison of Colin Middleton in January 1999.²¹ The case revolved around the issue of the state's procedural obligation to investigate a death possibly involving a violation of Article 2. The House of Lords ruled in March 2004 that, while not attributing criminal or civil liability, an inquest should find out 'how' the person died, not simply by 'what means' but also 'in what circumstances'.

The *Sacker* case was taken by Helen Sacker, mother of 22-year-old Sheena Creamer, who was found dead in August 2000 while on remand at New Hall Prison.²² The coroner had ruled that the inquest jury could not attach a rider of 'neglect' to its verdict. The House of Lords judged in March 2004 that the inquest had been deprived of its ability to address the positive obligation of Article 2 to safeguard life and ruled that a new inquest should be held.

The cases of *Amin*, *Middleton* and *Sacker* together establish the important principle that deaths of people in custody should be effectively and thoroughly investigated and that the investigation should cover the measures taken to safeguard an individual's life including the circumstances in which they died. Each of these cases relates to a death that occurred before the implementation of the Human Rights Act in October 2000, yet the Lords found that the principles of the European Convention on Human Rights apply. However, in the case of *McKerr*, relating to a lethal force shooting in Northern Ireland, the Lords ruled that there should not be a new investigation into the death of Gervaise McKerr, as the killing occurred before the Human Rights Act took effect.²³

Suicides and self-harm in prisons are growing concerns throughout the United Kingdom and in Northern Ireland. Such concerns are of particular relevance regarding women prisoners, who are over-represented in the suicide and self-harm statistics. When a death occurs in custody the state has a duty to ensure that it is effectively and expeditiously investigated. In England and Wales, deaths in custody are also investigated by the Prisons Ombudsman. In Northern Ireland, at present, deaths are investigated internally by the Prison Service, the police and through the inquest system. In September 2004 the Northern Ireland Office announced that, following a consultation on the creation of such an office, a Prisoner Ombudsman for Northern Ireland would be appointed.²⁴ While welcoming this decision the Human Rights Commission noted with

²¹ *R (Middleton) v West Somerset Coroner and another* [2004] UKHL 10.

²² *R (Sacker) v West Yorkshire Coroner* [2004] UKHL 11.

²³ *In re McKerr* [2004] UKHL 12.

²⁴ In February 2005, Mr Brian Coulter was appointed Prisoner Ombudsman for Northern Ireland.

concern that there was no specific legislative provision for the Ombudsman to investigate deaths in prison custody.²⁵

Torture, inhuman and degrading treatment are prohibited.²⁶ This prohibition is absolute and there are no justifications in international human rights law for the breach of Article 3, regardless of the circumstances. At European level, it is difficult to win cases based on Article 3 as the European Court of Human Rights sets a high bar in defining treatment as torture, inhuman or degrading. Yet, in a recent judicial review in the case of *Robert Napier*, concerning his treatment in a Scottish prison, Lord Bonyon ruled that the conditions in which Mr Napier was held were 'inhuman and degrading', thus contravening Article 3. In particular, the court was critical of the practice of 'slopping out'.²⁷ As more Article 3 cases are taken to the UK courts under the Human Rights Act, the high bar might be lowered. Further, United Nations' rules state that prisoners should not be expected to wear clothing which is degrading or humiliating.²⁸

An underlying principle is that deprivation of liberty should not be increased by further unnecessary punishment or degradation:

'... imprisonment and other measures which result in cutting off an offender from the outside world are afflictive by the very fact of taking from the person the right of self-determination by depriving him of his liberty. Therefore, the prison system shall not, except as incidental to justifiable segregation or the maintenance of discipline, aggravate the suffering inherent in such a situation.'²⁹

At the moment of imprisonment, people must be promptly informed of their rights and how to avail themselves of such rights. This should be transmitted in a language they understand.³⁰ There are

²⁵ Northern Ireland Human Rights Commission submission to Parliamentary Joint Committee on Human Rights. See: United Kingdom Parliament, House of Lords, House of Commons, Joint Committee on Human Rights Third Report: Deaths in Custody, Session 2004-05 [Online], list of written evidence at: <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1517.htm> [7 June 2005].

²⁶ For example, ECHR, Article 3; UN Body of Principles, Principle 6; *Universal Declaration of Human Rights*, Article 5; and *UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 1984.

²⁷ Opinion of Lord Bonyon in petition of Robert Napier (AP) against the Scottish Ministers, [2004] Scot CS 100 (26 April 2004).

²⁸ *UN Standard Minimum Rules for the Treatment of Prisoners*, 1955, Register 17(1).

²⁹ Above, Guiding Principle 75.

³⁰ UN Body of Principles, Principle 13.

principles that establish guidelines on access to lawyers and legal services for prisoners:³¹

'All arrested, detained or imprisoned persons shall be provided with adequate opportunities, time and facilities to be visited by and to communicate and consult with a lawyer, without delay, interception or censorship and in full confidentiality.'³²

Once in custody, remand prisoners should be held separately from convicted prisoners.³³ Despite their incarceration, prisoners have a right to a private and family life.³⁴ Prisoners have a right to respect for their cultural and religious beliefs.³⁵ Where possible, prisoners should be held in institutions reasonably near their home.³⁶ The state has a duty to provide assistance to prisoners' children.³⁷ The children of prisoners also have the right to a family life and to other rights laid down in international human rights law, particularly through the UN Convention on the Rights of the Child (UNCRC).

Prisoners have rights to proper medical care and to education.³⁸ Healthcare in prison should be linked to the general health administration of the community.³⁹ If mental health services are required to facilitate the rehabilitation of a prisoner, then these should be provided.⁴⁰

Medical staff have a duty to report to prison management whenever they consider 'a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment'.⁴¹ They also have a duty to visit daily prisoners held in punishment or segregation units, and must advise management if they are concerned that the conditions of punishment are likely to be damaging to the physical or mental health of prisoners.⁴²

³¹ For example, UN *Basic Principles on the Role of Lawyers*, 1990; UN *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, 1988; UN *Standard Minimum Rules for the Treatment of Prisoners*, 1955.

³² UN *Basic Principles on the Role of Lawyers*, Principle 8.

³³ UN *Body of Principles*, Principle 8.

³⁴ ECHR, Article 8; UN *Body of Principles*, Principle 19.

³⁵ UN *Standard Minimum Rules for the Treatment of Prisoners*, 42.

³⁶ UN *Body of Principles*, Principle 20.

³⁷ Above, Principle 31.

³⁸ Above, Principles 24, 25, 26 and 28.

³⁹ UN *Standard Minimum Rules for the Treatment of Prisoners*, 22(1).

⁴⁰ Above, Guiding Principle 62.

⁴¹ Above, 25.

⁴² Above, 32.

High standards are required of staff responsible for the care of prisoners and they are expected to 'respect and protect human dignity and maintain and uphold ... human rights'.⁴³ It is 'on their integrity, humanity, professional capacity and personal suitability for the work' that the proper running of the institution depends.⁴⁴ Prison officers are expected to provide a positive role model to prisoners in their care.⁴⁵ They should also ensure the protection of prisoners' health.⁴⁶ The confidentiality of prisoners' private lives must be respected by the authorities.⁴⁷ 'Whistle-blowing' by prison personnel is protected in human rights law. Prison staff have a duty to report to management any violation or potential violation of human rights against a prisoner.⁴⁸

The state is obliged to ensure effective independent monitoring and inspection processes.⁴⁹ Prisoners have the right to communicate freely and in confidence with those responsible for the inspection and monitoring process.⁵⁰ Where there are grounds to believe that a violation of human rights has taken place, the state is under an obligation to conduct a 'prompt and impartial investigation' or ensure that an inquiry takes place.⁵¹

The United Kingdom has recently signed up to the *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, adopted by the United Nations in December 2002. The object of the Protocol is 'to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment'.

Gender-specific rights

International human rights standards are clear that providing equality for female prisoners does not mean simply treating men and

⁴³ UN *Code of Conduct for Law Enforcement Officials*, 1979, Article 1.

⁴⁴ UN *Standard Minimum Rules for the Treatment of Prisoners*, Article 46.

⁴⁵ Above, Article 48.

⁴⁶ *Code of Conduct for Law Enforcement Officials*, Article 6.

⁴⁷ Above, Article 4.

⁴⁸ UN *Body of Principles*, Principles 7 and 14; and *Code of Conduct for Law Enforcement Officials*, Article 8.

⁴⁹ *Body of Principles*, Principle 29.

⁵⁰ Above, Principle 29.

⁵¹ *Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognised Human Rights and Fundamental Freedoms*, 1999, Article 9(5).

women in the same way. Positive measures to protect women's rights are encouraged:

'... measures applied under the law and designed solely to protect the rights and special status of women, especially pregnant women and nursing mothers, children and juveniles, aged, sick or handicapped [sic] persons shall not be deemed to be discriminatory.'⁵²

Different categories of prisoners should be held in separate institutions or locations within institutions, 'taking account of their sex, age, criminal record, the legal reason for their detention and the necessities of their treatment'. So far as possible, men and women should be detained in separate institutions. In those institutions holding men and women, 'the whole of the premises allocated to women shall be entirely separate'.⁵³

In women's prisons there must be special provision for pre-natal and post-natal care. Where possible, babies should be born outside prison. When babies are permitted to stay with their mothers in prison, there should be nursery provision staffed by qualified personnel.⁵⁴

Women's prisons should be staffed predominantly by female officers: 'women prisoners shall be attended and supervised only by women officers'. Although it is permissible for male members of staff, such as doctors and teachers, to carry out professional duties,⁵⁵ male members of staff should not enter the part of the prison set aside for women unless accompanied by a woman officer.⁵⁶

The rights of children in prison custody

There are human rights standards for the general protection of children's rights. Most significant is the United Nations' Convention on the Rights of the Child (UNCRC), alongside standards specifically dealing with the treatment of children in contact with the criminal justice system. Two key sets of standards relating to the treatment of children in the criminal justice system are the United Nations' Standard Minimum Rules for the Administration of Juvenile Justice (the 'Beijing Rules'), and the United Nations' Guidelines for the

⁵² UN Body of Principles, Principle 5.

⁵³ UN *Standard Minimum Rules for the Treatment of Prisoners*, 8(a).

⁵⁴ Above, 23.

⁵⁵ Above, 53.

⁵⁶ Above.

Prevention of Juvenile Delinquency (the 'Riyadh Guidelines'). While these standards are concerned primarily with children (that is, under-18s), wherever possible, they should be applied to young adults.⁵⁷

Human rights law defines a child as being a person under the age of 18 years.⁵⁸ Because of their special vulnerability, children are given special protection. A key principle of children's rights is that in taking any decision relating to a child, the child's 'best interests' must be the paramount consideration.⁵⁹ The UNCRC standards are intended to provide protection for all children without discrimination.⁶⁰ In line with the UNCRC 'best interests' principle (Article 3), the primary objective of the juvenile justice system is 'the promotion of the well-being of the juvenile'.⁶¹

Children are also entitled to effective protection from harm.⁶² Children in detention must be held separately from adults⁶³ and the detention of children must be used only as a last resort and for the shortest possible period of time.⁶⁴ As a rule, young people coming within the jurisdiction of juvenile courts should not be sentenced to imprisonment.⁶⁵

While in custody, children retain all rights established by the UNCRC including the right to health, education and family life. The Beijing Rules state:

'While in custody, juveniles shall receive care, protection and all necessary individual assistance – social, educational, vocational, psychological, medical and physical – that they may require in view of their age, sex and personality.'⁶⁶

The commentary to the rules notes that 'medical and psychological assistance, in particular, are extremely important for institutionalised drug addicts, violent and mentally ill young persons'.⁶⁷

⁵⁷ Beijing Rules, Rule 3.3.

⁵⁸ UN *Convention on the Rights of the Child*, 1990, Article 1.

⁵⁹ Above, Article 3.

⁶⁰ Above, Article 2.

⁶¹ Beijing Rules, Commentary to Rule 5.

⁶² *Convention on the Rights of the Child*, Article 19.

⁶³ Above; Beijing Rules, Article 37 (c), Rule 13.4; UN *International Covenant on Civil and Political Rights*, 1966, Article 10.

⁶⁴ *Convention on the Rights of the Child*, Article 37 (b); Beijing Rules, Rule 13.1.

⁶⁵ UN *Standard Minimum Rules for the Treatment of Prisoners*, Preliminary Observations.

⁶⁶ Beijing Rules, Rule 13.5.

⁶⁷ Above, Commentary to Rule 26.



It is expected that the institutionalisation of young people will be avoided and, accordingly, the Beijing Rules recommend the development of 'semi-institutional arrangements, such as half-way houses, educational homes, day-time training centres and other such appropriate arrangements ...'.⁶⁸

The standards prioritise supporting programmes in families and communities for young people to 'reduce the need for intervention under the law'.⁶⁹ Preventative work is emphasised to divert young people away from the criminal justice system.⁷⁰ Diversion from the formal criminal justice system is recommended on the basis that non-intervention may be the best approach to young people's offending behaviour. This recognises academic research findings that young people tend to 'grow out of' petty criminal behaviour.⁷¹ The Riyadh Guidelines, in particular, provide a detailed list of preventative services which should be available to young people experiencing problems in their lives.

Proportionality is an important principle:

'The responsibility to young offenders should be based on the consideration not only of the gravity of the offence but also on personal circumstances. The individual circumstances of the offender (for example social status, family situation, the harm caused by the offence or other factors affecting personal circumstances) should influence the proportionality of the reactions...'.⁷²

Children are entitled to basic safeguards, such as the presumption of innocence and the right to remain silent (the latter is no longer an absolute right in England and Wales or Northern Ireland).⁷³ Their privacy should be respected to 'avoid harm being caused to her or him by undue publicity or the process of labelling'.⁷⁴

The age at which children can be held criminally responsible should take into account 'the facts of emotional, mental and intellectual maturity', should not be set too low and be in line with other rights and responsibilities in society (that is, age of consent, marriage or the voting age).⁷⁵ The low age of criminal responsibility throughout

⁶⁸ Beijing Rules, Rule 29.1.

⁶⁹ Above, Part One 1.3; Riyadh Guidelines 6 and section III on General Prevention.

⁷⁰ Beijing Rules, Part One 1.3, 1.6, 1.7

⁷¹ Above, Rule 11.

⁷² Above, Commentary to Rule 5.

⁷³ Beijing Rules, Rule 7.1.

⁷⁴ Above, Rule 8.1.

⁷⁵ Above, Rule 4.

the United Kingdom (age 10 in England, Wales and Northern Ireland and age 8 in Scotland) has been a persistent source of concern raised by the United Nations' Committee on the Rights of the Child. Through its reporting mechanism, the Committee has criticised the UK Government for failing to raise the age.⁷⁶ The Government appears to have disregarded the Committee's criticisms. In Northern Ireland, children as young as 10 can be held in custody in juvenile justice centres and those as young as 15 can be held in prison custody.⁷⁷

Those working with children in the criminal justice system should be properly trained.⁷⁸ When in custody, the aim must be the rehabilitation of the child or young person so that they can be reintegrated into the community and play a constructive and positive role in society.⁷⁹ Following release, it is important that children are supported in their reintegration into society.⁸⁰

The Beijing Rules, which apply to children and young people, require that staff:

'... shall reflect the diversity of juveniles who come into contact with the juvenile justice system. Efforts shall be made to ensure the fair representation of women and minorities in juvenile justice agencies.'⁸¹

The Rules note that girls who offend tend to receive less attention than their male counterparts. It is important, therefore, to identify and respond to their particular problems and needs while in custody.⁸²

In England and Wales, it has been established through judicial review that the protection of the Children Act 1989 applies to children in custody. The Chief Inspector of Prisons, Anne Owers has stated, 'if the Prison Service cannot provide conditions that are compatible with the Children Act, it should not be holding children'.⁸³ This principle has still to be tested through the courts in Northern Ireland, where the Children (Northern Ireland) Order 1995 is the relevant legislation.

⁷⁶ Committee on the Rights of the Child *Concluding Observations of the UN Committee on the Rights of the Child: United Kingdom* October 2002, para 57.

⁷⁷ *Criminal Justice (Children) (Northern Ireland) Order 1998*, Article 13.

⁷⁸ Beijing Rules, Rule 12.1.

⁷⁹ Above, Rule 26.1.

⁸⁰ Above, Rule 28.2.

⁸¹ Beijing Rules, Rule 22.2.

⁸² Above, Commentary to Rule 26.

⁸³ Owers A (2004) 'Prison inspection and the protection of human rights' Issue 2 *European Human Rights Law Review* p 109.

While international human rights standards are important in creating 'expectations' and providing a measuring tool, Anne Owers makes a pertinent point when she comments, 'staff may not use human rights language to describe what they do; and some of them indeed would be scornful of it: but they nevertheless know what is right'.⁸⁴

'Equal' but 'different'

There has been growing and significant, theoretical and primary research literature on the punishment and imprisonment of women spanning the last three decades. Throughout this period, Pat Carlen has been, and remains, a leading academic and campaigner on women's imprisonment. Her most recent research study draws a series of significant and insightful conclusions.⁸⁵ She considers that women's imprisonment 'incorporates and amplifies all the anti-social modes of control that oppress women outside the prison'. This is consolidated because 'a coherent and holistic policy on women's imprisonment has never been developed'. There remains a broader failure within the criminal justice system to recognise that 'women's crimes are committed in different circumstances to men's; that women's lawbreaking is, on the whole, qualitatively different to men's'. Consequently, the penal response 'should be in part gender-specific rather than merely crime and sentence specific'. To develop a coherent strategy she proposes a Ministry of Social Justice which would be concerned with social exclusion and monitor 'potentially anti-social modes of punishment such as prison regimes falling below minimum standards of decency and humanity'. A Sentencing Council would 'monitor and regulate the sentencing of women' and a Women's Prison Unit would 'monitor regimes in the women's prisons'.⁸⁶

Within this broader strategic vision, Carlen argues that regimes and their programmes should be 'gender-tested and ethnicity-tested to assess their potential for differential impact'. The development of distinct regimes for men and women prisoners, and 'differential modes of rule implementation', are defended and justified 'on the principle of *ameliorative justice*'. This principle goes to the heart of establishing gender-specific regimes and programmes. It acknowledges that 'women (and black women in particular), because of their different social roles and relationships and other cultural difference, are likely to suffer more pains of imprisonment than men,

⁸⁴ Above, p 110.

⁸⁵ Carlen P (1998) *Sledgehammer: Women's Imprisonment at the Millenium* MacMillan, London.

⁸⁶ Above, p 10.

or to suffer in different ways'. Thus, the conditions of their imprisonment should 'make up for (or ameliorate) the differential pains of imprisonment attributable to gender or ethnic difference'.⁸⁷ Given that children as young as 10 can be incarcerated within the UK jurisdictions, age and age-specific regimes should be added to gender and ethnicity.

Carlen argues that three directions are open to the future of women's imprisonment: 'regressive, reformist and reductionist'. She proposes an amalgam of reform and reduction, warning from the evidence of her research that, should the *status quo* obtain, 'women's prisons will undoubtedly deteriorate still further'. Minimal or 'piecemeal' reform would retain the 'usual pendulum state of reform and regression'. A 'principled reform programme' committed to coherence and reductionism would 'avoid the regressive tendencies to which prisons... are prone'. Finally, Carlen does not place the 'major portion of blame for the state of women's prisons' at the door of the Prison Services. She is concerned to widen the debate to include the broader politics of criminal justice and its administration.

Gender specificity is not an abstract concept and the identification of, and response to, women's particular needs should not be used to demean or undermine appropriate and necessary provision. As Carlen and Worrall have noted, there is a general acceptance that:

'... women's healthcare needs in prison – both physical and mental – are more varied and complex than men's ... but the overwhelming experience of women in prison is that their health needs are not consistently dealt with in a respectful and appropriate way.'⁸⁸

At best, they argue, 'women's unpredictable bodies' are considered a 'nuisance' and 'at worst, a threat to security'. Particular needs extend beyond 'routine menstruation' and concern 'pregnancy, cervical cytology and breast cancer screening, and miscellaneous, hormonally-triggered "women's ailments", which may include chronic mundane conditions such as constipation and other digestive problems'. This recognition goes to the heart of the issue regarding the 'equal' but 'different' treatment of male and female prisoners. It is a recognition that extends beyond 'the physical'.

⁸⁷ Above, pp 10-11.

⁸⁸ Carlen P and Worrall A (2004) *Analysing Women's Imprisonment* Willan Publishing, Cullompton, p 61.

Carlen recorded 'pervasive criticisms of the generally inadequate provision of bathing and washing facilities in the women's prisons'.⁸⁹ The issue being that, 'because of their different bodily needs and upbringings women prisoners suffer more than men' regarding 'personal hygiene and personal presentation'. A lack of understanding of the needs specific to women was demonstrated starkly in her research in the course of a discussion with four long-termers over their inadequate access to baths. A male deputy governor could not understand the issue, as the women had constant access to showers. He failed to appreciate that women might need to bathe to gain relief or comfort during menstruation.

Carlen found that access to ablutions and the toilet was an issue of common concern among women prisoners; shared ablutions and 'time-limited access to flush toilets' caused embarrassment, discomfort and degradation.⁹⁰ Menstruation and menopause, when women bled heavily and regularly, were particularly problematic. Older women prisoners reported 'especial embarrassment' in experiencing lack of privacy when sharing ablutions. In-cell sanitation did not necessarily resolve these problems. Cells with toilets open to view, were 'frightening and demeaning' for women prisoners due to a combination 'of fear of the unsolicited gaze of officers' and 'the symbolic humiliation of "living in a lavatory", in a society where sanitary arrangements are usually segregated from domestic quarters'.

Carlen made the point that as 'so many prisoners – especially women – arrive in prison suffering the extreme health and social effects of poverty, addictions and physical and sexual abuse', it is desirable 'in the name of social justice (or, less grandly, human compassion)' that they be 'released from prison in a better state than when admitted'.⁹¹ Put another way, whatever the offence committed, however it is reported and perceived in the wider community, and whoever the 'victim/s', prisons should have a therapeutic purpose. Loss of liberty, particularly long sentences, cannot but damage or destroy personal relationships with family, friends and communities. Harsh, neglectful or uncaring regimes which tolerate or promote a climate of fear based on isolation, exclusion and aggression undermine the potential for building self-esteem.

⁸⁹ Carlen (1998) p 95.

⁹⁰ Above, pp 97-98.

⁹¹ Carlen P (2002) 'Introduction: women and punishment' in Carlen P (ed) *Women and Punishment: The Struggle for Justice* Willan Publishing, Cullompton, p 15.

In discussing the barriers to reform in English women's prisons, Jackie Lowthian listed common concerns.⁹² These include deterioration in healthcare and hygiene standards; emphasis on security and discipline over 'non-mandatory' tasks due to staff shortages; inappropriate allocation of prisoners; inadequate standards of care due to staff shortages, 'thus increasing the risk of bullying, self-harm and suicide'; curtailment of activities and education; increase in lock-down; and 'lack of holistic needs-based programmes for women'.

In her research into the treatment of women drug users in prison, Margaret Malloch noted:

'Combined with the emphasis of the prison system on control and security, the boundaries between care and punishment become blurred. For example, the need to monitor the condition of an individual withdrawing from drugs... leads to observation under secure (often strip) conditions... the overall effect is highly punitive. It is a denial of any clinical responsibility for the physical and psychological well being of the person "in care".'⁹³

Malloch concluded that in women's prisons 'informal and discretionary practices are more likely to operate'. Such practices 'are often more pronounced' in the responses to drug users. Despite the 'therapeutic language of rehabilitation', more 'punitive ideologies remain to the fore in the female carceral system (use of strip and silent cells). Medical care and treatment, or its absence, are framed in the context of punishment'.⁹⁴

An important issue in women's imprisonment is the representation of the prison and its regime to the outside world, as if by changing terms or descriptions the real meaning also shifts. The eminent Norwegian criminologist, Nils Christie, noted how words provide a 'good means of disguising the character of our activities'.⁹⁵ In the criminal justice system the reality of incarceration is covered, even reconstructed, by a 'shield of words'. The 'person to be punished' becomes a 'client', the 'prisoner' an 'inmate', a 'cell' becomes a 'room', 'solitary confinement' becomes 'single-room treatment' and so on. This process is presented as reflecting the reconstitution and new professionalism of imprisonment. As will be evident in what

⁹² Lowthian J (2002) 'Women's prisons in England: barriers to reform' in Carlen P (ed) (above), p 177.

⁹³ Malloch M *Women* (2000) *Drugs and Custody* Waterside Press, Winchester, p 100.

⁹⁴ Above, p 151.

⁹⁵ Christie N (1981) *Limits to Pain* Oxford University Press, Oxford, p 13.



follows, the 'punishment block' transforms into the 'special supervision unit', the 'prison hospital' into the 'healthcare centre' and the 'strip cell' into the 'dry cell'. A vocabulary of care and treatment has replaced that of security and punishment.

Christie concludes:

'Crime control has become a clear, hygienic operation. Pain and suffering have vanished from the text-books and from the applied labels. But of course not from the experience of those punished. The targets for penal action are just as they used to be: scared, ashamed, unhappy.'⁹⁶

The Prisons Inspectorate's view

Her Majesty's Chief Inspector of Prisons (hereafter the Inspectorate) carried out a thematic inspection of the female prison estate in 1997.⁹⁷ This was based on a study of every prison establishment in England and Wales which was holding women prisoners and involved interviewing women prisoners and staff in each institution.

The report documents the complex backgrounds and needs of women in prison. The research found that the majority of women had not been in prison before; were mothers of children aged below 16; had accommodation problems and poor employment and education histories. Additionally, many reported having suffered physical and sexual abuse in their lives and many had serious drug problems and had self-harmed or attempted suicide.⁹⁸ Because the needs of women prisoners are so complex, the Inspectorate recommended 'an on-going assessment of the needs of women prisoners ...'.⁹⁹

The review argued strongly that while the Inspectorate does not seek favoured treatment for women prisoners, treating male and female prisoners with uniformity does not amount to equality: '...women have different physical, psychological, dietary, social, vocational and health needs and they should be managed accordingly'.¹⁰⁰ The Inspectorate found that many staff, who had worked with male and female prisoners, commented on how different women in prison are from men:

⁹⁶ Above, p 13.

⁹⁷ Her Majesty's Chief Inspector of Prisons (1997) *Women in Prison: A Thematic Review* Home Office, London.

⁹⁸ Above, paras 2.20-2.21.

⁹⁹ Above, para 2.22.

¹⁰⁰ Above, para 3.46.

'They have learned that many women prisoners, being vulnerable and dependent, need more individual attention than most adult male prisoners do; they frequently worry about matters outside their control, invariably concerning members of their family.'¹⁰¹

The Inspectorate takes an unequivocal view that 'the women's prisons system ought to be managed, as an entity, by one Director, with responsibility and accountability for all that happens within the women's estate'.¹⁰² The Inspectorate's clear preference is for prisons for women to be entirely discrete: 'prisons dedicated to women only best meet their overall needs...'¹⁰³ However, where circumstances dictate (principally, the need to hold prisoners geographically near to their homes), a number of safeguards are crucial:

- 'total physical separation
- a separate identity reinforced by distinct management and staffing teams
- separate costing arrangements and management accounting systems to attribute costs of shared services
- discrete objectives
- separate visiting facilities
- separate catering facilities
- separate healthcare, and
- separate education, employment and physical education (PE) facilities.'¹⁰⁴

Further, it is the Inspectorate's view that strategic planning for the female estate should be based on the assessed needs of the female prison population¹⁰⁵ and open prisons for women should be provided.¹⁰⁶

The Inspectorate concedes that, given the relatively small number of women prisoners, it is inevitable on occasion that there will be mixing of different age groups within women's prisons. The review noted that this results in benefits and disadvantages. More positively, some older women enjoy being involved in parenting and supporting younger prisoners who, in turn, benefit from this care. However, given that younger prisoners are generally a more volatile group, some older prisoners, particularly long-termers and lifers, find

¹⁰¹ Above, para 3.47.

¹⁰² Above, Preface by Sir David Ramsbotham.

¹⁰³ Above, para 3.12.

¹⁰⁴ Above, para 3.12.

¹⁰⁵ Above, para 3.14.

¹⁰⁶ Above, para 3.15.

their presence unsettling.¹⁰⁷ The Inspectorate argues for sensitivity in dealing with age mixing.

Some mothers keep their babies and toddlers in prison with them in mother and baby units and, consequently, the Inspectorate recommends that particular attention be paid to child protection issues.¹⁰⁸

UK Government strategy

Although women constitute a small proportion of prisoners throughout the United Kingdom and Northern Ireland, the situation regarding women's imprisonment is alarming. Key concerns are the increasing female prisoner population, the relatively high rates of suicide and self-harm among female prisoners and the detention of girls in adult prisons. In England and Wales, the numbers of women in prison has trebled during the last decade. Two-thirds of these women are on remand and many are in prison for shop-lifting.¹⁰⁹

Juliet Lyon, Director of the Prison Reform Trust, describes the consequences of imprisonment for women:

'There is a high price to pay for overuse of custody. Imprisonment will cause a third of women to lose their homes, reduce future chances of employment, shatter family ties and separate more than 17,000 children from their mothers.'¹¹⁰

Women constitute six per cent of the prison population in England and Wales. Yet, 20 per cent of prison suicides from January to August 2004 were women.¹¹¹ In the first eight months of 2004, 11 women died in prisons in England and Wales. One-third of all women in prison were reported to have harmed themselves in 2003 compared with one in 16 men. Nearly half of all self-harm incidents in prison involve women.¹¹² Half of the total number of women in prison is on prescribed medication such as anti-depressants or anti-psychotic medicine.¹¹³

¹⁰⁷ Above, para 3.33.

¹⁰⁸ Above, paras 3.42-3.43.

¹⁰⁹ Lyon J (2004) 'High price to pay for jailing women' *The Observer*, 18 July 2004.

¹¹⁰ Above.

¹¹¹ Asthana A and Bright M (2004) 'Suicides rise as weekend jail fails women', *The Observer*, 1 August 2004.

¹¹² Above.

¹¹³ Lyon J (2004).

The Home Office's *Strategy for Women Offenders* was published in October 2000.¹¹⁴ It acknowledged:

'The current system does impact differently on women and men, because women are usually the primary carers for their children, and because their small numbers in the system can mean prison places them further from home.'¹¹⁵

The report noted that the most effective means to addressing women's offending was by improving access to services in the areas of health, drug dependency, family, housing, social service, education, training and employment. It called for further research and announced a consultation process whereby those working with women could respond to the report. In September 2001 a further report was published, presenting details of the consultation feedback.¹¹⁶ In a foreword to the report the Home Secretary announced:

'I have charged Home Office staff with the task of co-ordinating the development of a cross-government, comprehensive, targeted and measurable Women's Offending Reduction Programme. This will take effect in 2002 and conclude its first phase in 2005.'¹¹⁷

In April 2004 the Home Secretary stated that in future teenage girls would be held separately from adult women. He announced that by 2006 four specialist units would be built at existing prisons to end the practice of detaining teenage girls alongside adults. In England and Wales, more than 70 girls aged 16 and 17 are currently held with adults in prison.¹¹⁸ The Home Secretary commented: 'these prisoners have a particular vulnerability and should be cared for by specialist staff with facilities that address their unique education, health and social needs'. While welcoming the intention to separate girls from adult prisoners the Chief Inspector of Prisons, Anne Owers, warned: 'this alone will not deal with the multiple problems of girls in custody'.¹¹⁹ In the wake of a damning Ofsted report on education

¹¹⁴ Home Office (2000) *The Government's Strategy for Women Offenders* Home Office, London.

¹¹⁵ Above.

¹¹⁶ Home Office (2001) *The Government's Strategy for Women Offenders: Consultation Report* Home Office, London.

¹¹⁷ Above, p 6.

¹¹⁸ Figures from *Crime Info* [Online] Available: <http://www.crimeinfo.org.uk> [13 October 2004].

¹¹⁹ Travis A (2004) '£16m to build teenage prisons' *The Guardian*, 21 April 2004.

for children in prison,¹²⁰ Anne Owers commented that adult female prisons are not suitable for girls.¹²¹

Frances Crook, Director of the Howard League for Penal Reform, was also pessimistic, arguing:

'... specialist units for girls in adult prisons have been tried and failed not least because it is impossible to detach them totally from the rest of the prison. Even if physically separated from the adults, girls held in prison are still living in a punitive adult culture with high levels of self-harm, suicide, poor staff training and low staff ratios.'¹²²

Juliet Lyon, Director of the Prison Reform Trust, found government policy on women's imprisonment to be 'riddled with contradictions'.¹²³ She noted that on the one hand the Comprehensive Spending Review published in July 2004 promised that the Government would 'pilot radical new approaches to meet the specific needs of women offenders, to tackle the causes of crime and re-offending among this group and reduce the need for custody'. On the other hand, two new private prisons were being built to hold a further 800 women and £16 million were being spent on juvenile jail units.

Given the differential impact of imprisonment on women and their families, and in line with international human rights standards, it is recommended that government policy prioritises the creation of alternatives to custody for women. Funding should be made available for viable alternatives including those run by state and non-governmental organisations. (Recommendation 2)

Following from international standards, the expectations of the Prisons Inspectorate and academic literature on women's experiences of prison, it is recommended that gender-specific programmes be developed in consultation with relevant state

¹²⁰ Ofsted (2004) *Girls in Prison: The Education and Training of Under-18s Serving Detention and Training Orders* HMCIP, London.

¹²¹ See: press release 'Young people in custody – a unique insight' *HM Prison Service* [Online] (20 April 2004) Available: <http://www.hmprisonservice.gov.uk/resourcecentre/pressreleases/index.asp?id=1202,230,608,242,0,0> [7 June 2005].

¹²² See: press release 'Howard League for Penal Reform welcomes two reports highlighting the failings of the imprisonment of children and calls for the planned removal of children from prison service accommodation' *Howard League* [Online] (20 April 2004) Available at: http://www.howardleague.org/press/2004/2004_04.htm [7 June 2005].

¹²³ Lyon J (2004) 'High price to pay for jailing women' *The Observer*, 18 July 2004.

agencies, NGOs and women prisoners. Programmes should be an integral part of a broader framework of care through which women's mental and physical needs are adequately and appropriately identified and met. Gender-specific needs include separation from children, menstruation, pregnancy, post-natal provision, menopause and the consequences of sexual, physical or mental abuse. (Recommendation 3)

The women's custody unit should establish a distinct, gender-specific identity supported by a discrete management structure. The majority (baseline 80%) of management staff, prison officers and professional service providers in the unit should be female. At all times women prisoners should be guaranteed access to women staff regarding any aspect of service provision. (Recommendation 4)

Each prison and place of detention, and the government department to which it is responsible, should be required to detail its strategy and policies demonstrating compliance with all relevant and applicable human rights standards and establish implementation baselines for the operational practices of their regimes. (Recommendation 5)

As part of this reductionist strategy, it is recommended that the Government makes a commitment to ending imprisonment for the offence of fine defaulting, which in itself poses no direct threat to the safety of the public. (Recommendation 6)

Chapter 3

THE IMPRISONMENT OF GIRLS AND WOMEN IN NORTHERN IRELAND

From Armagh to Maghaberry

Armagh gaol was used for incarceration from the mid-18th century until it closed in 1986.¹²⁴ In its early days the gaol held both male and female prisoners and was also the site of executions.¹²⁵

Republican women were interned in Armagh gaol during the Second World War and during the 1956-1961 'Border Campaign'.¹²⁶ Throughout the 1970s and 1980s, Republican women in Armagh took part in the protests across the prison system for political status. In 1980, they began a no-wash or 'dirty' protest which continued for over two years. Women in Armagh also participated in the hunger strikes, which culminated in the deaths of ten male Republican prisoners in 1981. The strip-searching of women prisoners in Armagh gaol brought international attention and widespread condemnation.¹²⁷

Maghaberry Prison is situated near Lisburn in County Antrim. It is a high security, category 'A' prison built on the site of a Second World War airfield. Armagh prison was closed in 1986 and women prisoners were transferred to Mourne House at Maghaberry. Maghaberry male prison opened a year later and the male and female prisons were amalgamated in 1988. Mourne House, however, remained physically separate from the main prison with a separate Prison Officers' Association and separate staffing. The accommodation and other facilities were modelled on Cornton Vale Prison in Scotland and had a capacity of 59 cells spread over four wings.¹²⁸

Initially the male prison was intended to hold mainly long-term, sentenced prisoners. Following the closure of HMP Belfast (Crumlin

¹²⁴ Armagh Gaol was recently entered for the BBC's *Restoration* programme. A short history of the building is available at:

<http://www.bbc.co.uk/history/programmes/restoration/profiles/?6>.

¹²⁵ The last execution to be carried out in Armagh was that of Joseph Fee in 1904.

¹²⁶ McGuffin J (1976) *Internment* Anvil Books, Dublin, Chapter 6.

¹²⁷ For example, Amnesty International (1991) *Women in the Front Line* AI Publications, London.

¹²⁸ Details from: Northern Ireland Prison Service *HM Inspector of Prisons, Report of a full announced inspection of HM Prison Maghaberry, 13-17 May 2002* (Maghaberry Inspection 2002) p 157.

Road) in 1996, non-paramilitary and short-term, sentenced prisoners were transferred to Maghaberry. The Belfast (Good Friday) Agreement of 1998 led to the Northern Ireland (Sentences) Act 1998 and the release of politically affiliated prisoners. As a consequence of the dramatic reduction in prison numbers, the Maze Prison closed and those prisoners not entitled to early release were transferred to Maghaberry. In the Maze Prison, prisoners with allegiances to Loyalist or Republican paramilitary groups had been segregated, but in Maghaberry an integrationist regime compelled prisoners to mix.

Following protests in 2003 by prisoners and concerns about prisoners' safety, a review of arrangements at Maghaberry was commissioned by the Secretary of State for Northern Ireland. This review was carried out by John Steele, a former head of the Northern Ireland Prison Service, along with representatives from the Catholic and Protestant clergy.¹²⁹ The report, published in September 2003, recommended that Loyalist and Republican prisoners should be separated, but not segregated, in the interests of safety.¹³⁰ Separation for male politically affiliated prisoners was quickly established. At the commencement of the current research in March 2004, however, women Republican prisoners remained integrated with the general female population in Mourne House. The issues relating to the separation of paramilitary prisoners are discussed in more detail in Chapter 8.

An additional twist was the creation of a special accommodation block for male Loyalist prisoners within Mourne House unit. During the 2002 inspection there were three male prisoners in this special unit. During the current research only one Loyalist, Johnny Adair, was held there. As became clear during the research, the financing of this block and attendant staffing came from the Mourne House budget, with no additional resources made available to meet the additional responsibilities. To add to the complexity of the situation, from 2001 onwards, asylum detainees were held in Maghaberry, including female asylum detainees in Mourne House. Male asylum detainees were accommodated in the same block as Johnny Adair, but on a separate landing. These detainees were moved to a facility in Belfast (Crumlin Road) only in 2004.

What is clear from this brief history is that the population of Maghaberry Prison has become increasingly complex. The diversity of sub-groups of prisoners, 'all with different needs', is specified in a report by the Select Committee on Northern Ireland Affairs:

¹²⁹ Father Kevin Donaghy, a former chaplain at the Maze, and Canon Barry Dodds, a former chaplain at Belfast Prison.

¹³⁰ Safety Review Team (2003) *Review of Safety at HMP Maghaberry* (the Steele Review report submitted to the Secretary of State for Northern Ireland).

'males and females; ordinary remand prisoners; sex offenders; asylum seekers; members of different Loyalist organisations, both on remand and on sentence; members of different Republican organisations on remand and sentence; short-term sentenced ordinary prisoners, long-term sentenced ordinary prisoners, and so on.'¹³¹

In 2002, the Chief Inspector of Prisons began her report on Maghaberry by saying it represents 'the most complex and diverse prison establishment in the UK'.¹³² In evidence to the Select Committee, the Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO) stated:

'[it did] not know of any other prison regime in either Great Britain or the Republic of Ireland or, if you like, in Europe, that has those sorts of pressures existing in one site.'¹³³

At the time of the research, all women prisoners in Northern Ireland were held in Mourne House. The number of women prisoners is small, particularly in proportion to the overall prison population. Analysis of the most recent available statistics on women's imprisonment in Northern Ireland raises serious questions regarding the appropriateness of custody. Between June 2003 and May 2004, 167 women were admitted to prison as sentenced and 137 on remand. Total receptions, therefore, numbered 304. Of these, four were aged 14 to 16 years, 58 were aged 17 to 20, 111 were aged 21 to 29, and 83 aged 30 to 39. Two-hundred and twenty-six were categorised as 'single'. A third of all admissions were for fine default. Of the 167 women admitted, 109 were sentenced for less than 3 months. Month by month the average population was 25, with 17 in July 2003 as the lowest and 34 in February 2004 as the highest. Just as the prison is complex, so is the mix of women prisoners in Northern Ireland. During the research the groups of women in Mourne House included life prisoners, remand prisoners, committals, an immigration detainee, Republican prisoners and 'young offenders' (remand and sentenced).

Children in custody in Northern Ireland

The Northern Ireland Human Rights Commission has consistently campaigned against holding children in Prison Service custody, especially highlighting the situation of girls detained in an adult

¹³¹ House of Commons, Select Committee on Northern Ireland Affairs (2004) *Second Report*, para 4.

¹³² Maghaberry Inspection 2002.

¹³³ Select Committee on Northern Ireland Affairs (2004).

prison (boys and young men are held in Hydebank Wood Young Offenders' Centre). The principal pieces of legislation governing the detention of children in Northern Ireland are the Criminal Justice (Children) (Northern Ireland) Order 1998 (hereafter CJCO) and the Justice (Northern Ireland) Act 2002 (hereafter the Justice Act). Boys and girls aged 10 to 16 years can be remanded or sentenced to detention in a juvenile justice centre under the CJCO. There were formerly three juvenile justice centres (St Patrick's, Belfast; Lisnevin, Millisle; and Rathgael, Bangor). St Patrick's and Lisnevin were closed and, since September 2003, Rathgael has been the sole juvenile justice centre. The Northern Ireland Office plans to build a new detention centre for children on the Rathgael site.

The CJCO legislates for 'juvenile justice centre orders'. These comprise a split sentence divided into equal parts of time in custody and time spent under supervision in the community. A review of the criminal justice system in Northern Ireland recommended that children under 14 years of age should be detained in care institutions rather than in custody. As a result, 'custody care orders' for 10-13-year-olds were introduced through the Justice Act, although they have yet to be implemented in practice. Children can also be remanded to custody in a juvenile justice centre under the Police and Criminal Evidence (Northern Ireland) Order 1989 (PACE). The number of children detained under PACE remains of concern to the Commission.

The CJCO allows for girls and boys aged between 15 and 17 years to be remanded to a young offenders' centre if the child is considered likely to injure him/herself or others. Consequently, until June 2004 girls as young as 15 years were remanded to Mourne House into a high security adult regime where a landing was designated as a young offenders' centre. Boys were detained in Hydebank Wood Young Offenders' Centre. Since the transfer of women prisoners from Mourne House to Hydebank Wood in June 2004, girls have been detained there but not held separately from women prisoners.

The Justice Act, which will be implemented in 2005, allows 'vulnerable' 17-year-olds to serve their juvenile justice centre orders in Rathgael. Disappointingly, under this provision girls and boys aged 17, who have already had a custodial sentence imposed on them, will not be eligible for designation as 'vulnerable'.

The Prisons Inspectorate's Report 2002

In 2002 the Prisons Inspectorate carried out a formal announced inspection of Maghaberry. The introduction to the Mourne House



Unit report draws attention to previous Inspectorate reports recording 'the potential dangers' inherent 'in situations where the needs of a small group of women ... can become marginalised'. The report continues: 'It is essential to avoid the identity of the units for women prisoners becoming confused with the larger prison site'. Given the distinct needs and contexts of women's imprisonment, there 'needs to be safeguards, such as *total separation, distinct management and staffing teams and separate healthcare facilities*' [emphases added].

Overall, the inspectors were highly critical of aspects of the regime but considered that 'Mourne House has the potential, in our view, to operate as a high quality facility for women in custody'.¹³⁴ They also noted some 'good interpersonal relationships' and 'effective education and training'. They considered that Mourne had 'some high quality living accommodation and excellent physical facilities, not least the potential for its own healthcare provision'.¹³⁵ The inspectors found no evidence that women feared for their physical safety:

'... very few women in our survey reported problems with insulting comments, victimisation or assaults. Relationships were generally relaxed and respectful around the units. We saw some examples of staff working individually with women to manage challenging behaviour.'¹³⁶

However, the inspectors found that Mourne House was managed simply as another house unit of Maghaberry Prison with 'no recognition of the different needs of those held there'.¹³⁷ There were inappropriately high levels of staffing, not reviewed since the unit held significant numbers of high-risk paramilitary prisoners.¹³⁸ At the time of the inspection, 87 officers were designated specially to Mourne, which housed an average of 25 female prisoners.¹³⁹ The consequence of this extraordinary level of security meant that in practical terms women were 'routinely escorted over short distances from house units to the healthcare centre'.¹⁴⁰ This was unsatisfactory for women and for staff.

¹³⁴ Northern Ireland Prison Service *HM Chief Inspector of Prisons, Report of a full announced inspection of HM Prison Maghaberry, 13-17 May 2002* (Maghaberry Inspection 2002), NIPS, 2003, MH 01.

¹³⁵ Above, MH 02.

¹³⁶ Above, MH 23.

¹³⁷ Above, MH 03.

¹³⁸ Above, MH 04.

¹³⁹ Above, MH 14.

¹⁴⁰ Above, MH 24.

The inspection team found a regime based on lengthy periods of lock-up offering an insufficiently busy and active day. Some women had little to occupy them except cleaning duties. Activities were frequently cancelled due to 'operational difficulties'.¹⁴¹ There was inconsistent access to the gym and evening activities.¹⁴² Although the standard of teaching in the educational department was good, classes were frequently cancelled due to operational considerations.¹⁴³ The kitchen in Mourne House had been 'mothballed', thus preventing women from preparing their own food.¹⁴⁴ The horticultural instructor and horticultural activity received particular praise from the Inspectorate.¹⁴⁵ The craft workshop activity was positively noted, although the inspectors were disappointed that accreditation was not offered for the work being carried out.¹⁴⁶

The Inspectorate found an unhealthy balance of male staff to female prisoners, which caused some women prisoners to feel uncomfortable, especially if they were being visually checked while using the toilet or washing. The experience of violence and abuse in some female prisoners' histories contributed to their feelings of vulnerability.¹⁴⁷ Contrary to expectations, the inspectors found that female prisoners did not have separate transport but were taken to and from court in the same vehicles as male prisoners. The inspectors reported that some women experienced taunts and verbal abuse during these journeys.¹⁴⁸ The inspectors also noted complacency over record keeping, even with regard to a young woman who had a long history of self-harm. In this case, despite several incidents there had been no entries on her escort record to identify her as 'at risk'.¹⁴⁹

Further criticisms included: strip-searching of women without reasons being given;¹⁵⁰ insufficient information and support for women on their first night in prison;¹⁵¹ and no structured induction programme.¹⁵² The inspectors were highly critical of the regime's treatment of suicidal and self-harming women, especially young women. In particular, they were concerned about the use of the

141 Above, MH 25.

142 Above, MH 50.

143 Above, MH 82.

144 Above, MH 54.

145 Above, MH 87-93.

146 Above, MH 95.

147 Above, MH 26.

147 Above, MH 27.

148 Above, MH 28.

150 Above, MH 29.

151 Above, MH 30 and 31.

152 Above, MH 32 and 33.



male prison hospital to accommodate distressed women prisoners and of the regular use of the punishment block:

'The perception among female prisoners was that, should they declare their vulnerability to self-harm, there was the possibility that they would be taken over to the observation cells in the healthcare centre in the main prison or to the punishment unit on Mourne. It was not appropriate to accommodate distressed female prisoners in what were little more than strip cells in an environment which essentially centred on the care of male prisoners, many of whom had mental health problems. This was more likely to increase feelings of vulnerability.'¹⁵³

The inspectors raised the case of a 15-year-old, self-harming child dressed in strip clothing and located in the punishment block: 'we were told that staff were not good at recording all the work that had gone into trying alternative strategies with the young person before this action was decided upon'. The inspectors asked whether prison was the most appropriate place for this child, particularly as staff had not been specifically trained to respond to children's difficult and challenging behaviour.¹⁵⁴ The inspectors were concerned that the resettlement needs of women prisoners were not adequately addressed in Mourne and noted that 'resettlement for women lacked strategic direction and planning'.¹⁵⁵

The Inspectorate made many detailed recommendations on each aspect of the regime. Among the key recommendations were: Mourne House should be declared a discrete female facility, under the auspice of Maghaberry management; the Prison Service should draw up a policy and strategic plan for the treatment of women in custody to be delivered in Mourne House; all staff and managers should receive training, specifically preparing them for dealing with women in custody; Mourne House should be operated as a low security facility within a secure perimeter and with significantly reduced staffing levels; the healthcare facility in Mourne House should be reopened and all healthcare be delivered either in the unit or in the community.¹⁵⁶

¹⁵³ Above, MH 36.

¹⁵⁴ Above, MH 37 and 38.

¹⁵⁵ Above, MH 108.

¹⁵⁶ Above, MH 06-11.

Events at Mourne House, Maghaberry – suspensions

During the course of the fieldwork, the Northern Ireland Prison Service announced an 'independent investigation' into 'all aspects of alleged inappropriate behaviour in Mourne House'. The investigation related to circumstances leading to the suspensions and subsequent dismissals in April 2004 of four male and one female prison officers. The investigation was led by former RUC Detective Chief Superintendent Derek Martindale. The Northern Ireland Prison Service announced that the inquiry was to consider:

- allegations relating to inappropriate standards of behaviour in Mourne House
- allegations of staff having improper relations with female prisoners in Mourne House
- allegations of staff behaviour which falls short of the standards outlined in the Code of Conduct Discipline, and
- management action to address concerns raised.¹⁵⁷

The Prison Service assured the public that 'the Prison Service will rigorously investigate any allegations of misconduct and will not hesitate to take appropriate action if required'. In June 2004, the Director General of the Prison Service told a BBC reporter what had prompted the investigation:

"... the particular dismissals came up in their own course and were dealt with in the normal way but it didn't seem to us that these dismissals took care of everything that was being alleged as having happened in Mourne House. We looked at things we hadn't got any other evidence to act on against anybody else but we couldn't convince ourselves that that meant there was nothing further to deal with."¹⁵⁸

Representatives of the Prison Officers' Association complained to the BBC:

"... not only are they unhappy about the state of the investigation but they are unhappy at the way in which it was carried out. They told us that lockers were raided without

¹⁵⁷ Northern Ireland Prison Service 'Weekly situation report, week ending 15 October 2004, notable incidents (and NIPS response)', 'Mourne House Investigation', Available: <http://www.niprisonservice.gov.uk/report/report.cfm>.

¹⁵⁸ Pre-recorded interview, 10 June 2004, for BBC Northern Ireland *Spotlight* programme, transcript obtained from Media Monitoring Unit (programme broadcast, 12 October 2004).

prison officers being present, prisoners' cells were raided, personal items have not yet been returned."¹⁵⁹

While the Northern Ireland Prison Service referred to 'improper relations', local newspapers were not so reticent. On Sunday 14 March 2004, the *Sunday Life* published a story under the banner headlines, 'Sex-starved Black Widow snares warder; Jailhouse rocked by torrid allegations'. The newspaper article was unrelenting in its portrayal of a female prisoner, referring to her as the 'black widow', 'man-eating', 'ruthless', a 'cold-hearted adulteress' and 'one of a trio of killer wives in Maghaberry ... dubbed the Witches of East Wing'. The other female prisoners in the 'trio' were referred to as the 'Fermanagh blonde' and the 'Ballymena bruiser'. It alleged that, following 'the discovery of love letters, stockings, knickers and a mobile phone in the senior officer's private locker', the officer was suspended.

The media reported that four male prison officers were under investigation over allegations that they had sexual relationships with female prisoners, and that a female officer had been suspended in October 2003 and subsequently sacked for having a sexual relationship with a convicted member of the Loyalist Volunteer Force (LVF).¹⁶⁰

Female prisoners referred to in the newspaper accounts sought a meeting with the Maghaberry Governor at which they asked him to put out a statement refuting press allegations that the 'inappropriate behaviour' under investigation included sexual relationships.¹⁶¹ The Northern Ireland Prison Service did not publicly challenge media representations about the allegations.

This is not the first time that media allegations have been made about prison officers working in Mourne House. In an interview with the Director General of the Prison Service, a BBC journalist presented suggestions made by the Prison Officers' Association, that there had been a prior investigation in 2002 into allegations of inappropriate relationships" between prison officers and prisoners at Mourne.¹⁶² The journalist informed the Director General that:

¹⁵⁹ Above.

¹⁶⁰ For example, Breen S (2004) 'Sex-starved Black Widow snares warder' *Sunday Life*, 21 March 2004; Murphy S (2004) 'Sex Scandal rocks jail' *News Letter*, March 26 2004; 'Jailhouse rocked by scandal' *Sunday Life*, 18 April 2004; 'I was framed – sex case warder' *Sunday Life*, 9 May 2004.

¹⁶¹ Interview with female prisoners.

¹⁶² Pre-recorded interview, 10 June 2004, for BBC Northern Ireland *Spotlight* programme, transcript obtained from NIO Media Monitoring Unit (programme broadcast 12 October 2004).

"Members of the Prison Officers' Association in Mourne House have told us that they are convinced that a file exists that catalogues a number of inappropriate relationships between officers and prisoners at Mourne House. They have told us the file has become known as the 'dirty dozen' file ... these officers believe that two years ago an investigation, either officially or unofficially, was commissioned and that for two years they believe that there have been phones tapped, telephone calls recorded, that information is being gathered on officers working in Mourne House."

The Director General stated that this was the first reference he had heard of a 'dirty dozen' file and that the allegations regarding phone tapping were "all quite extraordinary". However, he acknowledged that in 2002 the press were making allegations about the situation in Mourne House¹⁶³ and that "we took some weeks trying to get to the bottom of the allegations that were being made" but "at that time we weren't able get any evidence that we could act on".¹⁶⁴

In January 2005, the Prison Service published a 'summary' of the Martindale report (a 56-page summary of a 961-page report). The inquiry rejected 43 of the 55 complaints it investigated but found serious managerial problems.¹⁶⁵ The Commission called for that report to be made public.

We recommend that the Prison Service's response to the 2002 inspection on Mourne House, and the circumstances in which prison officers were suspended and dismissed following allegations of inappropriate conduct, be the subject of further inquiry. (Recommendation 7)

¹⁶³ For example, on 28 June 2002 the *Daily Mirror* carried a story regarding alleged corruption in Maghaberry. Press Release, 'Statement by Peter Russell, Director General of the Northern Ireland Prison Service' 28 June 2002 [Online] Available: <http://www.niprisonservice.gov.uk/news/dgstatement.htm>.

¹⁶⁴ Pre-recorded interview, as above.

¹⁶⁵ Northern Ireland Prison Service (January 2005) *Summary Report of the Mourne House Inquiry* Available: <http://www.niprisonservice.gov.uk> [May 2005].

Chapter 4

THE MOURNE HOUSE REGIME

Reception, routine and regime¹⁶⁶

The following is an account of what the researchers for this report discovered about the way in which women were treated in Mourne House.

On admission, each woman prisoner was taken to reception, where she gave information on next of kin and contact details. She removed her clothes, was searched and provided with a sheet to cover her body. An officer recorded distinguishing features and identifying marks. Clothes and property were searched, recorded and put into storage. She showered, washed her hair, dressed and was escorted to her cell in the accommodation block. Each cell had integral sanitation and a television rented for 50 pence per week. Prisoners were locked up Monday to Saturday before 8.30pm and unlocked after 8.00am. Lunch was at 11.30am, followed by lock-up before 12.30pm. They were unlocked after 2.00pm and had tea (dinner) at 3.45pm. Although there were kitchens within the Mourne House site, these had been mothballed and food was brought across from the kitchens on the male side. The women were locked up at 4.30pm and unlocked after 5.30pm. On Sundays they were locked up for the night at 4.30pm. The evening unlock period was an issue of considerable controversy and tension. It was a discretionary unlock, "subject to change, regarding staff availability".¹⁶⁷ It was regularly replaced by what was termed a 'rolling unlock', whereby each landing was unlocked for a brief period. The tension concerned the restrictions that a rolling unlock, or a full lock-up, placed on women prisoners telephoning their families. It constituted a significant pressure on women with children.

The issue of unlock, however, was serious regardless of what happened over evening association. The maximum period out of cellular confinement was nine hours, the minimum six hours. This meant that women prisoners were confined to their cells for between 15 and 18 hours per 24-hour period. Sundays were always 18 hours of lock-up. Given the regularity with which evening lock-ups or

¹⁶⁶ Reception information on the daily regime is drawn from observation, interviews with staff and prisoners and policy documents provided by the Prison Service: Northern Ireland Prison Service, *Committal and Assessment Landing*, undated; and *Mourne House, HMP Maghaberry*, undated.

¹⁶⁷ Mourne House, HMP Maghaberry document, undated.

rolling unlocks occurred, women spent 75 per cent of their time in prison alone in their cells. The morning and afternoon unlocks were scheduled for work, education or gymnasium. The work sheds, except for the gardens, had been closed. The education timetable was impressive, with 17 classes offered over 10 periods. Classes included leathercraft, craft, hair and beauty, cookery, maths, English, art, music and ICT. The class lists gave the impression of a varied and well attended curriculum with five to seven women at each session. The Inspectorate's report noted the 'good range of education provision available'. The women 'felt particularly well supported by their teachers who instilled confidence by giving frequent encouragement and reinforcement of learning'.¹⁶⁸

Women prisoners earned £10 per week for cleaning, which could be spent in the tuck shop and on phone cards. Each convicted prisoner was allowed one 60-minute visit each week. These could not be accumulated. Remand prisoners were allowed three one-hour visits, which could be exchanged for a single two-hour visit.

The 'progressive' regime was introduced in November 2000 and comprised three levels: Basic; Standard; Enhanced. Basic level applied to prisoners 'who through their behaviour and attitude demonstrate their refusal to comply with prison rules generally and/or co-operate with staff'. Standard level applied to prisoners 'whose behaviour is generally acceptable but who may have difficulty in adapting their attitude or who may not be actively participating in a sentence management plan'. Enhanced level applied to prisoners 'whose behaviour is continuously of a very high standard and who co-operate fully with the staff and other professionals in managing their time in custody'.¹⁶⁹

Prison officers had considerable discretion in operating the progressive regime. Four consecutive weekly reports with 'favourable recommendations' had to be achieved to move up the regime ladder. Achieving the Enhanced level required 'continuous exceptional behaviour... judged on areas such as conduct, personal hygiene, participation in work and education and attitude to staff and other prisoners'. Two consecutive negative reports and endorsements resulted in a reduction in regime level.

¹⁶⁸ Northern Ireland Prison Service. *HM Chief Inspector of Prisons, Report of a full announced inspection of HM Prison Maghaberry, 13-17 May 2002*. (Maghaberry Inspection 2002), 2003. p 175.

¹⁶⁹ HMP Maghaberry *Progressive Regimes Guidance for Prisoners*, Prison Service Northern Ireland, undated.

Women's experiences of reception and induction

The Inspectorate reported that in its survey of women prisoners in Mourne House, 50 per cent 'said that they did not feel safe on their first night' and 'said that they had not been given any written or spoken information about what was going to happen to them'. Almost all, 89 per cent, 'said that they did not feel confident that they knew what was going to happen to them on their first night'.¹⁷⁰ Further, the Inspectorate found that there 'was no structured programme of induction for Mourne House'.¹⁷¹ It recommended an interview with a member of staff before first night lock-up, access to a telephone call paid for by the prison, a self-harm risk assessment, induction reception packs, a two-day induction programme with cross-discipline inputs and information on the regime, responsibilities and incentives. The induction programme's priority should be to 'generate a sense of support about the future' delivering 'an implicit message' that the prison is a 'safe environment'.¹⁷²

The first hours and days of imprisonment constitute a period of significant vulnerability. For those with no previous experience of prison, particularly women remanded for or convicted of serious offences, the situation can be harrowing:

"It was scary. I didn't know what I was coming to. I didn't know anyone in prison or anything about a prison environment. I was just brought into reception, just going through the paperwork and then I was just taken up and put in a cell and the door was closed. Nobody said anything about what way the prison worked. I was told to go into the cell and the door was just closed."

"I was absolutely petrified coming into prison. I came after long interrogation. I don't know how I coped. I came into reception. It was regimental: 'Get a shower.' 'Fill in this form.' No question: 'Are you alright?' It was all oppressive, no kind of reassurance. You were terrified."

"I know myself, when I came in, I was terrified. I'd never seen a jail, never mind been in one. And I was just thrown onto the wing. It was one of the other girls, actually, who told me the ropes and what to expect. It was the girls who were there for me, not the staff. It's still the same to this day."

¹⁷⁰ Maghaberry Inspection 2002, p 166.

¹⁷¹ Above, p 167.

¹⁷² Above, p 167.

"When we came in we were up in the committal wing for about 14 days. During that time we were on 23-hour lock up. When someone is coming into prison for the first time it's hard, 23-hour lock up."

Another woman, who had been in Mourne House for some time, commented:

"Reception could be handled a lot better than what it is. They seem to be brought in, showered, details took down. There's an elderly woman in at the minute. When she came in, it was about ten [at night] and she was just thrown in a cell, with a pint of milk and a tub of butter and she was told not to press the buzzer unless she was dying. That's what they said. Now that's not the way to treat anybody coming into prison."

Although some women had received a leaflet: "it didn't explain tuck or visits or anything like that". The Mourne House Principal Officer was supposed to provide a brief information leaflet covering accommodation, routine and other facilities (including weekly wages); the women disputed that such a document had been issued to them on arrival:

"It wasn't until the next morning that I was able to start asking questions. I asked if there was an induction booklet I could read but I didn't get that. If I could have read something to answer some of my own questions. Basic things: Can I ring my family? Can I ring my children? When can my family come up and see me? All my toiletries had been taken off me at reception. I had a bag packed when I came in. It was basic questions about things I needed there and then."

Many of the women commented on the lack of support from prison officers:

"The staff don't sit down and explain to the girls what they have to do. They don't explain that, if you're on remand you get three visits a week, and this is what you're expected to do or not to do. You find out all that information from other prisoners."

"If you're a prisoner: 'Go to your cell and don't bother anyone else'. That's the attitude I get from them."

The contrast between prison and home life was marked, especially for mothers with young families:



"Being used to working, being at home, running a house – you're used to being in control. I felt totally out of control in here. I didn't know how to solve my own problems and I didn't know who to ask. I didn't know what way the ranks worked. I didn't know who it was in the office. I didn't know whether you spoke to them by name or whether they had a title. You were just scared to speak to somebody in case you said the wrong thing and then you'd get in trouble. It took me a whole year to find my feet."

Prison officers were not trusted, particularly with personal confidences, and the women voiced a need for independent support:

"I felt desperate. I need to talk to somebody ... My family was always there for me, but I need to talk to somebody that could better understand what I was going through. Even though I was talking to my mum, I couldn't say because I knew it would break her heart, you know. I needed somebody who didn't know me personally."

Women's experiences of the regime

"A typical day in here is you get up. I work in the gardens. You come over to the gardens. You go back over for you lunch. Get locked. You're unlocked. Come back over to the gardens. You go back over again and you're left wondering, 'Am I going to be able to phone [children] or not?' You don't know from one day to the next whether you can speak to them." (Long-termer)

One of the main and persistent frustrations of the regime was whether the evening unlock would happen, with the women not finding out until 4.00pm whether they would be out of their cells later in the evening. A woman stated that "full lockdowns were a common occurrence from October through to December, nine in a row over Christmas". This was confirmed by the Prison Officers' Association. The reason given was insufficient staff to enable a full unlock on all landings simultaneously. She continued:

"All throughout the year it would be a rolling unlock every night. Full unlock would be a rare occurrence, probably once every two or three months. It was never an enhanced regime. The first year I was in, a rolling unlock was rare but towards Christmas it was a privilege. It made no difference that we were on an enhanced regime." (Long-termer)

The pressure, especially on women with children, was considerable:

"I'm on an enhanced regime. We were told we'd be unlocked every evening and have access to the phones every evening ... we're not out every night. Lately we're getting rolling unlocks, out for half-an-hour. All of us have children on our wing. You can't speak with them. I've two children – you can't speak to one and not the other." (Long-termer)

"There's one phone between seven of us. That's less than ten minutes if you're out for an hour. If you're unlocked for only half-an-hour, it's even worse. There's girls with young kids who expect their mammy to phone every day." (Long-termer)

A mother with young children explained the frustration and upset caused by not being able to maintain daily contact:

"I had to ring at three-thirty but if we were locked at that time I couldn't ring them. Then if we did get out at night, say for a rolling unlock, my children would be out at activities. So if we were just out for an hour then it would be a day missed speaking to my children until the next night. Unless I get to the phone at half-three, I have no guarantees of speaking to my children. I can't ask them to stay at home and not go to their activities just on the off chance that I can get out." (Long-termer)

Another long-termer stated:

"My only priority in my day is contacting my children. There's nothing worse than a day goes by and you don't speak to them. There's nothing worse than going to bed that night knowing that you've not spoke to them. If it's very limited access to the phones the chances are you won't even get on the phone and if you do, it will only be for two minutes and that's no good especially if there's any problem at home and they want to talk to you about it. They and I have such a close bond and there's things they don't want to say to [other family members]. You know what children are like with their own mammy. I just want to get through the day, one day at a time. One day less 'til I get back with my children. Maintaining contact and bonds, that's my top priority."

Maintaining telephone contact with children was expensive. As one woman stated, "The telephones are dear. I'm spending thirty pounds a week on telephone calls and [if unlocked] I get about twenty minutes [each time]. I can't understand why it's so dear". Women

also complained about the PIN telephone system in use: "You have to give the numbers, names and addresses of people you want to put on your card, so there is no privacy ...it can take a month to change the names". When the women complained to prison management they were told that the reason for the introduction of the PIN system was 'human rights based', with the aim of overcoming the potential for bullying and bartering, apparently a problem in the male prison with the old cards. The women were not aware that there had been any problems with bullying regarding telephone cards in Mourne.

Restriction on evening unlocks created problems other than telephone access and contact with families and friends. As another woman put it, "Association periods mean getting access to a bath rather than getting a quick shower in five minutes in the morning when you're rushed. If it's a rolling unlock you simply don't get a shower, let alone a bath".

The failure to deliver the enhanced regime, particularly evening unlocks, had "been going on for two years" and finally led to a complaint to the Secretary of State:

"... and we got a reply saying we had been unlocked [over Christmas] and we'd been allowed to use the phone and the yards, which was rubbish because we weren't. I'd like to know where they're getting their information from because it's not true. We were not getting anything. We were locked from 4.15 to the next morning." (Long-termers)

With the workshops closed, the only activity available other than the gardens was education. Despite the impressive range of classes on the timetable and the number of women signed up, the reality was that classes rarely took place. A long-term prisoner said, "You get up in the morning, you're ready to go to class and they [prison officers] will say, 'classes are cancelled', so then I have to go and change and put on my work clothes". Another woman, long-termers, confirmed this and had given up dressing for class: "Education can be cancelled at the last minute. When you get up, you put on your old gardening clothes because you'll be in the gardens, not putting on something better to sit in front of a computer".

For long-termers education classes were important, not only for the curriculum but also for the quality of contact with teachers. One long-term prisoner illustrated the point:

"I just manage by taking it one day at a time. That's how I cope with being here. Even if you try to look forward you're

knocked back. I put my name down for courses but you can't get to education because of shortages of staff. The prison officers aren't available to take us over. The education staff are dead on. They're used to me and they're used to my ways. If I was over and upset they'd know. They're there for you, not only for education but to talk to as well. You can talk to them and you know it's not going any further."

To walk the 150 metres from the residential accommodation to the education block, the women had to be given a prison officer escort despite being in a high security environment. Teachers were not permitted to collect prisoners as they were not discipline staff. The only reason that work in the gardens was rarely disrupted was because the person responsible was a prison officer who would collect the women from their landings. A woman prisoner commented that all it would have taken was a "wee element of trust ... to walk unescorted to education or to the [Mourne House] health centre".

Visits were also a major issue, particularly involving children:

"The visiting system at the moment, and for the last three years, is nothing short of disastrous.... Often you're lucky to get an hour, sometimes forty-five minutes. That's a dreadful thing for small children to live with. Children are every bit as much doing the sentence as their mother is." (Long-termer)

The absence of any form of 'family visits' created additional stress for children who were too young to understand why they could not spend more time with their mothers. A long-term prisoner described a conversation with her small child:

"My wee one ... says, 'Mammy, you and I haven't had lunch together for a long, long time'. Like [number of] years and I haven't even had lunch with them. I know it might sound ridiculous but ... children you've adored from when they were born, and me and them had a hard time before any of this happened ..."

Because they were unable to see the cells their mothers were living in, children sometimes found it difficult to picture the situation:

"If they were even allowed to stay over, even twice a year, you know, in the place to see what the place is like. There was mine saying, 'Mummy, are you in a cage, is there bars around you?' ... If you had time at visits to sit down and explain a few things. I left mine off at school one day. I've never been

home. Not once. ... You're only getting a few minutes here, a few minutes there. It's hopeless. To this day I've never been able to sit down and talk to my children about what happened."

Some women on shorter sentences did not take family visits because they did not want their children to face the ordeal of the prison: "It's too much being locked away from my kids. The kids' father hung himself. The kids think I'm in hospital having a baby" (Committal prisoner). Another woman on C2 was "too afraid to talk to them [her children] because I know I'll cry".

Long-termers

The impact of receiving a long-term prison sentence is immense. Apart from the emotion and upset of the trial, often accompanied by intense and not always balanced media coverage, the adjustment to facing many years in prison can be overwhelming. Prison services have come to recognise the importance of assessment, sentence planning and management as a crucial part of that adjustment. It is now usual for long-termers and life sentence prisoners to be accommodated in an assessment unit in the first months, during which time their sentence is discussed, planned and prepared for. The rationale for this is that, while effective programmes geared towards release can be put in place for short- to medium-term prisoners, they are not appropriate for prisoners who expect to be held in custody for over a decade.

The sense of despair and futility, together with guilt and remorse, places long-termers at risk early in their sentence. Assessment programmes, such as those pioneered in the National Assessment Unit in the Scottish Prison Service, attempt to establish the needs of individual prisoners while putting in place effective planning through which sentences can be managed more effectively. Whatever the advances of such initiatives, the reality is that prisoners face a long period of 'dead time' when time itself becomes the problem. A much quoted phrase is that prisoners 'languish' in jail. For long-termers, often locked up in their cells for many hours each week, 'languishing' is an apt description.

For most women long-termers the sentence is particularly harsh. Without underestimating the impact of a long sentence on male prisoners and their families, for most women with children and family responsibilities the sense of loss of role as well as freedom brings desperation. Without induction or counselling, with no

information or planning, the isolation leaves women particularly vulnerable:

"I was moved from the remand wing to the sentenced wing. I asked to speak to the long-term governor but he never came. I don't know what the story is about a sentence plan. They abandoned the personal officer scheme and there is no plan." (Long-termer)

"I sat there for nine months staring at the ceiling and staring at the walls. I could have been using my time more productively but I was just not in the right frame of mind for it." (Long-termer)

"The monotony is crucifying. Before I came in here I had such a busy lifestyle. I went from one end of the scale when I didn't have time to see the news at night to suddenly having hours and hours on my hands. That's what hit me when I first came in. I couldn't get used to that. I kept looking at my watch, thinking, 'What am I going to do with my time?'" (Long-termer)

It is well established in prison research that, once settled, long-termers and lifers devote considerable time and effort to making their surroundings more personal, often decorating their cells, communal spaces and landings. This sense of 'ownership' of space benefits the prison staff as well as the prisoners. A short-term prisoner commented: "A1 was different, more settled, they had their own cupboards, cleaning materials in their cells. It was more homely". A long-termer stated: "It's the wee, simple things that make a difference, the furniture we made in the workshop [now closed], that makes it more like home. Your own personal effects and having nice things around you".

The problem of being few women and not having a discrete landing for long-termers was a major issue:

"On the male side, long-termers are separated. I did fight for a long-termer's wing about two years ago and was told we would get one. And I scrubbed D1 and brought it to the way I'd like it. I moved all my stuff down from my cell and was told to move all my stuff back. They were playing with my mind; playing mind games with me. I'd scrubbed it and cleaned it for a long-termer wing." (Long-termer)

Apart from the noise and disruption, as a long-termer put it, "It's not fair to expect long-termers to mix with remands, and YOs ['young offenders'] and short termers". She continued:

"As a long-termer, when there's people who come in and are on parole, it's difficult. I haven't even got a tariff yet. I don't think it's fair to put people on the wing who are going out. You can't expect girls not to talk about their parole because of course they're excited about getting out. Management should see what that does to a long-termer."

Another long-termer agreed:

"On our landing there's a few short-termers. We get on OK but it's very disruptive when they come in and are on home leave ... two weeks to go ... one week to go. It's very unsettling. And short-termers have no real respect for where they live. We have a high standard of hygiene and want to care for what we have. Let's face it. That's got to be our home for the next lot of years and we want to make it as homely as possible and we just really want peace and quiet and we don't want to hear music blaring out all hours of the night and people shouting out of windows to one another. We just want to keep our heads down and get on with it ... People come in and wreck things. We're long-termers and we're on an enhanced regime and we should be treated that way."

This research revealed that the situation for long-termers and lifers in Mourne House was indeed dire. There was no appropriate induction and no sentence planning. Requests by the researchers for copies of Prison Service policies for women lifers were unfruitful. With the workshops and kitchens closed, education hardly running and evening unlocks severely limited, it was clear that lifers could expect to spend up to 75 per cent of their sentence in cellular confinement with little access to creative and constructive activities. Given the intense publicity surrounding some of the cases, with the women lifers being dubbed in one Sunday newspaper the 'Witches of Mourne', the stagnant regime that the women endured could only heighten their anxieties. As one woman put it:

"If someone had said to me about prison I would have said, 'Lock them up and throw away the key'. I can tell you, I have had my eyes so widely opened. I think it's incredible. The media's allowed to run with a free rein, there's so much manipulation."

Asylum applicants

At the time of the fieldwork, male and female 'immigration detainees' were held in Mourne House. Female detainees were held in the main building with other women prisoners and male detainees were held in a separate building which also accommodated a loyalist prisoner, Johnny Adair. During the fieldwork there was only one female immigration detainee being held in Mourne House: a young woman from Zimbabwe. She had flown from Zimbabwe to Dublin in October 2002. From there she travelled to Belfast to be with a relative, hoping to apply for asylum in the UK.

The prisoner described the persecution from which she fled, leaving behind a husband and two small children. In Zimbabwe her husband was a civil servant and she ran a small tuck shop. Through the tuck shop they distributed tee-shirts and she was also active in politics. The family was attacked. She was beaten and the house petrol bombed. The people who attacked her were "calling for my head". She said, "I realised my life was in danger and fled". She described how she desperately missed her children who did not understand why she had left. Her husband had given up his job to look after the children.

When she arrived in Northern Ireland, the woman applied for a screening interview. After a couple of weeks she received a letter from the Immigration Services indicating that her case could be heard in Dublin rather than in Northern Ireland. Meanwhile, she was informed that she should report every week to the International Airport at Aldergrove (about 20 miles outside Belfast). She was not receiving any benefit and had no other source of income. Consequently she was unable to attend Aldergrove each week. The immigration authorities made alternative arrangements for her to report to a Belfast police station. For several Fridays she reported to the police station without problems. One Friday she went to the station as arranged and, without warning, was arrested. Police officers told her that they had been instructed by the Immigration Service to make the arrest and she would be deported to Dublin where it had been decided her case would be heard. She was kept in the police cells and then taken to Mourne House. Her lawyer attended the police station but was refused access.

The woman was shocked, angry and distressed to find herself in prison. She considered it unjust to subject asylum applicants to the same regime as prisoners.

"I have never been jailed in my life. I am a law-abiding person. The pressure of being in a cell is too much ... I want my case to be heard in the UK. The UK is being unfair to Zimbabwe. What is happening there is the result of colonialism. Now they chuck us out ... There is nothing sinister about applying for asylum. There is nothing sinister about it. This is a prison, not a holding centre."

The woman reported that staff had a negative attitude to asylum applicants:

"They don't communicate with you the way they do with the white girls. One or two officers have been so nice. Two female officers have been nice but the male officers don't talk to me ... No-one takes care about you, I am so depressed. I have never been in such a situation. I just keep crying and there is no-one to help you. I feel inferior here. I am the only black girl. The other girls are friendly and help me but I feel left out. The prison officers don't ask me if I have any requests but they ask the other girls."

Other prisoners confirmed that she had been given little information on being received into prison. She had been anxious to telephone her lawyer, who was urgently applying for bail on her behalf, but had to wait until PIN numbers were arranged for the phone system. Of particular concern was an allegation that a female prison officer had made remarks which she perceived as personally offensive and racist. The incident was confirmed by other women prisoners:

"On Monday a staff lady said, 'Do you want to go for a bath?' I said I had already had a shower. She repeated that I should have a shower. I said, 'Is there something wrong with me?' She said, 'You're a wee bit smelly'. This made me feel inferior. Now I'm scared to go near the staff in case they think I smell. Some of the other lady staff were nicer. Other prisoners are nice and try to help."

Support had come mainly from other prisoners rather than from staff:

"There has never been any discrimination from the girls. Staff don't give you much attention. I prefer to stay in my cell most of the time. The Government and immigration officers think we want their benefits ... we are running away from a hard life. If they go ahead and give us papers we will work hard. I don't need their money. I just want to work hard and don't want handouts. I am running away from my country but it is not

the end of my life. I just want to be free, safe and independent without fear of being deported. I wish the Government would change their line on asylum seekers and just treat us as people under threat. We are applying for asylum and they are adding insult to injury.”

The day after the prisoner was interviewed, she was granted bail and was released. Following the transfer of female prisoners to Hydebank Wood in June 2004, future female ‘immigration detainees’ will be detained there while male detainees are now held in the ‘working out centre’ in HMP Belfast (Crumlin Road).

Women prisoners’ views of staff

The Inspectorate’s report considered ‘interactions between staff and the women’ were ‘relaxed’, with staff adopting ‘a helpful and constructive approach’. There were ‘many good examples of staff demonstrating care and concern for individuals in their care’. The Inspectorate had reservations, however, about the high level of staffing, the disproportionate ratio of male to female officers and the lack of ‘specific training for working with women’.¹⁷³

The research did not support the Inspectorate’s observations regarding the treatment of prisoners by prison officers. A typical comment was that, while some staff “love their job, others are here for the money. The ones who are here for the money just don’t care” (Long-termer). Another long-termer agreed:

“The majority simply don’t care. They do their job as a means to an end. There’s a minority who drive home the fact that you are prisoners, you’re the scum of the earth, you’re not deemed fit to mix with society.”

Occasionally, prison officers’ responses to women prisoners were offensive. A woman prisoner recalled an incident regarding officers’ responses to two Romanian prisoners:

“They [the Romanian women] found it hard enough with the language barrier because their English wasn’t that great. The screws had a pretty nasty attitude to them, not the ones on during the day, mainly at night. I was sitting in the cell one night last week or the week before and wee [baby] was very, very sick. I could hear her vomiting from my cell – she’s directly across. They did tell her to fuck off and everything

¹⁷³ Maghaberry Inspection (2002) p 170.

when she asked to see the doctor. That there shouldn't be allowed. OK, fair enough, they've done what they've done, but they don't need to be treated like animals, because they're human beings."

This account of the treatment of the Romanian women allegedly meted out by some officers connects to other accounts. The previous section noted the racism experienced by the asylum applicant interviewed and there is extensive discussion in Chapter 5 of officers bullying women prisoners with mental health problems. When asked why some officers behaved in this way, women who had been in prison for some time commented:

"The only form of power in their lives is when they don the uniform and come in here. They're the ones who are playing cards all day or in there [landing office] sleeping off a hangover. They just say 'no' to everything."

"They feel threatened by you. It's outrageous that they feel jealous. What of? The fact that you've been handed down a life sentence ... How could anyone, if they have a life outside, feel jealous? They just love to take the opportunity to put the boot in."

Trust was a major issue. Another long-term resident put it, "You have to be so careful what you say to people. Something innocent can be portrayed in a different way ... you have to be careful what staff you speak to". She continued:

"The problems I have are the attitudes. There's people ... I'm always respectful to them whether they're nasty to me or not. That's just the way I am. And when you have people who are just respectful back to you and treat you like a person and not like a prisoner, it makes a hell of a difference instead of just getting that door slammed on you and telling you to get in. Even a simple thing like somebody opening your door and saying, 'Have you got everything with you?' and then they lock your door. Just wee basic things."

Staff views

It was clear from the discussions with governors that their view of the Mourne House regime was one of stagnation and non-engagement by most prison officers. The poor industrial relations context at Maghaberry, together with officer redeployment when the Maze Prison closed, had fed a culture of withdrawal. While it was

generally accepted that the four-to-one ratio of male to female officers was inappropriate, particularly on night guard, the evidence suggested an institutionalised collapse of a previously positive regime. The number one governor stated that the lack of progress towards meeting the recommendations made by the Inspectorate was due to industrial relations problems with Mourne House prison officers. He considered the Mourne House POA branch to be intransigent and the Maze redeployment had exacerbated existing difficulties with the Mourne House staff culture. Few officers were willing to participate in an active regime. Another governor commented:

“Mourne House used to be excellent. The male ratio is too high, unhealthily high. In Mourne House older female officers mothered the prisoners. The key element was having older female officers who would have dealt with young prisoners the way they would have dealt with their own children.”

A nurse discussed the problems of administering a ‘healthy’ environment in a male dominated context:

“We got a call the other night that a female prisoner had stripped herself and was hanging and the prison officer couldn’t go in until a female officer came across. The prison officers that came to Mourne House came from the Maze. They weren’t used to dealing with prisoners. They didn’t know how to talk to prisoners. There needs to be a majority of female officers. Eight or nine years ago the women prisoners were more settled. There were more, older women prison officers. Initially it was to be 70 per cent of female officers and 30 per cent male. Then this idea disappeared. From the security point of view, even, they can’t do the job properly.”

A governor commented that a senior colleague had said that 20 per cent of prison officers were useless, 60 per cent were ‘in the middle’ and 20 per cent were committed to doing a good job. This lack of commitment overall to developing a positive regime had been exacerbated by the “only thing we’ve talked about over the last months” namely, the “50 separated prisoners” in Maghaberry and “not the 650 that we lock up every day”.

A female prison officer confirmed the difficulties of attempting to meet the rehabilitative ideal:

“When I became a prison officer I thought it would be about rehabilitation. But no rehabilitation is done at all. It’s [the

job] about trying to keep them alive. The role of prison officer for women is more involved than on the male side. Women prisoners are more emotional and put their trust in you. It's the staff on the landings that the women want to talk to but women prison officers should work with the women."

She considered that the key role was counselling but there were real inhibitions in Mourne House to developing good relationships with women prisoners:

"The approach of some of the prison officers can be frustrating. Caring can be interpreted as a sign of weakness by other officers. Draconian measures don't work with these women we have. A lot of the male staff love it in here because they see it as an easy option ... a different atmosphere has grown over the last few years and a very male environment has been created."

In addition to "paternalistic attitudes", privacy and vulnerability were significant issues for the women. She was particularly concerned about male prison officers "looking at the women in a state of undress, a bit of flesh showing ... the women don't like the men looking at them like that".

A sharp illustration of the collapse of the regime was the persistent frustration felt by education staff at not being able to run a full timetable. One of the teachers stated that staff shortages were used as an excuse not to escort the women to the education block. Plainly angry, the teacher commented:

"You're always working against a whole lot of things. Laziness, couldn't-be-botheredness. They [officers] see it as part of their [prisoners] time that you wouldn't give them anything. The women need skills, self-esteem. But you're really working against the system ... The education block used to be buzzing. It was a vibrant place but the closure of Mourne House has dogged us since September 2003."

The Head of Education was "appalled" by the changes that had occurred over the previous twelve months. Previously the women "were here every day" but "since last year the girls have done nothing in computer skills, nothing in essential skills". He stated, "50 per cent of the time we have to tell staff to go home because staffing levels of prison officers means the women can't get to education". He had tried to combat this problem by sending teachers to the landings: "They used to accommodate that but now they chase them off the landings so we can't even circumnavigate

the problems". As the women prisoners had stated, the education staff "know in the morning whether we are going to have difficulties according to which discipline staff [prison officers] are on".

The education staff were unanimous in stating that when classes did take place prison officers did not share the prevailing ethos of the education block and imposed rules over the heads of the teaching staff. A teacher stated that the regime in the education block "became so rigid that the girls didn't want to come over". The atmosphere was "oppressive, there was no movement out of the classrooms and the downstairs grill was locked". Another teacher said that officers "wanted to lock teachers and the girls in class with no access in or out until the end". Previously the learning environment had been relaxed but the regime imposed was one in which women could only leave the classroom to go to the toilet: "they even stopped us giving out coffee and biscuits". The Head of Education summed up the feelings of his staff:

"Prison staff have a vision of education that is rigid. It is a group of girls in class, head down, working away with a teacher. Informal talking, chatting and coffee are seen as heinous crimes. We try to insist that there has to be give and take but it just gets tighter and tighter."

The loss was not confined to learning. As a teacher stated, "we know at times that the girls just want to chat and get stuff off their chests and those conversations are more of use than anything". The situation had become unworkable and the previous term: "If you were open one session [out of 10 scheduled] you were lucky". On checking the attendance book held in the education block, it was clear that this was no exaggeration. The head of education concluded:

"If the present situation continues I would prefer this place shut. It is a shameful position that we can't plan or project ahead. We have very gifted, talented girls going out and we won't have helped them."

Collectively the education staff agreed the way forward. First, to "get the girls over here" and re-establish a routine based on a timetable that was constructive and relevant. Second, "stop obsessive worrying about security". A teacher said, "If a girl's in class doing essential skills and she has a cup of coffee, it's not a serious crime ... it adds to a pleasant working environment". Third, establish "sensible working hours such as 2.00pm to 4.00pm in the afternoon ... getting them here just before 3.00 to get them back for

3.30 is ridiculous". Finally, "the staff will have to be shaken up considerably ... there needs to be a real change in staff".

This report makes a series of recommendations aimed at improving the day to day situation for women in prison in Northern Ireland. These recommendations are aimed at the creation of a humane regime.

The research found that the 'progressive' regime was not working in the interests of women and that given staff shortages there was always a pull towards the lowest level, i.e. the basic regime. Women on the enhanced regime often did not receive their entitlements and nor was the regime working as an incentive for positive co-operation between staff and prisoners: rather it had become a bone of contention for the women. It is recommended, therefore, that there be an evidence-based review of the current framework of regime progression, with the intention of establishing a higher baseline level of service provision. Unlock time, length and frequency of visits and telephone access should not be determined by regime progression. (Recommendation 8)

While the current policy of regime progression remains, it is imperative that women prisoners on the 'enhanced' regime receive their full entitlements. (Recommendation 9)

The situation of long-term and life prisoners was particularly bleak. It is recommended that a comprehensive programme should be developed for long-term prisoners from reception, induction and assessment through accommodation, sentence planning and programmes to pre-release and throughcare. (Recommendation 10)

Detailed information packs should be provided to all women prisoners on reception outlining, in accessible and informal language, the expectations and practices of the regimes, the rights of prisoners and the procedures for seeking help and support during the first days of imprisonment. Care should be taken regarding literacy and language. The pack should be developed in consultation with women prisoners. (Recommendation 11)

A structured induction and risk assessment programme should be developed and implemented. A discrete and extended programme should be provided for long-term

prisoners. The induction programme should be developed in consultation with women prisoners. (Recommendation 12)

The terrible impact of imprisonment on women and their families was evident from the interviews. While the Prison Service cannot take away the pain of separation, it should do all in its power to ameliorate the damage to women and their children. Family-friendly policies should be developed and visiting arrangements introduced to maximise children's contact with their mothers. This should include extended child-centred visits in the privacy of family rooms. (Recommendation 13)

The current telephone arrangements based on a 'PIN number' should be abandoned and a system put in place which respects women's right to privacy and which maximises the potential for contact with family and friends. Access to telephones, including lock-up periods, location and cost should be reviewed. (Recommendation 14)

Women prisoners should be provided with a full range of education, work and rehabilitative programmes, including preparation for release and the 'working out' scheme. (Recommendation 15)

The regimes within the women's custody unit should emphasise constructive and creative engagement, with prison officers spending much of their time interacting with prisoners. There should be effective sentence planning administered by trained officers with specific responsibility for initiating sentence plans and monitoring their progress. (Recommendation 16)

Extended periods of lock-up and cellular confinement should be ended. Women prisoners should not be compulsorily confined to their cells for more than 12 hours in any one day, including Sundays. (Recommendation 17)

Detaining asylum applicants and 'immigration detainees' in prison criminalises people who may have committed no crime. It is recommended, therefore, that immigration detainees should not be detained in Prison Service custody. (Recommendation 18)

Chapter 5

MENTAL HEALTH, SELF-HARM AND SUICIDE

The Prison Service's Review of Prison Healthcare Services, 2002

Following the 1998 Belfast (Good Friday) Agreement, the significant reduction in Northern Ireland's prison population and the closure of the Maze Prison in 2000, the Prison Service undertook a fundamental review of healthcare provision. A Review Group began work in April 2001 and presented its report in April 2002.¹⁷⁴ It found 'the standard of healthcare provided to prisoners was equal to that available in the wider community' and 'healthcare standards are broadly comparable to those in prisons elsewhere throughout the United Kingdom'.¹⁷⁵ It was satisfied that the Northern Ireland Prison Service employed 'a professionally well-qualified group of healthcare staff, notably among healthcare staff'. It noted that healthcare needs 'are those of a multiply deprived population with high levels of chronic disease, mental illness, addiction problems and self neglect'. Such complex needs 'require co-ordinated multi-disciplinary team working with a large measure of delegated independence to team members'.¹⁷⁶

While recognising enthusiasm among staff for 'multi-disciplinary team working', the Review Group criticised the lack of 'top-down multi-disciplinary leadership'. These 'concerns' included 'communication, co-ordination and consistency of clinical practice across the healthcare disciplines between prisons'.¹⁷⁷ It found 'no clearly defined professional leadership structure', an 'inefficient central healthcare advisory structure' and a pressing need to revise 'Prison Rules in relation to healthcare'.¹⁷⁸ What had been lacking previously is implicit in the following:

'... healthcare standards must be bench-marked against external healthcare services. There should be service-wide adherence to evidence based protocols. The provision of healthcare should be professionally led in that nurses would be the first point of contact for

¹⁷⁴ Northern Ireland Prison Service (2002) *Review of Prison Healthcare Services*, NIPS, Belfast.

¹⁷⁵ Above, i.

¹⁷⁶ Above.

¹⁷⁷ Above.

¹⁷⁸ Above, ii.

prisoners; nevertheless prisoners should have unfettered access to a doctor when required. Where appropriate, healthcare staff should be encouraged to undertake specialist training. Participation in clinical audit and adherence to clinical governance principles are essential.¹⁷⁹

The Review Group was 'unanimous in its belief that a new more inclusive management style for healthcare professionals, which fully harnesses all the talents of those working in the system, would enhance the quality of healthcare in prisons'. To that end it emphasised that the responsibility for the health and healthcare of prisoners 'does not lie solely with the healthcare professionals and must be viewed against the whole range of services and activities provided by the Prison Service'.¹⁸⁰

While making 60 recommendations, ranging from the specific to the generic, the Review Group's comments are instructive. It noted broad satisfaction with healthcare provision in relation to the wider community and other UK prisons, yet it revealed a lack of leadership, poor communication, inconsistency in clinical practice, inefficient advisory structures, deficiencies in bench-marking and operational protocols and apparent restrictions on prisoners' access to doctors. Its concluding statement raised the crucial tension between healthcare professionals and prison officers in taking over all responsibility for the routine identification and realisation of the health and healthcare needs of prisoners.

The Review Group considered that the 'delivery of primary healthcare services ... should be substantially nurse provided at the local level'.¹⁸¹ Nurses should be the 'first point of contact for prisoners seeking help, advice or treatment' and they should deliver the 'bulk of continuing care'. This would be 'complementary to the role assumed by doctors' but prisoners 'would retain the right to see a doctor'.¹⁸² In its sole reference to women prisoners, the Review Group affirmed it "is essential that female prisoners should have access to a female doctor" provided for on a regular, sessional basis.¹⁸³

The Review Group noted 'increasing concern' regarding 'prisoners exhibiting severe personality disorders' for whom 'proper professional support is currently not available'.¹⁸⁴ While recognising 'it is not a

¹⁷⁹ Above.

¹⁸⁰ Above.

¹⁸¹ Above, para 4.29.

¹⁸² Above.

¹⁸³ Above, para 4.23.

¹⁸⁴ Above, para 6.10.

simple matter to make separate accommodation arrangements' for this small group, they 'should be provided to take charge of their management, assessment and treatment'. Such provision would 'relieve other parts of the prison system in dealing with a tiny group who create managerial difficulties out of all proportion to their numbers'.¹⁸⁵ Relatively few prisoners experience a 'diagnosed psychiatric illness' and provision existed, albeit delayed, for the mentally ill to transfer to a 'secure hospital setting'.¹⁸⁶

There was recognition that 'committal to prison results in significant numbers exhibiting various degrees of anxiety and depressive moods'.¹⁸⁷ Among these prisoners are those 'identified as vulnerable' and a 'small number exhibiting particularly violent, disruptive and difficult behaviour'. They could be managed effectively in the proposed special unit. But no strategy was 'in place to work with the most difficult prisoners'.¹⁸⁸ The Review Group recommended the delivery of 'cognitive behaviour therapies' by 'specialist' nurses within a coherent and co-ordinated 'mental health strategy'.¹⁸⁹ Such provision was essential, reflecting the Review Group's endorsement of the Boards of Visitors' submissions that the 'observation cells' in use were 'austere' and 'inappropriate for prisoners who are anxious or depressed'.¹⁹⁰

Given that the Review Group visited Cornton Vale women's prison in Scotland, and the Mourne House Unit was inspected at the time of the review, it is extraordinary that the physical well-being and mental health of women and girls received no specific attention or analysis. There was no consideration of menstruation, pregnancy, post-natal provision or menopause. The physiological and psychological consequences of sexual, physical or mental abuse were absent from the review. Neither was there any discussion of prescribed drugs or treatment programmes specifically designed for women entering prison or being prepared for release. The impact on long-termers of the deprivation of motherhood, so regularly raised by women prisoners as the primary contributor to depression and anxiety, appears to have been overlooked. The Review Group addressed its fundamental review of healthcare provision as a generic exercise. It failed to consider the crucial issues not only of gender and age but also of sexuality, ethnicity and disability. There was no recommendation that in initiating and developing a coherent

¹⁸⁵ Above.

¹⁸⁶ Above, para 6.1.

¹⁸⁷ Above, para 7.5.

¹⁸⁸ Above, para 7.6.

¹⁸⁹ Above, para 7.7.

¹⁹⁰ Above, para 11.2.

healthcare strategy, these issues and their associated particular needs and risks would be identified and addressed.

The Prison Service's policy on self-harm and suicide prevention

In March 2003, the Northern Ireland Prison Service published a draft of its new policy on self-harm and suicide prevention. Its aim is to 'identify prisoners at risk of suicide or self-harm and provide the necessary support and care to prevent the individual harming him or herself'.¹⁹¹ It establishes 16 specific objectives under the headings of identification, intervention, regime management, policy implementation and training. Every prisoner will be risk assessed during reception and all staff will be encouraged 'to identify those who appear to be at risk during their time in prison'.¹⁹² Central to intervention is a clinical, psychological and personal risk assessment, a plan based on the 'individual needs of each prisoner ... managed by a team composed of members with appropriate skills' and 'maximum contact and support from staff and persons outside the prison ... in assisting a prisoner's recovery from a crisis'.¹⁹³

Regime management consists of reducing the opportunity for suicide 'by regular review of the physical environment and management procedures affecting prisoners', an effective anti-bullying strategy and 'regime opportunities' promoting a 'good quality of life in prison'.¹⁹⁴ Each prison will have a 'self-harm and suicide prevention team', ensure positive communications between all disciplines, appoint a 'self-harm and suicide prevention co-ordinator', develop 'personal officer' and 'listener' schemes. With regard to training, all staff are to be made aware of the 'positive contribution they can make to improving the quality of life for prisoners in their care' and programmes in self-harm and suicide prevention management procedures will be given to healthcare, reception and *selected* residential staff.¹⁹⁵ The policy document is clear that '[a]ll staff carry an equal and continuing responsibility for the management of prisoners considered to be at risk of committing suicide or other acts of self harm'.¹⁹⁶

¹⁹¹ Northern Ireland Prison Service (2003) *Self Harm and Suicide Prevention Policy* (Draft), p 3 (hereafter NIPS (2003) (Draft) Suicide Strategy).

¹⁹² Above, p 3.

¹⁹³ Above, p 3.

¹⁹⁴ Above, p 4.

¹⁹⁵ Above.

¹⁹⁶ Above, p 5.



Each prison's self-harm and suicide prevention team (SPT) is considered pivotal in initiating, monitoring and reviewing strategy. This includes staff awareness, multi-disciplinary co-operation and communication, physical environment and local contingency plans drawing lessons from incidents, monitoring prisoners' progress in relation to action plans and monitoring staff training and information provided to prisoners. The policy document establishes risk assessment procedures, from reception through induction to regular, established contact over time. It affirms that the 'assessment of a prisoner's vulnerability must not ... be seen as a function discharged only by Healthcare staff on reception, but as a continuing shared multi-disciplinary responsibility until the prisoner's discharge'.¹⁹⁷

The IMR21 form (Referral/Assessment of Suspected Suicide Risk) has been replaced by the PAR1 form (Prisoner at Risk). The PAR1 form 'indicates that the prisoner may be at risk and requires further assessment'. The policy states that while 'staff may voice concern about a prisoner's behaviour at any time, notification *must* be made on a PAR1 where it is believed that a prisoner may be at risk of suicide or self harm' (emphasis in text).¹⁹⁸ Raising a PAR1, results in the convening of a multi-disciplinary case conference, culminating in a care plan including a treatment plan, a residential care plan and a healthcare plan. The PAR1 booklet requires a detailed report from the initiating member of staff, a report on initial action taken by the residential unit manager, a healthcare assessment, a record of the initial multi-disciplinary case conference including the care plans, records of subsequent case conferences, a discharge report and a daily log. The purpose of the daily log 'is to report on the prisoner's mood and behaviour and all ongoing action taken to help the prisoner. An entry should be made at least daily'.¹⁹⁹ The PAR1 is closed following agreement of a multi-disciplinary case review. The policy document also establishes procedures for incident management including contingency planning, immediate action on discovery of an incident (hanging, suspected drugs overdose, swallowed corrosive substances, severe external bleeding). It states: 'The action taken following discovery of an attempt at suicide or self harm and the timing of such action is a crucial element in securing, as far as possible, a successful outcome to the incident'.²⁰⁰ 'Key elements' noted under contingency planning, are 'easy retrieval of cell keys from a convenient location ...' and '[a]rrangements for an

¹⁹⁷ Above, p 17.

¹⁹⁸ Above, p 19.

¹⁹⁹ Prisoner at Risk (PAR1 booklet), p 6.

²⁰⁰ NIPS (2003) Suicide Strategy (Draft) p 26.

emergency response by Healthcare staff to the scene of an incident'.²⁰¹

Following a death in custody and as 'a matter of urgency, senior management must arrange for the immediate family or next-of-kin to be informed ...'.²⁰² The policy document continues:

'Informing relatives must be handled with sensitivity and sympathy and it would not generally be appropriate at such an early stage to volunteer the possibility of suicide ... A death in custody is a very traumatic event for a family and it may also be useful for the Chaplain or Probation Officer to offer to visit their next-of-kin in their own home. Governors should consider sending a letter of condolence to the next-of-kin as an expression of sympathy. This should not be avoided because of misplaced concerns that it may be viewed as an admission of negligence in the duty of care.'²⁰³

The new strategy,²⁰⁴ including the use of the PAR1 form, was introduced in Mourne House on 30 April 2004. The policy document makes no mention of the specific needs of or responses to women and girl prisoners.²⁰⁵

Monitoring suicide risk – the research findings

At the time of the research, the key monitoring document for those prisoners considered suicidal was the Referral/Assessment of Suspected Suicide Form (IMR21). An IMR21 could be initiated by any member of staff who suspected a prisoner 'presented' a risk of suicide. The originator was expected to provide an account of their concerns including 'any supporting background information'. The form was then passed to the Wing Principal Officer or senior discipline officer on duty, who had responsibility for the prisoner's residential location, and who entered their account of 'preventive/remedial management action' and 'monitoring arrangements'. If the situation could not be remedied, it was their responsibility to present a case for a medical assessment. The form was then submitted to the medical officer who gave a written medical assessment followed by instructions to healthcare staff. A healthcare plan or residential care plan comprising a primary aim and key elements was then formulated. As a residential care plan

²⁰¹ Above.

²⁰² Above, p 32.

²⁰³ Above.

²⁰⁴ NIPS Self Harm and Suicide Prevention Strategy, March 2004.

²⁰⁵ Above.

applied to 'normal' location, the IMR21 invited observations, signed and dated, from residential staff. The IMR21's final sections required a review by the medical officer and a 'record of discussion' and agreed action plan, including specified activities, arising out of case conferences. Once 'active', the IMR21 was filed in the prisoner's case notes and held on the appropriate residential landing.

Prison officers interviewed were concerned that IMR21s were little more than "paper exercises". An officer stated that they were "expected to report any untoward behaviour to healthcare, for example, signs of drug withdrawal". Care plans often recommended "optional personal contact" between officers and prisoners but in reality the "only contact would be through the [cell door] flap". A group of officers agreed that "once it's [the IMR21] written it's put in the [prisoner's] file and that's it – back to normal – nothing then happens". The doctor "will see her again and then close it". An officer, who had recently been "directly involved" with two serious suicide attempts and a suicide, expressed concern that prisoners on IMR21s remained in the "general population":

"As a prison officer, I have a 'duty of care' to prisoners and I am bound to the 'Safe and Humane Confinement of Prisoners' as well as their 'Health and Safety'. I feel that these duties are being compromised while prisoners 'on' IMR21s, considered 'suicide risks', are kept in the 'general population'."

He considered any prisoner "deemed to be a serious suicide risk" should be given full healthcare provision, including 24-hour observation, in a location where "immediate medical assistance is available if required". Such prisoners should be returned to the "general population" only when a medical assessment established they were "no further danger to themselves". Prisoners assessed as a "less suicide risk" or "deemed to be playing the system", should also be removed from the general population to a "dry cell" where "all articles and items which may be used for self-harm" would be removed. He continued:

"At present, there appears to be a reluctance to move prisoners deemed suicidal, particularly female prisoners, to the prison hospital on the 'male side', prior to an actual suicide attempt. In most cases ... a prisoner is removed to the 'male hospital' only after an actual suicide attempt and ... it also appears that this is for physical treatment only and when the prisoner is returned to the 'general population' they are still 'on' IMR21."

He cited five cases of suicide or attempted suicide in Mourne House. These women were held in the general population, four under an "active IMR21". Four attempts had occurred during a night guard period.

According to the Governor with responsibility for healthcare at Maghaberry, the IMR21 was "an old document ... a medical document", that "identified the prisoner is at risk". The prison officer specified the problems faced by the prisoner: "the doctor writes a care plan" and both "do this not in consultation with anybody". The IMR21 procedure was "absolutely useless" and the form "sits on the officers' desks and they don't even write on it". In contrast, a Prison Officers' Association representative was adamant that prison officers understood their 'duty of care': "A lot of our bosses think we're 'thick warders' but I wonder whether the prison management understands what 'duty of care' means to us as well as to prisoners".

Officers, particularly on C1, felt they had been "let down an awful lot" and "shouldn't have to put up with a lot of what we do". A woman prison officer commented, "We're not trained to deal with psychiatric cases. All they do is tell you how to dress, wear your uniform, stick by the book manual". Another woman officer agreed:

"People [officers] don't have the skills or the knowledge to deal with the complex issues. Females [prisoners] are more problematic and they will put their trust in you. But there's no continuity in personal support. It's the staff on the landing that they have to deal with ... There must be some sort of counselling. This should be done by NGOs and there needs to be a structure of programmes. AA [Alcoholics Anonymous] is often turned away at the gates because of lock downs. There are no facilities for personal counselling."

Her colleague agreed: "These women are ill, mentally ill and we keep saying that this woman isn't well, she's not bad, she's mad". She continued:

"We had a heroin addict in here. She was on meth [methadone] outside. They brought her in, the doctor wouldn't write her up and she brought in a tablet. The doctor took it from her. She was five days and couldn't hold water down. She was banging off the wall. She was genuinely hurting. She upset the whole landing ... So many women have come through this system who are ill and it's us looking after them ... There's no release for us, we're angry and frustrated. How far gone

has someone got to be for something to happen? Once that door's closed the demons are going to be there all right."

Women prisoners' accounts

"I find in this day and age I can't understand how it is legal – women who are constantly slashing their arms, legs, throats and trying repeatedly to hang themselves are stripped naked, thrown in a suicide jacket ... 'Don't even give her a mattress, let her lie on the floor, let her lie in her own ...' Women need help, counselling and therapy but to throw them in a strip cell, take away everything. I would hate to see a poor dog, bedding taken away treated like that." (Long-termer)

The interviews with women prisoners invariably centred on the treatment of those with mental health problems. All identified it as an issue on a continuum ranging from depression brought about by imprisonment through to mental illness that could have contributed to an individual's imprisonment. While all prisoners felt that they had suffered depression at some point during their time in prison, they recognised that many women, in some cases themselves, had a serious mental health condition. They were dismissive of clinical diagnoses that made distinctions between what they saw as serious health problems:

"As far as I'm concerned, if a woman's hearing voices, cutting up and bouncing off the walls, she is seriously ill and needs hospital treatment. It makes little difference whether a doctor diagnoses that she's got some mental illness or says it's a personality problem." (Long-termer)

For the women on the committal wing the long hours of lock-up contributed significantly to their state of mind: "You need communication and you're getting no communication ... you think you're being cornered, especially on a Sunday" (Committal prisoner, C2). Another young woman agreed, "We might have committed a crime, but we're not animals" (Committal prisoner, C2). The despair and isolation is well illustrated by the following quote:

"I tried to hang myself. They wouldn't move me from the cell and it's just provoking. I just wanted to kill myself. There's no hope for me in here. I suffer from depression and phobia. I didn't get my medication for the first week. The doctor wasn't seeing me for a week ... I had no medical treatment for that week. They cut down my medication. I was put in a cell and

locked down. Nothing given to us, just: 'Away to your cell!'"
(Committal, C2)

For women serving longer sentences, time was a major issue:

"You have too much time. You sit and think about your family ... you've nothing to occupy your mind. I have felt real depression and was put on anti-depressants. I needed a bit more support – someone to talk to. It's not like being at home where you have your whole family to explain a problem to. You can't openly talk to anyone in here. They said they'd get the psychiatric nurse to come and see me but she never came so I just had to deal with that in my own way. I have felt like giving up numerous times. It's only my children that give me something to go on for."

A long-termer recalled the admission of a young woman prisoner who had a heroin addiction. She had been "left to lie in her cell and had the sweats and couldn't eat ... just left to deal with it herself". The long-termer felt a general 'lack of care' contributed to the level of self-harm in Mourne House:

"I've never self-harmed myself but I know a lot of girls who have. They're just trying to find someone to talk to, to give them help. They need a counsellor. Young people cutting themselves. To me that's a cry for help. But instead of having someone to talk to they're just thrown in the punishment unit. It's not on ... They're just left in there; there's nothing there for them. Sometimes they'll throw in a magazine ... there's nothing. What can you do?" (Long-termer)

Another long-termer agreed that for "women with mental health problems" Mourne House was "dreadful, terrifying". She could not "believe that people who are in such an unbearable state are treated the way they are". A remand prisoner stated:

"There's people in here who shouldn't be in here. We have serious mental health issues in here. When you say [this] to people they laugh but it's no joking matter when you're on a landing with these people. We were actually moved here about a week or two ago and one of the wee girls self-harmed the whole way up her arm by taking a razor [sic] blade out of a sharpener. They wouldn't open the door until she put out that razor blade. Now that wee girl could've been bleeding to death but they still wouldn't open the door until she put out the razor blade first. I was really shocked."

For longer-term prisoners the lack of investment in counselling and creative activities contributed to mental health problems. A long-term prisoner commented:

“Mourne House simply houses prisoners. Place the prisoner in her cell with a TV and feed until release. TVs are cheaper than allocating more staff to organise constructive activities, but they become a 24-hour substitute. This is a debilitating process and, ultimately, leads to clinical depression over a prolonged period.”

Treatment by prison officers of those with mental health problems was a most significant issue for all women prisoners interviewed. A remand prisoner stated:

“A lot of people hate being locked up, it drives them mental. I’ve seen it in here. I’ve seen people trying to drown themselves in the sink. Again, that’s a lot to do with the screws not being taught how to deal with those sort of prisoners properly. Even showing somebody a bit of compassion goes a long way.”

A long-term prisoner remarked that, “if they [some officers] see you down or upset [they] will come into your cell and talk to you and ask you what’s wrong but most don’t give a damn”. She continued:

“They just want their day done and that’s that. That’s the attitude I get from them. If you’re a prisoner - ‘Go to your cell and don’t bother anyone else’. I’m sure you know there’s a lot of girls that cut themselves in here. There should be someone on site for those girls to talk to instead of nobody, really, other than the other girls and one or two staff.”

Of particular concern was the bullying treatment of women with mental health problems alleged by other women prisoners. One incident was heard by several women:

“I often sit in my cell and think, ‘I can’t believe I’m hearing this’. The week before last a senior officer on night guard ...this woman had twice that day tried to hang herself. One of the other officers said, ‘Could you leave the keys? I’m not content just looking through the flap, she could have a ligature around her neck’. ‘No, don’t be looking in at her. Don’t even look at her. Fuck her’. That’s the way it was going but it was top volume. ‘Fuck the old bitch, let her go...’ This was being boomed and everyone on our landing, even the hardened ones,

thought it was outrageous. There wasn't an ounce of respect shown to her as a human being."

A former prisoner recalled an older woman, desperate for a cigarette, being held in the strip cell in C1: "She ate with her fingers. They'd taunt her at the door by blowing smoke through the door. They would taunt her and laugh at her". She continued:

"She tried to hang herself and three of us saw her getting out of the ambulance. They walked her across the tarmac in February with a suicide blanket on. They had all the riot gear on. She was crying. They were bringing her back from hospital and she was put back in the punishment block. We just kept our heads down, just did our time."

Another woman felt that "some of the staff treat you like dirt" and had heard officers telling women "to shut the fuck up, calling them bastards". One night, she pressed "the bell" to ask "if there was a woman I could talk to". The male officer told her to "stop ringing the bell and to shut the fuck up. It made me feel worse".

At the time of the initial research visits, as well as the 17-year-old girl held in the punishment block, there was also an older woman prisoner held there. Although able to hold a conversation, she was in poor mental and physical health. She had bowel problems and used a colostomy bag; she suffered skin problems which appeared untreated, epilepsy and diabetes. She had been placed on Rule 32 following an incident in which she had allegedly thrown the contents of the colostomy bag at prison officers. She maintained that her bad behaviour was a result of their refusal to allow her cigarettes. She was in an 'intermediate' punishment cell with a wash basin, open toilet and bed, each bolted down. Until recently she had been on the basic regime and had been without a mattress for long periods which, she claimed, hurt her body. The prison officer on duty confirmed that staff had been informed only two weeks earlier that she suffered epilepsy and only the previous week that she was diabetic. Until that point her diet had not been controlled and much of the food she had been given had been unsuitable.

She could not understand why she had been taken off creams for her skin condition, which appeared painful and in need of treatment. It had been decided that she would be 'drip fed' 10 cigarettes each day. The rationale being that if she was given open access to her cigarettes she would chain smoke them until her supply ran out. More disconcerting, however, was her allegation that she had been refused tea for several days when she was first put in the punishment block. She had been given only water. The prison

officer confirmed the allegation. On being asked if cups of tea had been used as part of the officers' negotiation of her bad behaviour, he replied that this was the case. The situation in which this woman was held was demeaning and degrading. Locked up 23 hours each day and allowed out of her cell to clean the corridors, she was in obvious need of physical health treatment and psychological care. When asked about her situation she replied that she should not be in a punishment cell. She was "sick over mammy, my daughter and my grandson".

The most commonly raised issue regarding healthcare was the lack of a discrete facility for women. While women were visited in their cells or could go to the Mourne House healthcare facility for day visits, anything more serious or requiring an overnight stay took place over in the male prison hospital. Moving women prisoners to the main Maghaberry site, given its high security status, was not straightforward. Once escorted over, women were put in a holding cell until they were seen and then returned to the holding cell until officers were available to take them back to Mourne House: "Sometimes you're away for hours and you're in a filthy, smelly cell just for a quick visit".

"Going over to the male prison hospital is a nightmare. We've got our own hospital here. Why it's not used I don't know. We have to go over for the dentist or optician. Say I go over to the dentist. Say it's ten minutes. I have to sit in a cold, smelly, rotten cell for the whole morning until I'm brought back. If we could go to our own hospital we would be dealt with and put straight back on the wing. That's what the men do. They don't have to sit in that cell. It's a cell the men use. There's a toilet in it. There's no toilet roll, no privacy, and it's just awful. You wouldn't even ask a man to use it. And we're not allowed to take our cigarettes. You have to wait until everybody's dealt with. You have to wait for transport. Sometimes you're took over at nine; you get back at half-twelve. Your dinner's freezing cold and you're thrown into your cell with your dinner." (Long-termer)

The negative experience of visiting the male prison hospital was not confined to the conditions. Another woman stated:

"The hospital over the road is just for men. I was over there myself. It is very dirty and the men talk very dirty. It really upset me. There's men over there for rape and some of them men have raped young children. That really upset me. When I heard that I didn't feel safe around them." (Committal prisoner)

The situation was confirmed by a female nurse:

“Women are very vulnerable in the main hospital. Vulnerable to verbal abuse although they are accompanied by staff ... the male hospital is used as a place of safety but it’s not appropriate.”

A senior orderly agreed:

“It’s obvious that it’s not acceptable to lock up women prisoners over here ... They’re [the men] flirting with them, trying it on ... It’s just not acceptable that they’re housed in this area. There are flaps [in the cell doors] that can be opened and they’re visible from the yards. In the hospital it’s a bad mix of prisoners winding each other up.”

The conclusion drawn two years earlier by the Inspectorate was unequivocal. Inspectors found that ‘the perception among female prisoners was that, should they declare their vulnerability to self-harm’, they could be transferred to the punishment block or to the male prison hospital. It ‘was not appropriate to accommodate distressed female offenders in what were little more than strip cells in an environment which essentially centred on the care of male prisoners, many of whom had serious mental health problems’.²⁰⁶

Jane’s experience

Jane [not her real name] was interviewed by the researchers for this report in the prison hospital (healthcare centre) several days after the death of Roseanne Irvine, her close friend (see Chapter 6). The interview took place in an office and the level of noise outside was intense and constant. It seemed out of place in a healthcare facility accommodating acutely disturbed and distressed patients. Throughout the interview the daily routine of the prison hospital was happening beyond the door: loud male voices shouting and laughing; jokes and banter between staff; the constant rattling of keys; whistling; telephones ringing; and people’s names being shouted down corridors. All interpersonal communications seemed at full pitch.

²⁰⁶ Northern Ireland Prison Service (2003) *HM Chief Inspector of Prisons, Report of a full announced inspection of HM Prison Maghaberry, 13-17 May 2002* NIPS, Belfast, para 36:168.

Jane was agitated and cried. The researchers were given a cup of tea but the staff did not offer her a drink. Initially she had difficulty in focusing and apologised constantly for her emotional and physical 'state'. She talked about her mental health problems: "You get no support, the staff ignore you". In Mourne House she had twice received visits from a psychiatric nurse, "then it was stopped". She said that there was no support for women with depression. In the prison hospital "you're locked up 23 hours a day". She continued:

"If you're sitting there [in the cell] for hours there's stuff that goes through your mind. If I don't get out today I'll plan something. They think there's nothing I can do but I can. They think they know everything but they don't. I've got a plan. I know what I'll do. My first cousin hung himself."

She had not wanted to be transferred to the male prison hospital: "it's filthy". Jane was accommodated in strip conditions. The bed was bolted to the floor and the metal toilet, with fixed wooden seat, was open to observation. It was described by a senior orderly as a "basic suite" which the staff tried "to keep as clean and tidy as possible given the circumstances".

Jane wanted a return to Mourne House where she could have contact with other women: "The doctor doesn't want me to go back over there but I can talk better over there. Over here they don't even talk to you and it's supposed to be a hospital. Here, if you feel really down they don't care". She had been under the impression that her move to the prison hospital had been for "one or two nights". The isolation, particularly from other women, was the most difficult aspect of the 23-hour lock-up: "I've never been in prison before. I hate getting locked up ... it brings memories back to me". She disclosed a history of sexual abuse: "I'm lying trying to sleep, thinking about these things".

Then she stated:

"In the hospital they [male prisoners] talk filthy and dirt with the other prisoners. A man exposed himself. Said, 'I'll give her one'. He thought, 'I'll pull it out 'cos there's a woman there'. We were all outside together. One man is in for sexually abusing a child. We have to have association with them. They are crafty, some of them. I told them [staff] about what the man did but they never did anything about it. I did not feel safe around them."

This revelation was deeply disturbing. The senior orderly on duty confirmed that Jane had been on association with male prisoners in the recreation room. He explained:



"There are difficulties housing women prisoners in a male ward. These are acutely disturbed prisoners ... Unlock depends if there's sufficient female staff. But they do have association with male prisoners."

On hearing Jane's experiences in the recreation room, the orderly responded that they always made sure that a female member of staff was with her but he did not contest Jane's version of events. He simply stated that the "situation" in the prison hospital was "acute and volatile".

For Jane, grieving the loss of her friend while struggling with her past memories and current fears, the experience of incarceration was "like a nightmare and you think it's never going to end". Her concern was that "there'll be more deaths in this prison because people don't get the help they need". Jane wrote later:

"I have four kids and four grandkids and I miss them all so much. I keep thinking to myself I will never see mine again. I love them all so much too. But to me time is running out for me. I can't take much more. Every day is like a nightmare."

Other accounts

Throughout the research the issue that occupied the minds of managers, prison officers and other staff was the mental well-being of the women prisoners and the lack of adequate treatment to meet their, often complex, needs. Members of the Board of Visitors, among the few people not employed by the Prison Service who meet women at their most disturbed, voiced their concerns that the treatment of "distressed women on the other side [the male prison hospital]" was "totally inhumane". The holding cells where women could wait for several hours on each visit were "filthy" and "degrading". Another member of the Board stated, "There can be a brutality shown to women [who are] at rock bottom", women who were already "deeply damaged". Many had "been abused" and had suffered "domestic violence".

A prison officer stated:

"I've taken women prisoners over to the far side [male prison hospital]. It's very embarrassing for the women because of the remarks and comments made. This shouldn't happen. They're all in separate cubicles. We're transporting 16-year-olds to old ladies and they're being bullied and taking abuse."

While transport vehicles have individual cubicles, they are not sealed or silent. Mixed travelling, such as to court, was a Maghaberry practice criticised by the Inspectorate but it had persisted. A woman prisoner recalled the distress that a young woman had experienced using shared transport with male prisoners:

“The men were shouting out of the windows, ‘Look at that one. Show us your tits’. They were shouting to the wee girl, ‘Would you take it up the arse’, and that. They see you getting on the bus and they know the young girls. Some of the girls would sit and cry all the way.”

Education staff were particularly concerned that “any conception of a duty of care” had been lost. A teacher’s comment was typical:

“There is an issue of trust with us as education staff. We would hear of a prisoner being bullied, pass on the information to the governor who would talk to whoever is in charge and things would be resolved. Now it’s like talking to the wall. I can’t guarantee that confidentiality will be maintained. And our complaints are going straight back to officers. The majority of officers have lost any conception of the duty of care. They’ll shout down the landings information that others will hear. The young prisoners are the real victims of this change.”

A teacher reflected the shared view of the education staff regarding the prison officers’ responses to women with mental health problems:

“I have never met a girl that officers haven’t said was manipulative ... we all need training in how to deal with psychiatric cases and with young offenders and things would be improved so much with so little. If life is more pleasant for the girls, then it is for the staff. They should see that.”

Another teacher felt that the atmosphere in Mourne House had become increasingly punitive, particularly the isolation of self-harming women. The prevailing attitude was “I’m going to sort her out” and then, “they put a self-harming woman in the punishment block”. A member of the clergy agreed:

“The [Mourne House] environment is unsafe and psychologically poor. Most are vulnerable, fragile women with specific healthcare needs. I really worry about their safety at night, locked up alone for so many hours. In my opinion a

young woman who attempted suicide 10 days ago was unjustly treated.”

A comment consistently voiced by all staff interviewed reflected confusion and concern over whether the majority of women were ‘mad’ or ‘bad’. Interviews with medical staff established the key issue regarding diagnosis and classification of mental illness. Part Three of the Mental Health (Northern Ireland) Order 1986 provides for the transfer of patients with a recognisable mental illness to mental health hospitals to receive appropriate treatment. A prison doctor explained:

“They have to have a mental illness. You can’t transfer people who are disordered and violent to local hospitals. You need to be sure that they’re non-violent before transferring them. If they’re dangerous you can’t transfer them. Dangerous prisoners can only be transferred to Carstairs [state hospital, Scotland]. You can’t send remand prisoners, only sentenced.”

Anti-psychotic medication cannot be given against a prisoner’s wishes because under the Mental Health Order the psychiatric unit at Maghaberry is not recognised as a psychiatric mental health facility. It was estimated that 25 per cent of prisoners admitted to the Maghaberry ‘health centre’, or prison hospital as it is more commonly known, had a mental illness. The remaining 75 per cent had a “behaviour or personality disorder” which could include “hearing voices”. Those classified as disordered could not be transferred, “even if there is a hospital waiting to receive them because they do not have a recognisable mental illness”.

The overall Maghaberry prison population doubled between 1988 and 2004. While there had been no discernible increase in healthcare funding, there were a “large number of prisoners needing healthcare”. The doctor continued:

“This is the context we now find the women prisoners in ... There are more females coming into the prison system. Everything has been tried with these women: probation, mental health, services in the community, but they repeatedly shop-lift, etc., and the courts get fed up with them and send them to Maghaberry ... There are now two groups of women. One, young ladies who should be in Rathgael but get sent to Maghaberry. Two, older women in their forties for whom everything has been tried. The latter group are reasonably stable but have intractable problems with depression and low self-esteem and have poor networks of support on the outside.

They recognise the hopelessness of their situation. The young women have very little in the way of self control. They tend to be emotionally unstable with personality disorders characterised by mood swings, cutting themselves, can't resolve their own problems and get into a mess."

The older women who had been in and out of prison would have "had 20 years exposure to therapy and anti-psychotic drugs". While "cognitive and dialectical behaviour therapies" could be developed for younger women, "in a group of highly disturbed people the therapy will be largely ineffectual". Prison was not a place conducive to successful therapeutic intervention. He stated:

"Prison is a toxic environment. Any work you do is nullified by the system. You spend a long time talking to the prisoner and get somewhere and then they go back and cut themselves."

The central issue here is the relationship between the prisoner and pain. A simple explanation for the failure of treatment is the individual's personal pathology. But what is stated clearly here, and demonstrated throughout the research, is that any advance made through treatment or interpersonal discussion is reversed by the prison environment, the prison regime and its implementation by often insensitive and occasionally abusive staff.

While arguing that most of the women in Mourne House should not be in prison, a female prison officer outlined her priorities within the current situation:

"Understand the women and their needs, their basic needs, their children and their families; understand their mental health and behaviour issues, there is a real problem with the use and application of the mad v bad distinction; establish why women self-harm and attempt suicide; provide training in how to deal with self-harm ... you have to keep them safe but not in the punishment block; programmes to deal with solvent, alcohol and drugs abuse and with STDs [sexually transmitted diseases]; identifying when there is manipulation going on and when there's not; develop more corrective and rehabilitative measures rather than the present emphasis on draconian measures."

It is clear from the research that women's healthcare needs are not being appropriately met within the prison system in Northern Ireland. Many of the women in Mourne House had evident mental health needs and should not have been in prison at all – an analysis which Prison Service management

and most staff concurred with. This report recommends that as a matter of urgency, relevant Government departments and agencies must develop a coherent and multi-agency strategy on women and girl 'offenders' who are diagnosed mentally ill and 'behaviour' or 'personality disordered'. The primary objective of this strategy being to ensure that most will not be sentenced to prison but will have their needs identified and met in therapeutic facilities that offer age-appropriate and gender-specific programmes. An age-related, gender-specific and multi-agency strategy should be developed to identify and meet the mental healthcare needs of the few women whose offences require a prison sentence. (Recommendation 19)

An individual mental and physical health risk assessment should be conducted on all women and girls currently in custody and the outcomes discussed at multi-disciplinary case conferences. The women and girl prisoners should participate in this process and be fully aware of the outcomes. (Recommendation 20)

Without exception, the women's custody unit management, prison officers and professional service providers should receive significant training, supported by a training 'tool kit', for working with women in custody. Key training curriculum issues include mental health, suicide prevention and awareness, self-harm, physical and sexual abuse, young prisoners and human rights. (Recommendation 21)

A distinction should be made between the use of anti-ligature cells and a restricted regime for protection against self-harm and suicide and the use of punishment cells. There should be at least one cell on each landing that is ligature free so that women on observation can remain on general association. (Recommendation 22)

Women should not be transported in vehicles with male prisoners. (Recommendation 23)

Chapter 6

DEATHS OF WOMEN IN MOURNE HOUSE: THREE CASE STUDIES

Deaths in prison custody

'Current Prison Service policy fails to communicate the social dimensions to self-harm and self-inflicted death. It does not stress sufficiently the significance of the environment in which prisoners and staff are expected to live and work, or the importance of constructive activities in helping inmates to cope with anxiety and stress. Above all, it fails to give weight to the need to sustain people during their time in custody, the importance of relationships between inmates and between staff and inmates in providing that support.'²⁰⁷

In his 1990 *Review of Suicide and Self-Harm*, brought about by the growing number of suicides in prisons, the Chief Inspector of Prisons argued persuasively that an over emphasis on medicalisation had contributed to complacency within prisons, particularly regarding regime, environment and professional responsibilities. The Chief Inspector was clear in recommending that all prison regimes should be active, engaging prisoners in constructive activities. Alongside the structure of regimes, staff should be trained to be interactive as an essential element of that engagement. Further, the custom and practice of 'compartmentalisation' within prisons had to be abandoned in favour of an integrated approach involving all agencies and individuals concerned with the daily life of the prison. Central to policy initiatives that followed, and inscribed in prison service and prison establishment mission statements, was a new vocabulary of care, safety, opportunity, support, trust and responsibility.

Nine years after the 1990 review the Chief Inspector published a further thematic review, *Suicide is Everyone's Concern*.²⁰⁸ It recognised the continuing, rising rate of prison suicides and focused particularly on the need within prison services to develop strategies directed towards identifying and meeting the needs of women and young prisoners. It also affirmed the idea of the 'healthy prison' as a construct against which the operation of prison regimes should be

²⁰⁷ HM Chief Inspector of Prisons (1990) *Suicide and Self-harm in Prison Service Establishments in England and Wales* HMSO, London, p 7.

²⁰⁸ Her Majesty's Chief Inspector of Prisons (1999) *Suicide is Everyone's Concern: A Thematic Review* Home Office, London.

judged. In this construct, all prisoners, including the most vulnerable, and staff should feel safe and be treated with respect. Prisoners should be fully occupied, be expected to set goals for self-improvement within creative regimes and build strong links with families in preparation for release. Staff should be well-motivated by good leadership and consultative management and be expected to develop skills to match the high demands made of them. While cultures of engagement, active participation and constructive regimes, under the banner of the 'healthy prison', cannot be expected to resolve the complex and diverse circumstances in which prisoners self-harm or are suicidal, the departure from simplistic pathological models was significant. It recognised that negative staff responses and inappropriate regimes at best neglected the needs of prisoners and at worst added to the hopelessness, helplessness and desperation experienced by many prisoners made vulnerable through their incarceration.

In February 2001 the then Home Secretary, Jack Straw, announced a new strategy of suicide reduction and self-harm management to be implemented throughout prisons by April 2001. Again, it emphasised an integrated approach to risk assessment, prevention, safer cells and information sharing. Central to this initiative was the reaffirmation of staff awareness, understanding and training. Two years later, in her *Annual Report* for 2002/2003, the Chief Inspector of Prisons, Anne Owers, noted the continuing rise in prison suicides. A third of these were unconvicted prisoners one in five were women, one in five were in prison hospitals or segregation units, and two-fifths died within their first month in prison. She highlighted the relationship between suicide and mental illness and the use of segregation and isolation for disturbed prisoners: 'a disproportionate number are women, often young women'.

Since the introduction in England and Wales of the Government's 2001 initiative two women, Annie Kelly and Roseanne Irvine, have died in custody at Mourne House. The inquest into Annie Kelly's death took place in November 2004 and, at the time of publishing the second edition of this report in June 2005, the inquest into Roseanne Irvine's death had yet to be held. The contents of the internal investigations into the deaths have not been made public. Given that the research remit is concerned with Article 2 of the ECHR, these cases are discussed in some detail in this chapter. Prior to that discussion, however, it is important to consider the controversy surrounding the circumstances in which a third woman, Janet Holmes, died in Mourne House in 1996. Her case is important, not least because an inquest into her death was held and, as a consequence, the Coroner expressed serious reservations about the operation of the regime at Mourne House.

Janet Holmes

“You can’t watch people all the time as it is a fact that if someone wants to kill themselves or commit suicide they are going to do it. There is nothing anyone can do.” (Governor, Maghaberry, November 1996)

This statement was made to Des Doherty, solicitor acting for Janet Holmes, in the immediate aftermath of her death in Mourne House where she was held on remand. The 20-year-old woman from Derry/Londonderry committed suicide by hanging herself during night lock-up on 22 November 1996. The Governor’s comment is one regularly made by prison managers and their staff. Invariably such comments are accompanied by examples of the extremes to which prisoners will go to kill themselves. They reveal an underlying assumption that suicide is driven by an individual’s pathological condition; a force so powerful that it defies prevention. For those who have a ‘duty of care’, however, it provides a convenient rationalisation for non-intervention. It suggests inevitability regardless of the quality of support, whatever acts or omissions prevail in the operation of the regime. Yet complacency, negligence or intimidation could contribute to a troubled prisoner’s decision to end her or his life.

Without doubt Janet Holmes was vulnerable. She had been in care from an early age and had a history of drug and alcohol problems. A brief marriage had ended in difficult circumstances and she had committed a series of petty offences. In prison she was distressed and had been transferred to the prison hospital where, the day before her death, she had attempted to hang herself. While in the hospital she was placed on a 15-minute watch. Returned to Mourne House, the special watch was stopped and Janet was held in a standard prison cell. The bars on the inside of the cell window were not vertical but ornamental, offering multiple ligature points to a suicidal prisoner. On the day she died, a prison doctor considered her well enough to attend disciplinary hearings. As a consequence, she was denied evening association, access to the gymnasium, a radio, cassette or television. Other prisoners reported that she was so upset that she was unable to make herself a cup of tea.

According to Janet’s solicitor she was not deemed a suicide risk. In his written statement to the Coroner he noted that a governor had commented that there was ‘no knowledge of any previous suicide attempt’. Governors and prison officers casually remarked that her death was associated with a half-bottle of vodka that had been smuggled into the prison by Janet’s boyfriend. The post mortem report, however, confirmed that information was available regarding

a previous suicide attempt. The pathologist, Professor Crane, found no alcohol in her blood or urine but noted multiple scars, some of which were recent, on her arms. Janet had a history of self-harm. The report noted that on entering the prison cell prison officers 'found this woman hanging by a shoe-lace from the metal bars of the cell window. She was facing the wall, kneeling with her knees on the cell floor'. Other prisoners stated that they had heard Janet banging her radiator, situated below the window, at the time of her death. It appears that having hung herself, she kicked out against the radiator and the ligature slipped, eventually bringing her to her knees. After the alarm was raised it took 20 minutes to open the cell door. She was cut free with nail scissors.

In a written statement to the inquest, at which he appeared as a witness, Janet's solicitor stated that she 'was not looked after properly at Maghaberry [Mourne House] during the course of her stay there and, in particular, there was an inexcusable delay in having the cell door opened once the alarm was raised'. This reference reflected evidence from other women prisoners who stated that, on realising what was happening, they raised the alarm and there was a long period before prison officers gained access to the cell.

Des Doherty's statement continued:

'Furthermore, I am particularly concerned at the fact that the prison authorities advised me on the 12th December 1996 that they had no knowledge of any previous suicide attempt with regard to Janet when same is clearly documented in the report from Professor Crane. I am also concerned at the continual allegations made to me by Warders and other members of the prison authorities that 'this all started over a bottle of vodka being smuggled into the prison'. If one is to agree with that view, the bottle of vodka should not have got into the prison in the first instance. This did not cause the inordinate delay in the opening of Janet's cell door which in my opinion has cost Janet her life.'

The Greater Belfast Coroner, Mr John Leckey, commented on the 'tragic sequence of events' that preceded Janet's death. The inquest had focused on these events, which included the adjudication procedure within the prison and the issue of legal representation at adjudication proceedings. It was important to establish whether prisoners, in this case Janet, understood the questioning to which they were subjected within the adjudication process. Cross-examination of prison officers dealt with alarm points, procedures and provisions for the opening of cell doors, the holding and location

of keys for accessing cell doors in an emergency, 'suicide watch' and appropriate clothing for those prisoners considered to be at risk of suicide. The inquest also heard evidence on the training of prison officers in dealing with self-harm or suicidal behaviour and in responding to suicide attempts. A woman prison officer told the inquest that she had not received any training for such incidents, before or since Janet's death. Evidence was also heard regarding the completion of a serious incident internal report in the aftermath of Janet's death. The Coroner commented that the response at the time of her death had been 'unacceptable' and it was 'a matter of some concern that officers had received no training'.

Following the inquest the Coroner wrote to Robin Halward, then Director General of the Northern Ireland Prison Service. He recorded his concern regarding the adjudication process and its operation within the prison, the training of prison officers and the non-implementation of the Percy Report,²⁰⁹ the medical assessment of Janet Holmes prior to adjudication and the speed of access to her cell once the alarm had been raised. The inferences were clear: a failure in the duty of care, inadequate officer training and deficient emergency access procedures. Such serious criticisms from an experienced coroner required serious consideration and responses from the Prison Service.

Annie Kelly

Annie Kelly, the tenth in a family of 12 children, first came into conflict with the law when she was 13. Her family, from the Strabane area, saw a significant behaviour change following the tragic death of her brother. A year later she received her first conviction. After being held in St Louis' Training School she was sent to Rathgael. In July 1997, following the issuing of a Certificate of Unruliness in Rathgael, Annie was imprisoned in the Mourne House Women's Unit. Considered to have behaviour problems too difficult to manage in a juvenile facility a 15-year-old child was fast-tracked to a high security women's prison. Holding her in an adult prison breached international standards, not least the UN Convention on the Rights of the Child.

From 1997 until September 2002 she was committed to prison on 28 occasions. She presented the Prison Service, and those with whom she had daily contact, with a formidable challenge. Her convictions reflected a range of offences, including police assault, riotous and

²⁰⁹ *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1954-1957*, Chairperson: Lord Percy.

disorderly behaviour, criminal damage, theft and common assault. A teacher who worked with her in prison recalls Annie's arrival in Mourne House: "Nobody knew how to handle her. What happened was dreadful. She responded to the more aggressive staff by hitting out. She was held most of the time in solitary confinement. When I taught her our chairs were bolted to the ground". Yet, the teacher and her colleagues never felt threatened by Annie.

Throughout her time in Mourne House Annie was admitted to the male prison hospital on numerous occasions. Often agitated and disturbed, she said she heard voices. She also self harmed. She lacerated her arms, banged her head, inserted metal objects under her skin and strangled herself with ligatures, losing consciousness. From 1997, the five year record of incidents shows numerous assaults on staff and cell wreckings as well as 40 incidents of self harm. Her formal psychiatric assessment found no 'organic' impairment or mental illness. She was diagnosed as having attitudinal problems derived in a personality disorder. The diagnosis was offered as an explanation for her antagonistic behaviour towards staff, her self harm and her 'suicidal ideation'. On release she drank heavily. Her medical assessments, however, record a bright and intelligent young woman suffering from low self-esteem and self-denigration.

In April 2001 Annie was committed to prison over a weekend. Unco-operative and aggressive on reception, she was immediately placed on Rule 35 and escorted to the Punishment Block where, according to prison officers she assaulted them. It was decided that she should remain locked in isolation, unlocked only when three officers were present and a full length shield used as a barrier between Annie and the officers. Following a self-harm attempt she was strip searched by officers. The officers record being assaulted and a three person control and restraint team, equipped in riot gear, was deployed. She was restrained and handcuffed while she was medically examined. Officers stated that soon after she slipped the handcuffs and smashed the spy-hole glass. This incident was presented by officers and managers as typical and used to justify holding her in solitary confinement.

Annie's continuing violence towards prison officers was used as justification for keeping her in segregation, unlocked only when three members of staff were present, protected by riot gear and a full-length shield. In June 2002, she wrecked a punishment block cell equipped with an open toilet, sink and bed. A report recorded that she pulled the ceramic hand basin from the wall, removed the taps and used them as instruments to break through the cell wall. She

was returned to the basic punishment regime in a 'dry cell'. Dressed in a 'protective' gown, she was given a 'non-destructible' blanket. There was no mattress, no bed and no pillow. She slept on a raised concrete plinth. According to officers she considered the strip cell 'hers' and became aggressive if she thought another prisoner might be located there.

Without the means to cut herself, Annie regularly lay on the plinth and banged her head on the floor. She tore ligatures from the supposedly indestructible clothing and blankets. Her self-strangulation was not taken seriously by most officers, who felt she was faking or feigning suicide to irritate them. But a clinical psychologist expressed concern that Annie might cause herself an accidental suicide. All 'key' staff were aware of this concern.

Other prisoners also worried that Annie might die. One said:

"I talked to Annie. She was a very young girl. She needed a lot of attention and some of the girls upstairs [young prisoners] need the same. But we can't do anything. We know somebody's talking about it [suicide] and we tell staff but we don't know what they do with that. It's not really taken seriously ... some of them take it seriously but others will go, 'She's always at it'. That's not the attitude to have."

Annie was transferred to the male prison hospital. She wrote a harrowing account of the transfer to her sister. It was to be her last letter home. 'You wouldn't believe the way I'm treated. You would need to see it with your own two eyes'. She described how the 'control and restraint team landed over and told me I had to take off my clothes and put a suicide dress on'. She refused and the all male team told her they would hold her down and so she complied.

'Then they all held me out in the corridor. I only had the suicide dress on and I was told I could keep my pants cause I'd a s.t. [sanitary towel] on. But when the men were holding me they got a woman screw to pull my pants off. That shouldn't have happened. Then they covered me in celatape to keep the dress closed and handcuffed me and dragged me off to the male hospital.'

The male hospital was a 'dirty kip' and she 'stuck it out for 6 days cause they threatened to put me in the male p.s.u. [punishment and segregation unit] if I smashed it'. She 'wrecked' the hospital cell and was returned to the Mourne House punishment block. 'I'm just relieved to be back'. Still in a 'suicide dress', she had 'hung myself a pile of times. I just rip the dress and make a noose. But I am only

doing that cause of the way their treating me. The cell floor is covered in phiss cause they took the phiss pot out the other night'. She complained of flies in the cell: 'They won't let me clean it. I haven't had a shower now in 4 days. I've had no mattress or blanket either the past few nights'.

Annie told her sister:

'At the end of the day I know that if any thing happens me there'll be an investigation. (I never ripped the mattress or blanket nor did I block the spy). So if I take phenumia it'll all come out.'

She wrote that she was not drinking or eating:

'I think you can only last 10-12 days without drinking cause then you dehydrate and your kidneys go. I've no intention of eating or drinking again so their beat there. I know they'd all love me dead but I'd make sure everything is revealed first.'

She asked for her sisters to pray for her, to be remembered to the 'wains' [children] and for her solicitor to be told what was happening and to visit her 'straight away'.

Prison Service records supplied to the Commission indicate that a management plan, scheduled for introduction on 12 August, had been agreed. Annie was to be transferred from the hospital to a normal association landing with other women prisoners where she would have access to standard equipment in her cell. She rejected the plan and demanded a return to the Mourne House punishment block. When told she could not be transferred immediately she smashed the hospital cell. Annie was moved on 10 August. It appears that between 10 and 13 August, the day she wrote her letter home, she was held without basic sanitation or bedding. She refused food and water.

According to the records, further negotiations ensued and she moved from the strip cell to an intermediate cell in the punishment block. After six days she wrecked that cell and applied ligatures, demanding a return to the strip cell, 'her' cell. She was moved into strip conditions and continued to rip her clothing and apply ligatures to her neck. On 30 August she was visited by a member of the Board of Visitors. She was refusing to eat and food was strewn about the floor of the cell. She said she had 'no ambition except to die'. The Board of Visitors reported that a 'different approach concerning Annie should be made with some urgency – perhaps a medical approach, assessment and treatment elsewhere'. She was placed on

Rule 32, solitary confinement in the punishment block, for a further 28 days. On 5 September, she made what was to be her final court appearance at Enniskillen Crown Court. Convicted on two counts of attempted robbery and burglary, she was sentenced to 18 months.

The next day Annie was seen by a doctor. It was 'alleged' that she had tied two ligatures around her neck and he noted faint marks. Her care plan was updated and she was classified 'at risk'. The doctor wrote:

'The whole area of what appears to be an increasing number of young disturbed females needs to be looked at with a view to having a regime in place including specialist help and training for staff in an environment which does not come under the standard application of the prison ethos.'

Late on 5 September, a confrontation took place between Annie and Night Guard duty officers. Following the incident, the prison officer in charge wrote a statement, headed 'A. Kelly Fake Ligatures'. The senior officer had been told by staff that Annie had blocked the spy holes. It was agreed 'to open her cell on the chain and clear them'. Minutes later an officer told him that Annie 'was lying on the cell floor with a ligature around her neck tied to the window'. The senior officer called for two additional male officers 'to make up a control and restraint team' and a hospital officer. The officers arrived ten minutes later. As the team was about to be deployed the senior officer 'observed F929 A Kelly get off the floor laughing and get into bed'. He ordered the staff into the cell 'to clear it of anything that could block the spies', while Annie continued to taunt the officers. The team returned to the cell twice within five minutes to remove further ligatures from her neck. 'All the ligatures were made from her suicide blanket? [sic] one of them being 9ft long. Lack of female officers made it impossible to search or strip Kelly to prevent this'.

That night a woman prisoner, admitted to a cell directly above Annie's in the punishment block, heard Annie screaming and shouting. According to her account the following evening was significantly quieter. However, in the early hours of the morning of 7 September she heard noises from Annie's cell. A male voice, she assumed it to be a prison officer, was shouting, 'Come on, Annie, come on'. It then went quiet. During the morning Annie was unlocked, taken to the shower and returned to her cell. Three officers were responsible for Annie and there were no other prisoners held in the punishment block. From prison officers' accounts, their interaction with Annie was minimal.

Annie Kelly died in her cell during the early afternoon. A female officer looked through the spy-hole and saw Annie at the window, ligatures around her neck and her tongue out. The other ends of the ligatures were attached to the diamond mesh through a gap between the inner metal window frame and its Perspex cover. The officer walked from the cell to the office and told her colleagues that Annie was using ligatures again. The officer did not use the emergency button. Donning riot equipment, and expecting that Annie might be 'feigning' the officers entered the cell. Annie failed to respond and the officers realised she was dead or dying. The woman officer then pressed the emergency button and Annie was cut free and lowered to the floor. A prison officer and a nurse officer attempted resuscitation but to no avail. She was pronounced dead at 2.58pm.

Following Annie's death, a case conference was held to discuss the lessons that might be learnt and actions that might be taken. Minutes of the meeting recorded 'the need for an understanding of the tools to draw on and the appropriate knowledge to deal with prisoners who suffer from acute personality disorders'. Also identified was a 'need for a co-ordinated multi-disciplinary approach and the disclosure of the necessary information to deal with these cases'. These conclusions are instructive. They reveal that the concerns raised, noted and transmitted by the Belfast Coroner, John Leckey, to the Prison Service following the inquest into the death of Janet Holmes had not been transformed into a coherent policy or established practice.

An issue of profound and continuing concern was how, given her history and recent behaviour, Annie had the means to commit suicide. She was in a strip cell modified specifically for her use. There were two observation windows in the cell door, a cell window protected by metal diamond mesh in a steel frame covered by Perspex. The ceiling was metal sheeted with no exposed seams. All conduits, ducting and pipes had been removed. There was no integral sanitation or electrical fittings. She was usually dressed in non-destructible, protective clothing, her blanket made from similar material. Officers and managers knew that the blankets and clothing could be torn. Further, the modification to the cell windows enabled access to the diamond mesh through a gap sufficiently wide to take ligatures and hold her weight. It proved to be an oversight with fatal consequences.

The Prison Service's internal inquiry into Annie's death recommended issuing electronic pagers or alternative means of contact to nursing staff for swift emergency response. It called for updating and replacing monitoring equipment and upgrading protective blankets

and clothing. It also recommended an inspection of the cell to consider 'modifications that may be necessary as a consequence of this tragedy'. More broadly, the Inquiry Team 'recognises and endorses the general concern ... that an adult institution is an inappropriate place to commit a juvenile female'. It considered that the Prison Service 'should consult with all relevant bodies to consider the provision of a secure community based facility for juveniles with personality based disorders within Northern Ireland'. The Prison Service Suicide Working Group's terms of reference 'should be extended to include the management of juveniles with personality disorders' and staff training should be provided 'as a matter of urgency'.

The inquest into the death of Annie Kelly was held at Belfast Coroner's Court between 10 and 23 November 2004, two years and two months after her death. At the inquest it was the shared view that Annie should not have been in prison but in a secure, community-based facility. Governors and officers, supported by others who worked with her in prison, portrayed her as a deeply disturbed and manipulative young woman beyond management or control. She was a danger to herself, to other prisoners and to staff. Her predicament, they argued, although unacceptable to 'normal' people, was of her own making. The collective view was that Annie chose the strip cell, 'her' cell; she 'faked' suicide to 'taunt' prison officers; she was capable of formidable violence; she could wreck cells and destroy anti-suicide blankets and clothing with her bare hands. As an officer put it, 'She wasn't mad but bad'. It was a representation not universally shared. A teacher who knew her well stated in interview that after Annie died "a lot of people had to look at their consciences. Some staff [officers] would respond positively to her, put a radio by her door, but other staff ... and things did happen. Annie was goaded and she would hit out".

Annie's mother, Ann Kelly, also gave evidence at the inquest. In her signed statement she records how prison visits to see Annie 'were difficult because of the strict supervision engaged in by Prison Staff who were both very hostile towards Annie and ourselves'. Annie had complained 'on numerous occasions' to Ann 'about the rough treatment she was receiving from Prison Staff and being constantly under control and supervision of male staff'. This was particularly demeaning 'in situations where she was being searched'. Annie had also complained 'that she had been detained in exercise areas which were shared by male prisoners'. This was a reference to Annie's time in the male prison hospital. Ann accepted that it was Annie's intention 'to upset Prison Staff by engaging in mock suicide attempts to create panic and cause staff to feel upset about her and her detention'. Yet, it was hostility from prison officers that had given

'rise to a lack of concern for Annie's safety and led her to be placed in a cell which increased the likelihood of Annie engaging in mock suicide attempts'.

Ann Kelly felt that the 'strong hostility among Prison Staff and Governors towards Annie' had led to complacency: 'I am not satisfied a proper regime was in place to supervise her given that there had been numerous instances of this nature which gave rise to her death prior to it happening'. Following a visit to the cell in which Annie died to offer prayers, Ann concluded that 'nothing had been done by Prison Authorities to ensure that she was placed in a safe environment which would have prevented these mock suicide attempts which were usually in the form of hanging'.

The jury was unconvinced by the proposition that Annie had brought death on herself. Detailed and thorough, the jury's narrative verdict was unprecedented in its indictment of the endemic failures prevalent within Northern Ireland's Prison Service. The jury found the 'main contributor' to her death by hanging to be a 'lack of communication and training at all levels'. For prison managers, governors and officers the verdict offered no hiding-place, no opportunity for buck-passing and no escape from responsibility. 'There was', concluded the jury, 'no understanding or clear view of any one person's role in the management and understanding of Annie'. They identified a 'major deficiency in communication between Managers, Doctors and the dedicated team' responsible for Annie's health, welfare and safe custody. There were 'no set policies to adhere to', specifically a lack of appropriate management and staff training. And there was 'no consistency in her treatment and regime from one Governor to the next'.

Having established that the Prison Service was institutionally deficient at all levels, the jury listed five 'reasonable precautions' that should have been taken to meet minimum standards in securing a duty of care. The anti-suicide blankets were 'deficient' and an 'anti-ligature window should have been installed from the outset'. Given the events of 5 September, 'clearer guidelines on observation and monitoring' Annie might have removed the 'opportunity of making ligatures'. A search on the day would have discovered the ligatures she used. Finally, 'cell inspection should have been carried out frequently and thoroughly especially in regard to the window'.

The jury identified six further 'factors relevant to the circumstances of her death'. They criticised her 'very long periods of isolation' and the lack of appropriate 'female facilities'. They recommended better 'availability of resuscitation equipment within the Prison' and the

availability of first aid equipment 'on every landing'. Responding to evidence concerning the paucity of adolescent mental health care in Northern Ireland, the jury called for the provision of a 'therapeutic community'. Failing this, the 'Judicial system should strive to provide a like environment'. Finally, the 'Northern Ireland Mental Health Order needs to be updated to include personality disorders'. Given the failures in broader care provision, the deficiencies in communication and training 'at all levels' and the inadequate and inappropriate treatment of Annie, the jury doubted that Annie had intended to end her life, concluding that she did not die 'by her own act'.

The wider context and specific circumstances of Annie's death provide a partial insight into the abject failure of the criminal justice and penal systems in their handling of children and young people in conflict with the law. As the jury noted, the lack of appropriate adolescent mental health care in Northern Ireland results in the imprisonment of vulnerable children and young people who require care and support relevant to their needs. Whatever Annie's mental health diagnosis, the punishment and segregation unit of a high security adult jail was not an appropriate location. To portray her as a devious manipulator, who voluntarily and eagerly took herself to the point of no return, is disingenuous. It constitutes an abdication of institutional and professional responsibility. Her long-term pain and suffering throughout the most significant years of older childhood left her bereft of rational judgement and trapped in an ever-diminishing world of isolation, containment and punishment.

The warning signs were there but staff and management complacency prevailed, its implications reaching well beyond Annie's treatment to all aspects of the imprisonment of women and girls in Northern Ireland. In May 2002, just months before Annie died, the Prisons Inspectorate visited Mourne House. In their subsequent report the Inspectorate stressed that holding children 'assumed to be a significant management problem' in adult prisons was 'specialist work for staff with the appropriate training, skills and knowledge base'. In the Inspectors' view, neither officers nor managers had the ability or capacity required.

Reflecting on Annie Kelly's death, a governor who knew her well stated that prison officers had a 'mind-set' of 'ordering prisoners to do things' rather than 'discussing the issues' with them. A male prison officer working in the punishment and segregation unit disagreed: 'The prison hospital weren't interested when Annie Kelly was banging her head. It was left to us. I personally don't think I should be dealing with this. I'm not psychiatrically [sic] trained in any way, shape or form. I'm not a counsellor'.

Just two days after the jury presented its detailed narrative verdict the Coroner, Mr John Leckey, wrote to the then Secretary of State for Northern Ireland, Paul Murphy. He listed 15 issues derived in the verdict: communication problems between management, medical staff and prison officers; inadequate officer training; deficient policies and procedures; inconsistency of approach by successive governors; deficient suicide blankets; failure to provide an anti-ligature and anti-suicide cell; inadequate observations and monitoring; ineffective searches for ligatures; more frequent and thorough cell searches; long periods of isolation; inappropriate facilities in the prison for young female offenders; need for detention in a therapeutic community; availability of resuscitation and first aid equipment; need for legislative change to accommodate people suffering from personality disorders; the need for the establishment of a therapeutic community in Northern Ireland.

Mr Leckey noted that as Secretary of State Paul Murphy was 'in a position to ensure that action is taken to prevent, as far as possible, the recurrence of similar fatalities'. He continued: 'I understand that Ann [Annie] was not a unique prisoner and that there are other young offenders held in prisons in Northern Ireland who have personality disorders and would therefore be at risk in a similar manner to her'. Finally, he drew the Secretary of State's attention to the Human Rights Commission's report on the imprisonment of women and girls stating that the co-authors, Professor Phil Scraton and Dr Linda Moore, had given evidence at the inquest. He concluded: 'They expressed concerns that the death of Ann constituted a breach of both Articles 2 and 3 of the European Convention on Human Rights. As the State's representative in Northern Ireland, I would ask you to consider their views as to non-compliance with Articles 2 and 3'. Within a month the Secretary of State announced that the Northern Ireland Human Rights Commission was to be given rights of access to all places of detention in Northern Ireland.

On 15 December 2004, the Secretary of State for Northern Ireland responded in writing at length to the issues raised by John Leckey, the Belfast Coroner. He stated, 'it is important to learn lessons from tragic events such as the death in custody of Ms Kelly'. He continued:

'...I wish to acknowledge that Prison staff did work closely with Ms Kelly during her periods in custody to ensure she was held in conditions commensurate with the circumstances presenting at the time. It is important that we appreciate that Ms Kelly presented the Prison Service with serious control problems including her threat and use of violence against staff, prisoners and herself.'

He illustrated the extent of the 'control problems' by listing the numbers of assaults, self harm incidents, wrecked cells, threats and other adjudications. No explanation was given regarding the criteria used to assess the appropriateness of 'conditions' under which Annie Kelly was held or their relationship to 'circumstances presenting at the time'. It was clear that the Secretary of State was satisfied that the criteria adopted for such assessments, and the arrangements that followed, were acceptable.

He addressed each of the 'key points' raised by the jury and outlined by the Coroner. In relation to concern over communication problems between management, medical staff and prison officers, he noted the introduction by the Prison Service of a new policy for self harm and suicide following a 'full review'. He referred specifically to the requirement within the policy of 'better co-ordination between staff, Healthcare [sic] and others', the introduction of a 'multi-disciplinary case conference within 72 hours of someone being identified at risk' and the 'new PAR (Prisoner at Risk) process ... provid[ing] for residential care plans and Healthcare plans which follow the prisoner wherever they are in the system'. The Secretary of State did not comment on the procedures in place to ensure the accuracy of assessments or records entered in the plans. The previous care document, the IMR21, also had required detailed cross-disciplinary entries but they were rarely achieved and regularly ignored. Under the new procedures, however, the prison suicide prevention co-ordinator has been given responsibility 'for ensuring PAR forms are completed correctly and case conferences held'. As stated elsewhere in this report, the inadequacy of the IMR21 form was due to a lack of training and, at best, little appreciation of the significance of inter-disciplinary work. At worst, it reflected hostility between professionals and a deep-seated resentment by frontline prison staff that they were unqualified to deal with complex mental health cases.

In response to concerns over inadequate training, the Secretary of State noted that the Prison Service recognised the need to improve training. Previously this amounted to a limited number of staff attending a 'half day suicide awareness training seminar' and receiving unspecified refresher training to retain their certification' in first aid. The new policy for self harm and suicide provided all staff with 'briefing packs' with managers attending one seminar, then 'cascad[ing]' the training received at this seminar to their staff. This was to be supported by the 'availability' of a 'half day training pack'. Further, 'staff managing females in custody [had] commenced training on 'Working with vulnerable and Personality Disorder Prisoners'. Training is ongoing.' The Secretary of State provided no details of this training, its depth or purpose. Given the complexity of cases, particularly among women prisoners, it is questionable

whether half-day seminars, briefing packs, 'cascading' the content of single seminars and half-day training packs, represent a comprehensive programme of training for staff without any background in dealing with mental health problems.

In terms of deficiencies in the policies and procedures adopted in the management of Annie Kelly, the Secretary of State reassured the Coroner that the Prison Service was currently committed to the development of new policies for the management of women in custody. These policies 'will be informed by the conclusions of recent unannounced inspections by HCMI [sic] on behalf of the criminal Justice Inspectorate and by the recent report of the Human Rights Commission'. Provision for 'better procedures, systems and guidance to staff on the management of vulnerable prisoners' were now ensured by the self harm and suicide policy thus addressing many of the deficiencies 'identified at the inquest'. The jury had been concerned that prison governors managed Annie Kelly differentially. The Secretary of State considered that the provision of a coherent care plan had been 'difficult given the unpredictability of her committal and discharge from custody'. In future a suicide prevention co-ordinator at each prison would 'provide greater consistency in managing difficult cases such as this'.

With specific regard to the issue of deficient suicide blankets, the Secretary of State noted that the blanket issued to Annie Kelly 'was supplied by the Prison Service to an approved British standard'. He quoted evidence 'given by male officers to the inquest' that 'they could not tear the blanket'. This evidence had been contentious and had depicted Annie Kelly as a young woman of exceptional strength and guile. The Secretary of State provided no comment on the fact that she had regularly torn ligatures from her blankets and, regardless of what constituted the 'British standard', the material was not fit for purpose. Blankets and suits 'are now supplied by the Scottish Prison Service and are of a higher standard to that [sic] supplied previously'. On the jury's particular concern regarding the failure to accommodate Annie Kelly in a ligature free cell, the Secretary of State conceded that there 'should not have been any ligature point at the window grille'. He commented that the 'polycarbonate sheet may have been removed for maintenance and in refitting the small gap was left'. This statement was not attributed to any contemporary source and was not evident in the internal prison investigation report into Annie Kelly's death. It was presented as conjecture. Further, when the researchers visited the cell in March 2004 the gap was still evident. In a statement that has implications for future prisoners 'identified at risk', the Secretary of State assured the Coroner that '[i]n so far as is practicable anti-ligature windows will be fitted'. Cells at Hydebank Wood for

'vulnerable female prisoners have anti-ligature windows fitted' and 'new buildings will comply with the safer cell design ...'

Responding to the concerns raised regarding the inadequacy of observation and monitoring of a prisoner locked alone in a cell for long periods of time, the Secretary of State noted that Annie Kelly 'had been observed some 13 minutes before she was found hanging'. He referred to the evidence of a Forensic Psychiatrist who had 'emphasized that where there is an intention to take ones [sic] own life that this can be achieved in 4 minutes'. Further, Annie Kelly 'frequently reacted if staff were overly intrusive in supervising her'. At the inquest lengthy consideration was given to discussing the regularity of checks on prisoners deemed to be at risk and held in the punishment block. There was also dispute over whether Annie Kelly was checked immediately prior to her death. Clearly the jury remained concerned that the evidence before the court raised serious doubts as to the adequacy of the observational and monitoring arrangements operational in her management. The Secretary of State concluded by noting that it 'is necessary to strike a balance [regarding intrusion] and the case conference arrangements under the self harm and suicide policy will provide clear guidance for staff on observations required in any particular case'.

Further specific concerns concerning the frequency of searches for ligatures, cell inspections and isolation were also considered by the Secretary of State. He stated that searches accorded 'with the procedures laid down' but it 'would have been helpful if, given the risk to herself, staff were required to give additional searches'. No comment was made on the lack of female officers available to conduct regular searches or on how Annie Kelly could conceal a ligature nine feet in length in a bare cell. While stating that 'higher frequency of searches did lead to confrontation' the Secretary of State recorded that 'it is accepted that Ms Kelly should have been subject to additional searches, including her cell and property'. Again, he was reassured that the new policy on suicide and self harm 'addresses this issue'. Regarding isolation, the Secretary of State noted: 'It is accepted that keeping a prisoner in isolation for long periods is unhealthy but unavoidable where that prisoner is so disruptive and threatening to his/herself and others'. Given that she 'was disruptive when located on a normal landing' and 'presented significant control problems for staff and when intent on self harm', observation was 'difficult to maintain ... when she had the freedom to move through the landing'. Yet, when she was held in isolation, contact with those with whom she had positive relationships (teachers and other non uniform staff) 'could not be provided all the time'. Yet it was clear in the internal report and in evidence to the

inquest, that when held in the punishment block such contact was minimal. In responding to the issue of 'virtual isolation', the Secretary of State reiterated figures on officer assaults and cell wreckings, noting the 'many occasions' she had 'used debris' to self harm'. The inference being that there was no alternative option available than isolation in a punishment block for such a disturbed young woman.

The Secretary of State did not respond to the jury's concern that the facilities at Mourne House were inappropriate for holding young female offenders other than to state that following the transfer to Hydebank Wood, young women were accommodated in a 'low risk establishment with a relaxed and varied regime'. This would be enhanced as a consequence of the 'recent inspection' through which 'further improvements are planned to deliver more constructive activity including education'. While reassurance was given regarding the potential benefits of a developing regime, the failure of the regime at Mourne House went unaddressed. The Secretary of State, however, suggested that Hydebank Wood provided an appropriate alternative. His conclusion remains contested by the findings of this report and accounts from women held in Ash House concerning strip searches, abuse from young male prisoners, inadequate sanitation and healthcare facilities shared with young men.

The jury's final concerns related to the appropriateness of holding Annie Kelly in prison rather than in a 'therapeutic community'. The Secretary of State noted that the 1986 Mental Health Order (NI) 'excludes personality disorder, whereas it is included in English/Welsh legislation, the result being that therapeutic community facilities exist in England and Wales but not here'. Instructively, he added: 'Prison, with its disciplinary approach is 'the place of last resort' and could be considered an inappropriate establishment for persons suffering from the disorder'. Rather than concluding that the Northern Ireland legislation might warrant reform, however, he placed on Annie Kelly the responsibility for her lack of therapeutic support:

'As one of Ms Kelly's problems was reported to be missing her family, sending her to such a community in England and Wales was deemed geographically inappropriate. Ms Kelly was also required to give her consent to the transfer, but had refused in the past.'

Yet the jury had been specific in its criticism of the mental health legislation in Northern Ireland, recommending a change in the law to bring it in line with England and Wales. The Secretary of State failed to respond to this important point, simply commenting 'See above'.

At no point did he seek to explain the significant discrepancy between jurisdictions. Neither did he express any intention to pursue legal reform. His conclusion was pessimistic and was at odds with the intention to 'learn lessons from tragic events' stated at the outset of his response: 'The Prison Service continues to seek alternative approaches to managing those with severe personality disorder and whilst prison is not ideal there is no alternative provision available in Northern Ireland'.

Roseanne Irvine

'Death in custody

The NIPS [Northern Ireland Prison Service] wishes to express its sympathy to the friends and relatives of Roseanne Irvine, a 34-year-old female remand prisoner who was found dead in her cell at around 22.15hrs last night (3 March 2004) in Mourne House, Maghaberry. Her next-of-kin and the Coroner have been informed.'

This announcement was published by the Northern Ireland Prison Service on 4 March 2004. Roseanne Irvine was discovered hanging by the neck. An officer who entered the cell stated:

'Although RI was 'on' an IMR21 and we were aware that there was a strong possibility that she was liable to attempt suicide, we were unable to avert this suicide, as it was impossible to observe her continually throughout our shift ... Not only was it a very stressful and traumatic experience having to deal with this unfortunate death, it has been made worse by the fact that although we were aware of the situation, we were helpless to prevent it.' (Statement supplied to Commission)

There is no question that prison officers and their managers were aware that Roseanne Irvine was a serious suicide risk. Her case was brought to the attention of the Maghaberry Prison Governor in 2002 during a previous period of imprisonment. On 22 March of that year, on behalf of the prison officers concerned, the Mourne House branch of the Prison Officers' Association (MHPOA) chairman informed the Governor in writing that Roseanne had attempted suicide during the night guard period. The correspondence noted that although on arrival she was thought to be a suicide risk, the prison doctor did not meet her. She was located on the C2 committals landing where the hospital officer administered an initial check. An IMR21 was raised confirming that she was a 'potential suicide risk' but the doctor did not visit her. At 22.05hrs there was an emergency unlock.

Roseanne had attempted to kill herself using a ligature and 'lying face down'.

The Night Guard attended her until a hospital officer arrived from the male prison hospital. This took 35 minutes. Eventually, she was examined by a doctor at 00.10hrs. It was recommended that she be transferred to the male prison hospital for 'special care'. This did not happen and she was placed in the 'prison support unit' (the punishment block), dressed in an anti-suicide tunic and put on 15-minute observation.

Noting the criticisms of prison administration made by the Janet Holmes internal inquiry, the MHPOA's letter posed a series of questions:

- 'Why does the Prison Hospital continue to ignore the contents of the Suicide Awareness Manual? [This question related to the policy statement that when a prisoner 'attempts suicide or commits an act of self-harm he will be taken to the Health Care Centre for necessary treatment' followed by 'observation and assessment'.]
- Why are hospital management so reluctant to accept women prisoners and then for only the shortest period?
- Why are IMR21s raised by Mourne House staff consistently brushed aside by hospital officers?
- Why did it take 35 minutes for the Night Guard hospital officer to reach C2?
- Why was Irvine not admitted to the prison hospital immediately after attempting to take her own life?
- Why was she placed in a segregation cell in the prison support unit? [The letter noted that officers on duty were already traumatised by the incident.]
- Why was there no leave provision granted for prison officers who had dealt with the incident?'

In a further letter to the Governor the MHPOA branch chairman stated that Roseanne had made a further attempt to commit suicide. He alleged that the regulations laid down in the Suicide Awareness Manual had been ignored and she had been left in her own cell and placed on 15-minute observation by the night guard. The chairman stated that in October 2001, at a meeting between the MHPOA and the previous Governor, it had been agreed that prisoners on 'special watch' should not be left on residential landings. Yet the Governor with responsibility for healthcare and the prison doctor were 'of the opinion that prisoners who are not in clinical need should be kept in a residential house'. Responding to this, the MHPOA believed that

'prisoners deemed at risk should be in the Health Care Centre'. The MHPOA proposed that the Mourne House healthcare centre should be staffed 'at night by a nursing officer who would be used in the male prison'.

On 19 April 2002 a 'failure to agree' was registered with the Governor. With reference to paragraph 7 of the Industrial Relations Procedural Agreement, the MHPOA made the following statement:

'Hospital management are continuing to ignore the regulations governing the treatment of prisoners who are attempting self-harm. This is placing an intolerable burden on discipline staff by placing these prisoners in residential units instead of the healthcare centre. Prisoners deemed to be at risk of self-harm by medical staff should be placed in the prison hospital.'

On 2 May 2002 the MHPOA chairman advised a healthcare meeting 'that it was necessary to have a Health Care Officer in Mourne House during association and at night and requested the matter be looked into' (minutes of the meeting). A month later, on 6 June 2002, the MHPOA wrote again to the Governor stating that as there had been no reply to their 'failure to agree' letter there was no option but to move to stage 2 of the industrial relations procedural agreement. On 24 June 2002 the Governor met with the MHPOA chairman. His note of that meeting records that the Governor 'stated that he understood the MHPOA views and how self-harm prisoners were viewed by the healthcare centre and it could be construed that the "yellow manual wasn't being complied with"'. According to the note the Governor 'made the following points':

- 'prisoners were admitted into hospital on a clinical need basis determined by the doctor and/or nursing staff
- self-harm/attempted suicide prisoners were not necessarily a medical problem but should be seen as a multi-disciplinary problem
- the recent HMIP report on this prison would highlight that point; these self harming prisoners should be dealt with on normal location
- HMIP were unhappy about female prisoners being moved to the male healthcare centre; they may recommend the reopening of Mourne healthcare centre.'

The Governor stated that there was a working party on the implementation of the new suicide awareness arrangements and that the recent healthcare review had recommended that, whenever possible, 'at risk prisoners' should be 'handled on normal location'. Meanwhile, the healthcare governor had been asked to review bed

space in the healthcare centre. The MHPOA requested 'a review into the possibility of re-opening Mourne healthcare centre'. The Governor agreed to include this possibility in the review of bed space but refused to commit to a re-opening.

In September 2002, a further incident involving Roseanne occurred and the MHPOA chairman sent a further letter to the Governor. It was headed: 'Treatment of Prisoners deemed to be at risk of self harm'. It noted that on Sunday 15 September, Roseanne had 'committed an act of self harm on C2 landing'. It continued: 'As usual the regulations contained in the Inmate Suicide Manual ... were ignored by prison management'. The Deputy Governor had 'instructed that she [Roseanne Irvine] should be placed on 15 minutes observation and remain in her cell in C2'. The MHPOA chairman commented that 'Night guard staff untrained in medical procedures are being placed in an intolerable situation'. He also noted that no Mourne House officers had been included in a prison-wide team regarding the care of self harming prisoners.

Interviewed recently, the MHPOA chairman stated:

"There are only two healthcare officers at night on the male side. If you have two medical emergencies you've had it. You must have a healthcare officer available for Mourne House at all times."

An officer involved on the night of Roseanne's suicide, who had attended several other incidents, considered the "response times of getting medics over from the hospital" to be a serious issue. He warned, "a life could be lost because of the slow response time".

On release from prison in November 2003, Roseanne lived in a hostel on the Antrim Road. She had problems with alcohol, glue, gas and drugs. She transferred to a hostel on the Ormeau Road where she was very unhappy. She reported being intimidated by the men who lived at the hostel. She moved again to a flat at Grainne House. Her habit, however, impelled her back to the Ormeau hostel, where there was 24-hour supervision. According to a member of the clergy, who visited her in prison and on her release, Roseanne's 'mood became very low and she said she wanted psychiatric help'. One night she was put out of the hostel and left on the streets. The social worker at the hostel considered her health needs could be met only with proper psychiatric care. She was given an appointment for early February 2004. On 21 January, while out with others from the hostel, she was attacked by one of the group. Frightened, she asked to be taken to prison for her safety.

Within two weeks, following a suicide attempt, Roseanne was admitted to the Mater Hospital. The member of the clergy visited her and found her 'very withdrawn and depressed'. Yet Roseanne remained optimistic that she would receive care and treatment following an appointment with the hospital consultant. The following afternoon the member of the clergy visited her again:

'When I arrived I could see Roseanne was very depressed and did not know what was happening to her. She had seen [the consultant] in a room with many other people, which she found very distressing, and was unable to communicate. I went to see the ward sister who came with me to Roseanne's bedside and told her that she was being discharged under the care of the community health team. Roseanne was very distressed.'

Roseanne was discharged from the hospital without medication and the hospital had no information on her whereabouts. Taken to the Homeless Advice Centre, she was allocated a place in a house occupied by men who suffered multiple problems, mainly alcohol and drugs related. She was 'very frightened' living at the house. The caretaker was on duty only from 7.00pm until 7.00am. Roseanne kept her February appointment with the consultant who told her that she should be in hospital. An appointment was made for her to attend the day hospital for medication. The member of the clergy stated in correspondence:

'I went to [the house]. I could not get in several times. Then, on one occasion a drunk man answered the door and he told me Roseanne was out. I left a message for Roseanne to phone me. I eventually got to see Roseanne. I brought another sister with me as I was afraid to go into this house by myself. Roseanne was in a terrible state of depression, confusion. She said she was frightened 'out of her mind', had taken drugs, drink and glue and no medication.'

The member of the clergy was concerned that Roseanne had not received a formal visit to assess the appropriateness of the conditions under which she was living. She telephoned Roseanne's care manager to report that she 'was depressed, suicidal ... and unable to stand, her eyes rolling'. The care manager arranged for Roseanne to attend the day hospital. That evening she telephoned the member of the clergy 'quite drunk and suicidal'. Within a week she was in police custody and 'appeared in court in her pyjamas'. She had self-harm laceration marks on her face and body. This was confirmed by a probation officer.

The death of Roseanne Irvine is particularly shocking by its apparent inevitability. As one officer put it: "We have our own list, our own worries as to specific women who might have died ... she displayed the symptoms, the prior attempts. The warning bells were there". A professional worker stated that, "everyone realised that Roseanne had great needs ... she couldn't cope here and couldn't cope in the community". The provision, however, "fell short because no-one put their hand up for overall responsibility". Given Roseanne's personal history of self-harm and attempted suicide, the lack of an effective care plan for her, a highly vulnerable young woman, raises serious concerns about the circumstances in which she died. She had arrived in prison in a deeply distressed state and had voiced real worries that she might lose access to her daughter. Her friend in prison, Jane (not her real name) recalled:

"She [Roseanne] was always talking about her wee daughter. She loved her so much she talked about [her] every day. She hadn't seen her daughter for three weeks and she really missed her. She said to me that she did not think she would see her again because of what her social worker [allegedly] told the prison officer to tell her. She told Roseanne that [her daughter] was happy and it would not be right to bring her up to the prison to see her. That really hurt Roseanne. You could see it in her face when she was telling me. It was Roseanne's child and she had every right to see her."

A prison officer stated that Roseanne "was not getting to see her daughter" but did not know why. But a probation officer had "left a note for Roseanne" confirming that she would be able to see her daughter and a social worker would visit to make necessary arrangements. Clearly, Roseanne was worried about the situation. A prison officer noted: "In a letter a week ago she told her daughter that she was not well, but that she really missed her and wanted to see her. She loved her daughter but she was ill and it [the illness] was no fault of her own".

It appears from the accounts of other women prisoners on C2 that Roseanne had recently been held in the punishment block. One woman stated that "she had had to lie on wood" and another commented that she "was sore on her back after the punishment block". Considered a suicide risk, she was held in C2, in possession of several ligatures and in a cell with multiple ligature points, not least the patterned metal-work of the cell window bars. She received no counselling, had little meaningful contact with staff and was locked up, unobserved, for extended periods.

A woman prisoner stated that earlier in the evening of her death:

“Roseanne told me not long before we got locked up that the staff did not check on the women every hour and she said to me that one of these nights they will find someone hanging and they will be dead. That very night Roseanne was found dead.”

She continued:

“If the staff had checked on Roseanne more often that night she might be alive today. They knew she was down ... The girl needed help which she did not get. She was so down. This place is like hell on earth.”

A woman in her cell on C2 could hear another woman “squealing and shouting” to Roseanne but “no buzzer went off”. She was convinced that the officers had turned off the emergency cell buzzers.

Another woman stated:

“What happened to Roseanne was frightening. You think you’re going to bed safe and you wake up and ask a warder where someone is and they say she hanged herself ... All she wanted was to see her child but they didn’t listen to her. Roseanne’s death could have been prevented.”

The impact on the other women prisoners was immediate:

“The next day I just sat and cried. I then had panic attacks. They didn’t get the nurse over. I pushed the [emergency] button and they came to the door. I asked to see the nurse and they just said ‘No’. They said, ‘You’re not allowed to push the button. It’s for emergencies only’. I said I was having a panic attack. They said, ‘Take deep breaths’. It was early evening. I sat up on the bed with a pillow and cried and cried.”

Roseanne’s closest friend on the landing, Jane (not her real name), was devastated and was transferred to the healthcare centre on the male side. She commented:

“The way that girl was treated the system let her down. There should be a hospital for women. It was disgusting, dirty in here ... I always told her not to do anything to herself. I tried to see her that night but we only got 20 minutes out [of the cells]. I started to write things down myself. I wrote there

should be more support for women with mental health problems.”

She said that if “they’d doubled me up [shared cell with Roseanne] then I could have saved her life. She was worried about whether she would ever see [her daughter] again”.

In the immediate aftermath of Roseanne Irvine’s death, a woman prison officer reflected on the situation. Two weeks earlier a 17-year-old had nearly died by hanging, another 17-year-old was being held in C1 in strip conditions and Jane had been moved to the prison hospital in a deeply distressed state. The officer commented, “after Annie Kelly we felt it couldn’t get worse than this ... and it has”. Roseanne’s death was the subject of an internal Prison Service investigation conducted by the Governor of Magilligan Prison. The report on this investigation has not been made public and at the time of publishing the second edition of this report (June 2005) no date had been announced for the inquest.

This report recommends that the circumstances of the deaths of Annie Kelly in September 2002, and of Roseanne Irvine in March 2004, be subject to further inquiry. This should include analysis of the extent to which the lessons from the death of Janet Holmes, including the recommendations of the Coroner, were taken on board by the Prison Service and changes made accordingly. (Recommendation 24)

Chapter 7

THE MOURNE HOUSE YOUNG OFFENDERS' CENTRE

Human rights principles and children's imprisonment

Human rights principles define a person below the age of 18 as a child, a definition accepted in the Children (Northern Ireland) Order 1995. Barry Goldson noted that institutions that incarcerate children are rarely openly referred to as 'children's jails with preference given to euphemistic terms: borstals, young offenders' centres, secure units or training schools'.²¹⁰ In Northern Ireland the terminology has moved from borstals to training schools to juvenile justice centres and young offenders' centres. Goldson reflects how children in these institutions are referred to as 'delinquents, inmates, convicts, prisoners, criminals, lawbreakers, malefactors, miscreants, wrongdoers, offenders, trainees, youths and juveniles', and how 'it is striking how infrequently the terms 'child' or 'children' are used'.

A core principle of the UN's Convention on the Rights of the Child (UNCRC) and other international human rights standards is that the 'best interests' of the child should be the primary consideration in all actions and interventions concerning the child (Article 3). Again, this is integral within the Children (Northern Ireland) Order 1995. The Northern Ireland Human Rights Commission, along with the children's rights sector in Northern Ireland, has lobbied for the incorporation of the 'best interests' principle into domestic youth justice legislation. However, it is important to consider Goldson's cautionary warning that the 'best interests' principle, while a cornerstone of children's rights, may also be employed to restrict children's liberty by being cited as justification for the use of secure accommodation.²¹¹ In the course of the research a case arose in which a child came close to being refused bail, not so much because her alleged offending behaviour constituted a serious risk to the public, but rather because it was in her 'best interests' to be refused bail as the local health and social services trust was unable to offer her an appropriate level of care (see case study below).

²¹⁰ Goldson B (2003) 'Custody Battle – children in secure settings', Issue 63 March/April *Young Minds Magazine*.

²¹¹ Goldson B (2002) *Vulnerable Inside: Children in secure and penal settings*, The Children's Society, London, p 1.

Given their special vulnerability, children have the right to protection from harm and to have their 'physical integrity' protected (Article 19 UNCRC). The detention of children should be used only as a measure of last resort and for the shortest appropriate period of time (Article 37). Further, 'every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human persons and in a manner which takes into account the needs of person of his or her age'.

Article 40 of the UNCRC establishes that:

'State Parties recognise the right of every child alleged as, accused of, or recognised as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth.'

While in detention children and young people should be kept separate from adult prisoners.²¹² The UNCRC protects children's rights to education, health, leisure, privacy, family contact and an adequate standard of living. Since October 2000, the European Convention on Human Rights (ECHR) has been incorporated into the law of Northern Ireland through the Human Rights Act 1998. While the ECHR is not a child-specific instrument, its provisions have implications for the treatment of children in custody, some of which have been explored through the courts. The Howard League for Penal Reform has developed a research and litigation strategy aimed at improving the care, and reducing the numbers, of children in custody.

Case law relating to children in prison

The Howard League research and associated legal cases have been important: first, in exposing how children in custody in England and Wales have been treated and second, in challenging breaches of human rights through the courts. The League's 1997 report, *Lost Inside*, a study of the use of prison for girls under 18, found that girls were being held alongside adult women in adult jails. It also found that staff had little or no training in dealing with vulnerable girls. Yet the vulnerability of girls was marked: 22 per cent had self-harmed; 65 per cent had experienced family breakdown; 40 per cent had been in care; and 41 per cent reported drug or alcohol abuse.²¹³

²¹² *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*, 14 December 1990, GA Res 45/13, Rule 29.

²¹³ Howard League (1997) *Lost Inside: The Imprisonment of Teenage Girls*, Report of the Howard League Inquiry into the use of Prison Custody for Girls Aged Under 18, Howard League for Penal Reform, London.

It is in this context of vulnerability that between 1993 and 2003, 19 children killed themselves in prison in England and Wales.²¹⁴

Following the publication of *Lost Inside*, the Howard League supported and gave evidence at a judicial review of Home Office policy concerning the holding of under 18-year-old girls alongside adult prisoners.²¹⁵ The court ruled that it was unlawful for the Secretary of State automatically to place children in an adult prison. Following this ruling, the Government announced it would prioritise the removal of girls from adult prisons. The then Home Secretary, Jack Straw, told Parliament:

'The Government has concluded that establishing distinct units for the very small number of 15- to 17-year-old girls held in Prison Service accommodation is not the best way forward or in their best interests.'²¹⁶

In 2002 the Howard League set up a legal department and its first case was a successful challenge to the Prison Service insistence that the protection of the Children Act 1989 did not apply to children in prison.²¹⁷ In January 2004, in another case taken by the Howard League, a High Court judge held that holding a 16-year-old girl in an adult prison was not in her 'best interests' as required by human rights law but, because there were insufficient places in secure children's homes, he could not find it unlawful. In his judgement, Mr Justice Hooper said: 'It is difficult to see how it can be said to be in the best interests of a 16-year-old, such as the claimant, to spend a considerable amount of time on association with those 18 and over'.²¹⁸

In April 2004, Home Secretary David Blunkett announced that teenage girls were to be held separately from adult women prisoners. By 2006 a network of four specialist units will be built, to avoid the practice of girls being held alongside adult prisoners. Outlining the plans, David Blunkett stated: 'these prisoners have a

²¹⁴ Parliamentary Joint Committee on Human Rights, *Inquiry into Human Rights and Deaths in Custody*, written evidence from inquest, 15 December 2003.

²¹⁵ *R v Accrington Youth Court, ex parte Flood* [1998] 1 WLR 156.

²¹⁶ Cited in: Howard League (2004) *Advice Understanding and Underwear: Working with Girls in Prison*, Howard League, London, p 3.

²¹⁷ *R (on the Application of the Howard League for Penal Reform) v Secretary of State for the Home Department* [2002] EWHC 2497 (Admin)

²¹⁸ *DT, R (on the application of) v Secretary of State for the Home Department* [2004] EWHC 13 (Admin).

particular vulnerability and should be cared for by specialist staff with facilities that address their unique education, health and social needs'.²¹⁹ The Chief Inspector of Prisons, Anne Owers, welcomed the commitment to the separation of girls and adult prisoners, but warned: 'that this alone will not deal with the multiple problems of girls in custody'.²²⁰ Continuing its campaign to end the imprisonment in adult prisons, the Howard League concludes:

'...there have been a number of positive steps to improve conditions for girls in prison... There have been moves to encourage prison staff to adopt a child-centred approach when working with children... However, you cannot escape the fact that a prison is still a prison. It is run by prison officers who often have limited specialist training for work with teenagers and it is based on a regime designed largely for an adult male population.'²²¹

The Prisons Inspectorate's view on children in custody

The Prisons Inspectorate has publicly called for an end to sending children to adult prisons.²²² In 1997, the Inspectorate published a *Thematic Review of Young Prisoners*. The then Chief Inspector of Prisons, Sir David Ramsbotham stated:

'...there is no justification for any cynicism about the treatment of young people in custody. The only raw material that every nation on earth has in common is its people, and woe betide any that does not do everything it can to identify, nurture and develop their talents. Young Offenders may have lost their way in society but that does not mean that they are without talents which can be turned to advantage – their's and the nation's – given proper encouragement. Young prisoners will return to the community, and therefore it really does matter how they are treated in prison.'²²³

²¹⁹ Batty D (2004) 'Girl Prisoners to be removed from adult jails' *The Guardian Unlimited*, 20 April 2004 [Online] Available: <http://politics.guardian.co.uk/homeaffairs/story/0,11026,1196067,00.html>.

²²⁰ Above.

²²¹ Howard League (2004), p 23.

²²² HMCIP (1997) *Young Prisoners: A Thematic Review by HM Chief Inspector of Prisons for England and Wales* Home Office, London, preface.

²²³ Above.

The review found that prison is expensive and did not prevent high reconviction rates. The Chief Inspector argued that 'the Prison Service is essentially an organisation for adults, neither structured nor equipped to deal with children'.²²⁴ The Inspectorate noted the absence of any effective guidelines or standards underpinning the treatment of children in prison as distinct from adults. It affirmed the importance of needs assessment based on all available information on the child's background. Its recommendations included: reduction of time spent on remand;²²⁵ the bringing together of all criminal justice and community agencies who are concerned with children involved in crime within a single unified framework;²²⁶ special training for staff working with children in custody;²²⁷ acknowledging and addressing mental health problems among young people in trouble with the law;²²⁸ appointment of a Director of Young Prisoners who would be responsible for the quality and delivery of consistent regimes for young prisoners held by the Prison Service.²²⁹

Custodial institutions for young people should provide:

- a safe environment
- a culture which promotes social responsibility
- opportunities to grow up and to change
- opportunities for education and work skills
- continuing care involving families, and
- preparation for a life free from offending.²³⁰

The Inspectorate also carried out a survey of the views and experiences of young people in prison between November 2001 and March 2003. The main findings established that: approximately a quarter of all young people reported they had experienced insulting remarks from staff; over a third stated they felt unsafe at some point during their time in custody; and boys were more likely than girls to have been subject to restraint or assault from other young people. Nearly half of all girls had experienced insulting remarks from staff. Over a third said they felt unsafe at some point during their time in custody. Boys were more likely than girls to have been subject to restraint or assault from other young people. 50 per cent of all girls reported being on medication compared to less than 25 per cent of boys. Boys were more likely to be employed within the establishment whereas much higher numbers of girls were involved

²²⁴ Above.

²²⁵ Above, Chapter 9, Recommendation 3.

²²⁶ Above, Recommendation 6.

²²⁷ Above, Recommendation 8.

²²⁸ Above, Recommendation 13.

²²⁹ Above, Recommendation 18.

²³⁰ Above, Recommendation 10.

in education and learning skills or a trade. Boys had better access to the gym, but girls had more association and outside exercise.

Approximately half of the girls surveyed had been in care or foster homes. Alcohol and drug use were reported as significant problems for young people. Most wanted to stop offending in the future but nearly a third of those about to be released considered they needed further support with resettlement. A finding of particular significance for the current research was that 'girls in the smallest units were the most negative about their experience. Unlike boys, they are held in adult female establishments, where it is more difficult to meet their specific needs'.²³¹

Girls in prison in Northern Ireland

In Northern Ireland, girls aged 10-16 years can be remanded or sentenced to custody in a juvenile justice centre under the Criminal Justice Custody Order. At the time of the research, girls aged 17 were remanded or detained under the Order to the Young Offenders' Centre (YOC) at Mourne House. The Order also allows for girls and boys aged 15-16 years to be remanded and sentenced to the YOC if they are considered a risk to themselves or to others. Following the Criminal Justice Review recommendations,²³² 17-year-olds identified as 'vulnerable' can be sentenced to serve juvenile justice centre orders at Rathgael. The preconditions are that they do not turn 18 during the period of the order and have not received a custodial sentence within the previous two years.²³³ Children can also be sentenced to the YOC at the Secretary of State's Pleasure (the equivalent to an indefinite life sentence for an adult).

The Northern Ireland Human Rights Commission has expressed concern regarding the small number of teenage girls being held in Rathgael alongside a significant majority of boys. This was highlighted during a period in 2003, when a pregnant 16-year-old was the only girl accommodated in Rathgael. The Commission, together with Northern Ireland children's rights NGOs, has consistently lobbied for an end to children being held in Prison Service custody. The rights of children established in English case law have not yet been established in law in Northern Ireland (for

²³¹HM Chief Inspector of Prisons (2004) *Juveniles in Custody: A Unique Insight into the Perceptions of Young People in Prison Service Custody in England and Wales* HMCIP, London, p 4.

²³² The review was set up following the Belfast (Good Friday) Agreement 1998 and reported in 2000.

²³³ *Justice (Northern Ireland) Act 2002*, Part 4.

example, that they are entitled to the protection of the Children Order; and that punishment/segregation cells should not be used).

At the time of writing, the Chief Inspector of Criminal Justice for Northern Ireland, in partnership with the Social Services Inspectorate is conducting an assessment of girls in custody in Northern Ireland. The remit of this survey includes girls held in Rathgael and in Prison Service custody. It is anticipated that the findings will be published in 2005.

The Prisons Inspectorate's views on the Mourne House YOC

At the time of the 2002 Maghaberry inspection, only one child, a 15-year-old girl, was held in Mourne House. The Inspectorate commented favourably on the efforts made by staff to maintain external links with other professional agencies such as the Probation Service.²³⁴ Yet, the Inspectorate also reported:

'serious concerns regarding the ability of the residential staff to adopt a truly child-centred approach, and also the establishment's capacity to meet the needs of this child, or others who may follow, on a day-to-day basis.'

It continued:

'Children who are placed in adult prisons must be assumed to be a significant management problem. This aspect of childcare is specialist work for staff with the appropriate training, skills and knowledge base.'²³⁵

The Inspectorate criticised child protection policy and procedures in Mourne House:

'As part of the effective implementation of robust child protection arrangements, there should be great care to ensure that appropriate and ongoing vulnerability assessment are undertaken before mixing children with adult women. We were provided with draft child protection procedures that had been drawn up to inform staff within Mourne House, but they were limited and fell far short of the standard that would be required

²³⁴ Northern Ireland Prison Service *HM Chief Inspector of Prisons, Report of a full announced inspection of HM Prison Maghaberry, 13-17 May 2002*, MH 103.

²³⁵ Above, MH 104.

for staff working with very needy and damaged children in a custodial setting.²³⁶

In principle it would be appropriate for child protection procedures operational in prison to be consistent with guidelines throughout the system.²³⁷ Child protection policies and procedures are important not only for children in the YOC but also for children accommodated in prison with their mothers.

The Prisons Inspectorate noted potential serious child protection issues in mixing young prisoners with adults, who may include women convicted of offences against children.²³⁸ The Inspectorate recorded particular concern regarding the care of the 15-year-old girl, who had been involved in incidents of self-harm:

'It was believed that she had in her possession an object recorded as a piece of glass. Records on the fact were not clear; she was subject to control and restraint and placed in the strip clothing on a punishment unit in Mourne House. We were told that staff were not good at recording all the work that had gone into trying alternative strategies with the young person before this action was decided upon.'²³⁹

The Inspectorate raised the issue of whether prison was the most appropriate place for this child:

'Staff had not been specifically trained to respond to difficult and challenging behaviour from such children. The influence of the adult female environment in which she was held was unlikely to be a supportive one.'²⁴⁰

The regime

When the fieldwork began in March 2004 children and young adults (18-21) were accommodated on a separate landing in Mourne House, A2, comprising seven cells. By creating a YOC holding 18- to 21-year-olds, the Prison Service was in breach of international human rights principles by mixing children with adults. However, given the small number of children in Mourne House, to separate them from young adults could have resulted in solitary confinement which would

²³⁶ Above, MH 105.

²³⁷ The Youth Justice Agency has recently (2004) published for consultation its draft child protection policies and procedures, which will become operational in autumn 2005.

²³⁸ Above, MH 18.

²³⁹ Above, MH 37.

²⁴⁰ Above, MH 39.

also have breached international principles. The answer to this predicament is not to hold under-18s in Prison Service custody at all. Similarly, remanded and sentenced children are mixed in the YOC, given the small numbers. Cells in the YOC were like other cells in Mourne House in that young people were allowed to decorate their cells with cards, pictures and photographs and to have their own possessions. However, nothing specifically established it as a children and young persons' landing. In all respects it was physically identical to the adult landings. Staff working with young prisoners wore standard issue uniforms, a practice criticised in 2002 by the Inspectorate.²⁴¹

Given the small number of girls in custody, it is not surprising that mixing of age occurs and the Inspectorate found this to be the case in Mourne House.²⁴² The research, however, found the situation less consistent. The case of a girl from Eastern Europe who was six months pregnant, under 18 years of age and on remand in Mourne House is illustrative. Previously, she had been remanded to Rathgael but subsequently moved to Mourne House. The move went ahead despite efforts by Rathgael staff to establish a 'foster-remand' package for her. Staff in Rathgael stated that she wanted to move to be close to two relatives on remand in Mourne House. Women prisoners and a member of staff in Mourne House, however, reported that the child had not been allowed to associate with her relatives because prison officers said it would be 'against her human rights' to associate with adults. On the day the research fieldwork started, she had been transferred to a local hospital. In other situations, however, age mixing did occur. Following the granting of separation to two Republican women, the YOC was abandoned and children and young adults were located on a general landing.

The regime and routine for children and young adults was no different from that for adult prisoners. Opportunities for education were restricted in terms of the time allocated, because of the long periods of lock-up and because, like the adult prisoners, children were unable to attend classes due to prison officer 'staff shortages'. There were no training or employment opportunities, the exception being hairdressing classes when escorts were available. The children and young people did not experience the active, creative and productive regime advocated by the Inspectorate. Children also had to use the prison hospital on the male side. A prison officer interviewed expressed concern that a 17-year-old girl had been held in the hospital in a cell adjacent to a man who was imprisoned for sexually assaulting and murdering a young woman.

²⁴¹ HM Chief Inspector of Prisons (1997) *Young Prisoners: A Thematic Review by HM Chief Inspector of Prisons by England and Wales* Home Office, London, 4.20.

²⁴² Maghaberry Inspection 2002, MH 18.

The small number of female officers in Mourne House created problems for providing appropriate and effective responses to girls and young women who had suffered emotional and sexual abuse. They had received no training on these sensitive and complex issues. A woman officer recalled an incident regarding a child's disclosure of suffering sexual abuse. The officer was called away to an incident: "I had to go and do a full search [on another woman prisoner]. I had to leave a 15-year-old girl who was telling me her intimate details of what had been done to her, and lock her down". The woman officer requested that Nexus, a charity specialising in dealing with sexual abuse, be invited to counsel the child but she was advised that the service was for adults only.

Girls were put in the embarrassing and degrading position of having to ask male officers for tampons and sanitary towels during menstruation. The vulnerability of children was not considered regarding the use of the punishment block (or Special Supervision Unit, as the Prison Service euphemistically refers to this landing). On three occasions the authors interviewed the same 17-year-old in the bare cells of the punishment block, on 23-hour lock-up (see case study below). The use of segregation cells for children is now illegal in England as a result of the Howard League case referred to above. The use of the punishment block for children breaches Articles of the UNCRC and, possibly, Article 3 of the ECHR which is enforceable under the UK's Human Rights Act 1998. This was tested in a judicial review which is described in the case study on self-harm (later in this Chapter), where a High Court judge ordered that this particular girl should be removed from the punishment block to the prison hospital. Following this, the researchers were astounded to find the same girl, having been released and re-admitted to prison, returned to the punishment block only days after this judgment.

YOC staff had no specific training on dealing with children and adolescents, again contravening Inspectorate expectations. A staff member stated that officers had requested a visit to Rathgael to see how the regime operated but that this had not been arranged (interview, discipline officer). No age-appropriate information for children about the regime or about their rights in prison was given to the researchers. Yet this is a key requirement of the UNCRC (Article 12) and is expected by the Prisons Inspectorate.²⁴³ Nor was there any evidence of separate induction regimes for children and young adults, as recommended by the Prisons Inspectorate.²⁴⁴

²⁴³ HM Chief Inspector of Prisons (1997) *Young Prisoners: A Thematic Review by HM Chief Inspector of Prisons for England and Wales* Home Office, London, 4.14.

²⁴⁴ Above, 4.06.

A minority of staff interviewed were acutely aware of the girls' vulnerability and needs. One member of staff was granted permission by the Prison Service to maintain contact with a girl who was accommodated in a secure unit in England, despite previously having been assaulted and injured by the child. The most common response from prison officers, however, was that the girls were manipulative, attention-seeking, and 'trying it on' through self-harming behaviour. A male prison officer stated: "she [child] said she was suicidal last week and was doubled up [shared cell] with another girl but they were just bouncing about having a laugh" (interview, YOC). He continued:

"We tried to impress on [young person] that time spent on your own IMR21 means not giving others attention ... [both girls] are looking for attention. YOs are like that. [Name] cut her finger accidentally; [other name] cut hers deliberately to get a plaster."

A clear illustration of how the presumption of manipulation impacted on routine but significant decision-making was observed during the research. A landing officer telephoned the senior officer in charge to inform him that a young prisoner had requested that she be 'doubled up' (placed in a shared cell) because she did not want to be locked up alone. She had been disruptive throughout her time in Mourne House and had recently made a serious attempt to hang herself. From his office, the senior officer was dismissive. Over the telephone he told his colleague that she was "trying it on" because she wanted to be "doubled up" with her friend. He instructed that she was "not to be doubled up" and "doesn't need to be doubled up". He continued, "if she carries on, clear the cell, make it a bare cell"; and, "if she really misbehaves then put her in C1" (the punishment block). The officer made his decision without visiting the child. It was a confident response based on his "knowledge" of the child and on the shared presumption that she was "extremely manipulative" (field notes).

Three children and one 'young offender' were interviewed. All were subject to IMR21s, considered at risk of suicide or self harm. One child had made a very serious hanging attempt and three weeks later the mark on her neck was still very evident. The young prisoners described their regime. One child stated that she was locked up from 4.30pm as she was on the basic regime. She was not allowed food, not even toast or water, after that time. She had no television in her cell. All four preferred Rathgael to Maghaberry:

"Staff in Rathgael don't belittle you". One of the children said that a prison officer told a child convicted for car crime: "If you stole my car I'd put a bullet in the back of your head" (interview, young prisoner, YOC).

One girl was held in the punishment block for most of the period of the research, over four weeks during one stretch. The others commented that while they had access to the gym every day, they "hardly ever" went to education classes due to staff problems. The girls said that staff "put a front on for you [the researchers] and when that nun is in [clergy visits]". The girls criticised the lack of therapeutic support:

"In Rathgael you had support. Psychiatric people don't come near you here."

"I would do five years in Rathgael compared to here. Rathgael should be able to keep you until 21."

One of the children alleged that another young person had been urging her to kill herself:

"[Name] was harming herself. I could hear everything she was doing. She was talking about my cousin. It's too harsh, locking someone up from four o'clock."

The girls felt that being doubled up would give them protection from their self-harming and suicidal thoughts: "On IMR21 you're meant to be on 15-minute watch but you're lucky if you get them here every hour". A girl considered that her suicidal thoughts were not taken seriously by staff who said, 'Stop playing on it... stop playing at hanging yourself'. Her comments were consistent with responses made by prison staff. They were convinced that the child was "play acting" and trying to get attention.

The girls were anxious about the punishment block where a child was being held:

"If you're suicidal they threaten you with the punishment block. 23-hour lock up on punishment block – puts your head away. They don't even look in on you. I'm surprised this whole jail hasn't killed themselves."

The girls complained that on the basic regime they were entitled only to a half-hour visit each week. Family contact was difficult and inadequate. They maintained that in Rathgael, children were entitled to free phone calls whereas in Mourne House they had to have



money to use the phone: "Your mammy can't phone in and talk to you. You can't talk to your mammy if you have problems unless you have money". Despite the human rights principle that children have a right to family life, and contact with family is crucial in terms of children's rehabilitation, there was no evidence of any appropriate and essential provision by the Prison Service to ensure that children and young prisoners were given as much access as possible to family or friends. At Rathgael, for example, there is the possibility of families having overnight visits where the centre provides accommodation for families who have come some distance. No such provision was available for children in the YOC. In fact, families regularly made long, complicated and expensive journeys for a short visit.

Two girls, both Catholics, alleged that some staff had subjected them to sectarian intimidation. Staff refuted this, arguing that one of the members of staff on at the time of the alleged incident was Catholic. One of the girls stated that, "Staff are the height of sectarian. Yesterday one staff put a shamrock on and whistled the 'Fields of Athenry'".

The girls did not complain about bullying by other young people but a prison officer commented that under-18s were subject to bullying. The officer also stated that "sex education doesn't happen". "We're supposed to have a juvenile unit but we don't".

Barry Goldson observed that children in prison can be 'innately' and/or 'structurally' vulnerable.²⁴⁵ Children in prison have more often than not suffered family breakdown, poverty, educational failure, and a large proportion of girls in prison have experienced abuse: 'The social circumstances of the children who steadily fill our prisons are invariably scarred by multiple and inter-locking forms of disadvantage and misery'.²⁴⁶ Imprisonment adds to that vulnerability.

The children and young people interviewed in Mourne House were both innately and structurally vulnerable (for example, experiencing mental health difficulties and being in an adult prison). Yet, there was inadequate staff training, assessment and recording (staff openly admitted that IMRs were routinely filed away) and little or no staff training for dealing with such vulnerability.

²⁴⁵ Goldson B (2002) *Vulnerable Inside: Children in secure and penal settings* The Children's Society, London, p 7.

²⁴⁶ Above, p 27.

Case study

Within hours of beginning the research in Mourne House prisoners, prison staff, members of the Board of Visitors and other professional workers raised the issue of a 17-year-old young woman held on the secure observation landing. The landing, C1, was also known as the punishment block. Prisoners in C1 are held under Prison Rule 32. Rule 32 (1) states:

‘Where it is necessary for the maintenance of good order or discipline, or in his [sic] own interests that the association permitted to a prisoner should be restricted either generally or for particular purposes, the governor may arrange for the restriction of his [sic] association’.

In addition to cellular confinement as a punishment for offences against prison discipline, prisoners were also placed in C1 if they were considered disruptive, non-compliant or at risk of self-harm. C1 had cellular confinement for seven women. At the time of the research, two women were held in C1. The landing consisted of a standard central corridor giving access to cells on either side. It was secured by a barred gate across the corridor between the cells and the prison officers’ office. The area, but not the cells, was monitored by CCTV. Two types of cell were opened. The ‘anti-suicide cell’ had bare walls, what appeared to be thick, Perspex lining to the barred window and a metal plated ceiling. There was no bed but a raised plinth built into the floor, a mattress, a padded non-destructible sleeping bag and a small plastic potty as a toilet. There was no wash basin. It was classified ‘basic’. The other type of cell, classified as ‘standard’, was similar but had a steel-framed bed bolted to the floor, an open metal flush toilet and a hand basin bolted to the wall.

The 17-year-old was interviewed in her cell. Her ‘standard’ regime consisted of 23-hour lock-up in her cell with the opportunity for one hour’s recreation each day. She sat on the bed, cross-legged, throughout the interview. She was dressed in a non-destructible, short-sleeved gown that had Velcro fastenings down the front. She had extensive and recent wounds to both legs and both arms, consistent with cuts by a sharp implement and scouring with the rough edges of the Velcro fastenings. There were no visible signs of flesh free from injury.

She had just finished writing a letter, having been given pen and paper by an officer on duty. She also had a newspaper and a Bible in her cell. The former had been ‘loaned’ by an officer. Throughout the interview, she was lucid and clearly understood her situation and

the circumstances of her imprisonment and confinement.

She felt compelled to self-harm: "It's how I cope". She said, "I was in a hospital out there [in the community] and I still harmed myself then. I'm not getting the right treatment". She continued:

"They don't understand why I cut myself and I tell them I have to do it. It's my only way of coping. I seen Dr [the psychiatrist] and he gave me medication which helped...

"I shouldn't be down here. There's nothing to do. It's worse in the night. I hear voices and see things. But no-one helps me.

"I should be in the hospital wing. This place needs a women's hospital or a special wing for nurses to control and deal with women with problems.

"They could have got people in to talk to me. To help me deal with my drink and drugs problems. I've had no counselling since I've been in here."

She did not take her hour's allocated recreation because she would have to go outside in the exercise yard in a gown and slippers – in winter conditions. A prison officer verified that there were no appropriate clothes available for the exercise yard.

Officers stated that she had completed over two weeks of a 28-day period in cellular confinement under Rule 32. An IMR21 form (Referral/Assessment of Suspected Suicide Risk) was operational as she was considered a 'suicide risk'. She had also been accused of inciting other women prisoners to self-harm or commit suicide.

Part of the 'care plan' was 'optimal contact' with staff and other prisoners. Yet she was held in isolation from prisoners, on 23-hour lock-up, experiencing minimal contact with staff. One officer stated that 15-minute observations no longer applied and prisoners in C1 were checked "as frequent as necessary". This could be "two or three times an hour" during the day "depending on the officer", and "roughly once an hour at night". 'Checks' were confined to "looking into the cell" through a spy-hole. Contact between staff and prisoner was minimal and entirely at the discretion of individual officers. Prison officers interviewed on C1 stated that they did not consider themselves qualified or appropriately skilled to deal with such difficult cases.

The young woman prisoner was due to be released, time served, the following week. In the meantime, leave for a judicial review of the conditions under which she was held was lodged with the Appeal Court. It was heard the day before her scheduled release. At the hearing, it was established that she had been placed on Rule 32 eight days after her admission to prison and two days after a case conference. Issues of disruptive behaviour, failure to conform to prison discipline and personal hygiene had been presented at the case conference. She had been classified as 'conduct disordered' rather than 'mentally ill'. It was clear that the conditions under which she was being held mitigated against even partial fulfilment of the agreed care plan. The judge granted leave and ordered her immediate removal from C1 to Maghaberry's healthcare centre (prison hospital). She spent her final night in isolation in the male prison hospital and was released from there into the community the following day.

Within weeks of release, the young woman was arrested following a disturbance. She was returned to Mourne House and, despite the judge's previous order, she was put in C1 on the basic regime. The second research interview was conducted in her cell. She was lying on the raised plinth in the foetal position. There was no mattress and she slept on a non-destructible blanket. She was dressed in a non-destructible gown. The Velcro had been removed. She was not permitted underwear. There was a plastic potty for a toilet and no sink or bowl to wash her hands or body.

She stated that, at home, her doctor had refused to treat her "so I had no doctor to set up my medication". She had "taken other stuff to calm me down" and had "tried to stick a glass bottle in my neck". When the police arrived she "didn't threaten them at all". She was charged with possessing an offensive weapon: "The only reason they got me in here's to get me off the streets". She continued:

"I was put in the hospital wing for nine days. They brought me over here for one night. That night I tried to hang myself and they wouldn't take me back over."

How did you try?

"I ripped up a pillow case."

What was going through your mind?

"Everything. I just couldn't cope. Look ... [she indicated self-harm] ... and on my legs as well."

How did you do that to your legs?

"I rubbed this here [the edge of the gown] up against it."

Velcro?

"No, not Velcro, just the edge."

Why do you do it?

"Because I hear voices and see things. The voices tell me to do them. And I release the pain as well."

When you rub it, and feel the pain, that releases pain from you?

"Yes."

Does that make you feel better?

"Yes. But I'm not on the right medication. It's an anti-psychotic to stop me from hearing voices. They try to say I haven't a mental illness even though they've got me on anti-psychotic medication."

She stated that she was not given a mattress to sleep on. She slept on the indestructible blanket on the bare plinth. She had no sleeping bag.

What's it like at night?

"It's terrible, so it is. You sleep and you keep changing positions. I suffer from a bad back 'cos I was in a car accident. And they won't even give me my own clothes... in case I did anything stupid.

"Just look what they make me go to the toilet in. That's for night time... It's a disgrace."

Are you having any time with anybody? Is anybody talking to you?

"No one at all."

Do the prison officers come in and speak to you?

"No."

Do you have any conversation with anybody during the day?

"No, not really. Only if I knock the door and ask for something, and that's it."

Do they spend any time with you at all?

"No."

Do you think it would help if you had people to talk to?

"That's why I want back over the hospital wing, 'cos there's nurses there I can talk to."

When you were in the hospital wing, did you have any time out of your cell with the men?

"On two occasions. But that was for mass."

She confirmed that she had not been provided with underwear:
"None whatsoever".

Do they look after you during your periods?

"No. They don't give me underwear or nothing."

So how do you manage?

"It's hard. They just give you a wee sanitary towel and that's it."

How do you keep that in place?

"It's hard."

She had been refused bail and was due for sentencing but anticipated release, being time served. Her hope was for a place in a "proper hospital for treatment".

"I don't know what's set up for me. They're not doing anything for me... I want out of here. The [prison] hospital's the right place for me. Nursing staff talk to you. If you knock the door, they'll come and talk to you. The prison staff – they don't know nothing of my medical stuff and what I've suffered from. Over there [the prison hospital] they know my medical stuff. Here they're just prison staff and they're only here to look after me, which they're hardly doing. They won't even

lend me a pen. How am I supposed to keep contact with my family?"

At a subsequent judicial review application at the High Court, a medical report confirmed that she required structured, therapeutic intervention and daily practical assistance. It stated that such therapeutic provision was not available in the prison. In fact, it was not available in Northern Ireland. She was diagnosed as 'personality disordered' and not as suffering from a 'mental disease'. The Court noted that at a recent case conference it had been decided that she might be able to return to a normal residential landing. This happened.

On 17 June 2004 a bail application was heard in Downpatrick Magistrates Court. The police objected to bail and social services representatives informed the court that there was not suitable secure provision in the community to ensure the child's safety. The court also heard evidence from one of the Commission's researchers about conditions in the punishment block in Mourne where the girl had spent much of the previous month. The magistrate determined that on the basis of this evidence she would not be content to allow the child to continue to be held at Maghaberry, because of the possibility that she may be returned to the punishment block. Bail was granted, however, shortly afterwards the child was re-arrested and remanded to Hydebank Wood YOC. Dr Moore was invited by her social work team to attend her case review to be held in Hydebank Wood but the Prison Service refused access to the review.²⁴⁷

It is recommended that children under 18 years of age should not be held in Prison Service custody. (Recommendation 25)

A separate young prisoners' centre for young adult women should be established, providing age-specific regimes and programmes. Its use should be a matter of last resort and relate only to grave offences. (Recommendation 26)

Age appropriate reception and information packs and induction programmes should be provided for young prisoners. (Recommendation 27)

Whatever the circumstances, children should not be held in segregation or punishment cells. (Recommendation 28)

Whatever the circumstances, the practice of 'slopping out' should be ended. (Recommendation 29)

²⁴⁷ Since the publication of the first edition of this report (October 2004) the Prison Service appears to have rescinded its ban and the researchers have been permitted to visit the young women in her cell in Hydebank Wood.

Chapter 8

SEPARATION

Background to separation

Following the closure of Crumlin Road prison (HMP Belfast) in 1996 and the Maze in 2000, Maghaberry accommodated a number of different groups of prisoners, including remand prisoners and politically affiliated prisoners not released early under the Belfast (Good Friday) Agreement 1998. As the Select Committee on Northern Ireland Affairs noted in 2004:

'HMP Maghaberry has historically functioned as an integrated establishment in which prisoners of all persuasions and backgrounds are required to live and work together.'²⁴⁸

Despite absorbing prisoners from different political factions, divided between loyalist and republican groups and also split within these broad allegiances, the State initially attempted to continue to operate Maghaberry as an integrated establishment. In summer 2003, however, protests were staged by prisoners demanding separation claiming their safety was threatened by the policy of integration. The protests included rooftop demonstrations regarding overcrowding. Protests were made by both Loyalist and Republican prisoners and prisoners affiliated to dissident Republican organisations conducted a 'dirty protest'. Other incidents, compromising the safety of prisoners, included two occasions when live rounds of ammunition exploded in toasters on the prison wings, prisoner-on-prisoner assaults and hoax devices in prison blocks.²⁴⁹ Attacks on prison officers' homes increased, particularly by Loyalist paramilitary organisations.

The Government was put under pressure by political parties and organisations outside the prison. It commissioned a review of conditions in the prison, led by John Steele, former head of the Northern Ireland Prison Service.²⁵⁰ In responding to the consultation on the Steele review, the Northern Ireland Human Rights Commission concluded that separation was necessary for prisoner safety. It also maintained that a degree of separation was necessary to protect prisoners from opposing paramilitary factions

²⁴⁸ House of Commons Select Committee on Northern Ireland Affairs (2004) *Second Report, Summary*.

²⁴⁹ Above.

²⁵⁰ Safety Review Team (2003) *Review of Safety at HMP Maghaberry* Northern Ireland Office (the Steele Review).

and to protect 'ordinary' prisoners from bullying by, or recruitment into, paramilitaries. In September 2003, the Secretary of State accepted the Steele recommendations that 'Republican and Loyalist prisoners with paramilitary affiliations should be separated from the rest of the prison population on a voluntary basis'.²⁵¹ Loyalist and Republican prisoners were transferred into a temporary special regime. Two of the six male accommodation houses at Maghaberry, Bush and Roe were adapted for the location of separated prisoners. Bush and Roe are the most modern and best accommodation in the prison and were chosen as the layout of the older wings was considered difficult for close observation.²⁵²

At the time of the 2002 Inspectorate report, two male Loyalist prisoners were accommodated, for their own safety, in a separate building in Mourne House. The building also accommodated male immigration detainees on the lower landing. By 2004 only one Loyalist prisoner, Johnny Adair, was imprisoned there, occupying the top landing. The Governor of Mourne House stated that the cost of running this facility was borne by the Mourne House budget.

An all-party House of Commons Select Committee conducted an inquiry into the separation process and interviewed groups from different perspectives, including the Director General of the Prison Service, prison officers, prisoners' groups and NGOs. The Select Committee report documented the vehement opposition by prison officers' representatives to separation. They argued that despite attacks on officers' homes and the threat to their lives, they could contain the situation within the prison. They did not wish to return to a Maze-type regime in which prisoners controlled their wings.²⁵³ The Select Committee concluded that separation had been granted for political rather than safety concerns but:

'the report recognises that, having made the decision to implement separation, the Government cannot now turn back from it. But it asserts that the Government must pay the full costs which arise from the decision in terms of support for the prison and ensure that no concessions are ever made to the separated prisoners which might undermine or diminish the control exercised by prison officers.'²⁵⁴

²⁵¹ Northern Ireland Prison Service (2004) *Compact for Separated Prisoners* NIPS, Belfast.

²⁵² House of Commons Select Committee on Northern Ireland Affairs (2004) *Second Report*, para 17.

²⁵³ Above, Summary.

²⁵⁴ Above.

Steele distinguished the concept of 'separation' from that of 'segregation' thus distancing the proposed regime from the evocative association with the earlier Maze regime. The arrangements for the new regime have been set out in a 'prisoner compact' to which prisoners are expected to agree as a prerequisite of entry to 'separated status'. They are not required to sign an agreement and the compact is not enforceable in law. The compact was issued for public consultation in September 2003.²⁵⁵ It gives details of 'who can go into separated conditions, the routine and regime, the level of privilege available to separated prisoners as well as the arrangements for cell checks and searching'.²⁵⁶ The explanatory notes state the aim is to 'provide a safe regime for both prisoners and staff and importantly, where staff remain in control'.²⁵⁷ Having applied for separation, prisoners are interviewed about why they feel unsafe in integrated conditions. They are expected to demonstrate an understanding of what, according to the compact, living in separation will mean.²⁵⁸ The original compact stated explicitly that it applied only to male prisoners.

The numbers anticipated for separation were 75 Republican and 120 Loyalist prisoners.²⁵⁹ In line with Inspectorate recommendations, the compact applies to over-18s only.²⁶⁰ Steele also recommended that to ease pressure on the regime and also as a point of principle, fine defaulters and immigration detainees should not be held in prison custody.²⁶¹

Additional security measures included new grilles, search facilities and cameras and the erection of a 'cage' over the exercise yard. The cost of the changes was estimated at £7 million, which the Select Committee was assured had been provided in addition to the normal annual budget of the Prison Service.²⁶² The Steele review recommended that while prisoners could be accommodated separately, wherever possible they should continue to participate in integrated activities such as education.²⁶³ The compact notes,

²⁵⁵ Northern Ireland Prison Service (2004) *Compact for separated prisoners, an explanatory booklet* NIPS, Belfast, February.

²⁵⁶ Above, Executive Summary.

²⁵⁷ Above.

²⁵⁸ Above, 1.5.

²⁵⁹ House of Commons Select Committee on Northern Ireland Affairs (2004) *Second Report*, para 66.

²⁶⁰ Northern Ireland Prison Service (2003) *HM Chief Inspector of Prisons, Report of a full announced inspection of HM Prison Maghaberry, 13-17 May 2002*. (Maghaberry Inspection 2002).

²⁶¹ Select Committee on Northern Ireland Affairs (Above), para. 82.

²⁶² Above, 83 and 84.

²⁶³ Safety Review Team, *Review of Safety at HMP Maghaberry* (The Steele Review).

however, that it could be problematic for separated prisoners to attend integrated activities. It states:

'because it will become clear to other prisoners that you are from a particular community and/or political viewpoint by your allocation to a residential house, it will be very difficult to ensure your safety in a 'mixed' area of the prison'.²⁶⁴

The Director General of the Prison Service explained to the Select Committee that, in terms of risk management it had been decided that separated prisoners should also be provided with separate activities:

'... if the suggestion is that prisoners from all three groups ... can all simply go to the one educational class, then I do not think that is simple at all ... that is highly problematic for the safe management of the prison and that is why I say that we will be starting by aiming to take activity provision mostly to the wing, to the prisoners, and not escorting them through the jail.'²⁶⁵

The 'Compact'

The regime available to separated prisoners is 'standard level' including access to television and a limited weekly income but no opportunity to work towards an 'enhanced' regime. In theory, separated prisoners receive less time out of cell and fewer opportunities for association and activities than those in the integrated regime.²⁶⁶ As this research demonstrates, for women prisoners such opportunities were persistently severely restricted.

The daily regime for separated prisoners is described in the compact:

'8.30 prisoner requests at cell doors; 8.45-9.05 prisoners unlocked to collect breakfast and return to cell; 9.15 prisoners on landings can access exercise in the dining hall and/or exercise yard. Not all landings will have access to exercise each day and prisoners on those landings not designated for exercise will be offered in-cell association and access to shower, laundry, telephone etc. 11.45 prisoners locked up for number check; 12-12.40 prisoners unlocked to collect lunch

²⁶⁴ Northern Ireland Prison Service (2004) *Compact for Separated Prisoners* NIPS, Belfast, para 2.4.

²⁶⁵ Select Committee on Northern Ireland Affairs (2004), para 48.

²⁶⁶ Above, para 49.

and return to cell; 12.45-14.00 prisoners locked up for staff handover and lunch, 14.00-14.30 numbers checked, and opportunity for exercise for designated landings and prisoners on other landings offered in-cell association and use of other facilities; 15.45 lock-up. 16.00-16.30 prisoners unlocked to collect tea and return to cell; 16.30-17.30 prisoners locked up for staff handover and meal break; 17.30 routine same as 9.15 and 14.00. Supper meal available. 20.15 lock-up.'

As with 'ordinary' prisoners, there is no association available on Sundays and all prisoners are locked up from 4.30pm.

The compact notes that there is no inter-wing association and that education and cell craft are organised within Houses. Religious observance and healthcare are organised within each House but prisoners might be transferred to the prison hospital if considered necessary. Prisoners might also be required to share rooms although there is a commitment to single cell occupancy. Cells are checked every day. Remand and sentenced prisoners are accommodated together.

Republican prisoners in Mourne House

At the outset of the research in March 2004, two female Republican prisoners were located in Mourne House. Both were members of the same Republican organisation. They had been held in Mourne House for five months and had demanded separated status since they were first imprisoned. Their claim for separation had been refused despite separation going ahead in the male prison:

"Since we came in here we've asked for separation. I got turned down flat. I spoke to a couple of governors and they didn't even have the decency to come over to tell me they'd refused the separation. They sent the SO [senior officer] over and he says you've been turned down flat because there is no risk to you on this landing." (Republican prisoner)

"I have asked for separation since day one. The boys across the way are getting their separation with conversions costing £19 million." (Republican prisoner)

Both women were on remand, facing potentially long sentences if convicted. One had refused to disclose her identity to the authorities and had still not been identified. She was known by a pseudonym. As she was withholding her identity from the authorities, she was

unable to receive visits or letters from family or friends as this could have assisted in her identification.

The women argued that while the charges against them were serious [and were subsequently dropped]; the security measures used by the police and prison staff had been over-zealous and retributive:

“When we were first arrested and taken to court the cops had the whole place surrounded. You would have thought we were the most wanted people in Ireland. The security was unbelievable. They totally outflanked our families in the dock. There was riot squads the whole way round our families. Not to mention the fact that the RUC took our families’ registration numbers with video cameras.” (Republican prisoner)

Whenever the women were moved in Mourne House they were accompanied by several prison officers: “I was put out on a visit yesterday and there were six staff on the visit for one person. I’m not that high a security risk”. Both women were angered by the high security presence when they attended religious worship.

“There were a couple of POs [prison officers] who took an instant dislike to me ... did they not like Republicans or just not like prisoners? Their attitude towards certain people and their prejudices ... it’s eye contact and dirty looks. But they are able to get away with it.” (Republican prisoner)

As part of the campaign for separation, the women refused association with other prisoners which meant they spent long periods confined to their cells. They said they were prepared to participate in education although education staff suggested that one of the women had been refusing to attend. As was the case with all women prisoners, however, the opportunity to attend education was often not available.

The key arguments for separation were expressed in terms of prisoner safety. Both women raised concerns regarding their integration within Mourne House. In particular, they were anxious that while no other prisoner had declared herself to be affiliated to a Loyalist group, some women undoubtedly had Loyalist connections:

“There was an incident at Christmas time – they brought over two Loyalist associates. We thought they were associated with the UDA but from what I’ve been told they were associated with the LVF. Now I went to security about it and I raised the issue and said, ‘Look these people are associated with the LVF.

What's going on?' I said their boyfriends were killers with the LVF. We said we didn't want them on the wing but they had to amalgamate the two wings because there weren't enough staff so the ones from C2 came over from B2." (Republican prisoner)

Given the presence of women they perceived to be Loyalist on the wing, both women voiced their concerns over future personal safety. This extended to their perceived antipathy of some officers to them because of their Republican allegiance and to the proximity of Johnny Adair, held in a separate building within Mourne. They were particularly concerned about his presence during visits.

"There was another incident where the other Republican female was in the same visiting area as Johnny Adair. Even though he was locked up, he was in a wee room of his own, that didn't matter. He should not be on our visits. I went and says 'this is a serious security breach, something could have happened coming out'. Them two could have met each other and there could have been a whole thing. The size of Johnny Adair would scare anybody so I found that really unsettling. Plus we had a girl on the wing who was writing to Johnny Adair. Every time we came into the room she was bringing up his name and then when I brought that up they told me I was being paranoid. And I says 'right, I suppose the boys were being paranoid too before they went on protest when the Loyalists brought in the gun'." (Republican prisoner)

Both women noted that Johnny Adair knew to call one of the Republican women by the nick-name 'Mrs X', as her fellow Republican prisoner teasingly dubbed her on the wing. The women had serious concerns about information about them being passed from other women prisoners, via prison staff, to Johnny Adair. They commented that the Mourne House Governor insisted that no Loyalist women were located on the landing. The Republican prisoners complained that sectarian comments had been made by some women prisoners but noted this happened infrequently. One of the women commented: "I think they know we'd turn around and slap them".

In addition to concerns over personal safety, the women resented being held with women prisoners they described as "druggies" and "ordinary criminals". They were incensed by the presence of drugs on the landing. Both had complained to staff about drug taking, one describing it as a "total insult to Republicans". A woman said:

"I don't want to be associated with drugs ... it's not the girls, it's the fact that there's no programmes. The prison officers have no basic training on these issues..." (Republican prisoner)

The women were concerned that their letters were delayed either by prison censors or by the police. Letters took weeks to get in and out of the prison, if they were received at all. One woman in particular voiced concerns about prison security, believing that information about her was being passed to the police either by staff or other prisoners. She was worried that her cell and other parts of the prison were bugged and information was being passed to the police. Consequently, she was reluctant to speak openly, even within her cell. The women were also angry that they were not allowed to communicate with their Republican compatriots, particularly the 'OC' [officer in command], on the male side. They suggested that an internal visit should be facilitated once a month.

Despite being critical of their location with ordinary prisoners, the Republican women recognised the real problems faced by these women:

"We have serious mental health issues in here. When you say to people, they laugh but it's no joking matter when you're on a landing with these people. We were actually moved here to B2 about a week or two and one of the wee girls self-harmed the whole way up her arm by taking the razor blade out of a sharpener. They wouldn't open the door until she put out that razor blade. Now that wee girl could have been bleeding to death but they still wouldn't open the door until she put out the razor blade first. I was really shocked. I didn't know what to do because she was next door to me. So obviously you're always going to have a bit of compassion for everybody – you're always going to want to know if they're ok or what's happening." (Republican prisoner)

The two women had disagreements with each other and were not always on speaking terms. Given their reluctance to associate with other prisoners, this left them isolated. This was exacerbated during the period when they were moved to a separate landing and, eventually, granted separation. The dispute between the women was constantly referred to by prison staff who spoke of one of the women in a disparaging manner. For example, when told that the researchers were going to interview the women, a senior officer stated that one of them was "alright" but "best of luck with the other. You'll know what I mean when you meet her". Other male officers made similar comments.

The Republican women were unconditionally opposed to the move to Hydebank Wood, stating their intention to go on hunger strike or dirty protest if they were moved. Their opposition was because of conditions and the perceived Loyalist presence at Hydebank Wood:

"My main concern about this move to Hydebank would be that the fella I was arrested with previously – I was released without charge that time – he was kept in, he was shifted out of Hydebank because of threats from the UDA. He was beat up in the prison. He was only 17. For his own safety, when he turned 18, they moved him down from Hydebank to Maghaberry. Now they're preparing to put two similar females into the same circumstance."

"From what I can gather there's two ways in [to Hydebank]. The screws won't use the way that the visitors use for security reasons. They won't use it because it's like a forest area. Who's to say that someone doesn't set up an ambush there – knowing your dates, your times, your registration number – the RUC could give them to the UDA because they're in collusion with them anyway. You're sitting there and next thing you hear your family's been shot dead. I would rather die in jail than have that happen to my family. At present there will be a protest because we're in here five months and our backs are getting raised. I think basically because we're female they're just taking the hand out of us.

"... Plus the staff in Hydebank are anti-republican and always have been. There's been previous occasions where young lads that have been charged with being members of the provisional IRA years ago got a serious hard time because they were Republican. Now I know from the visit areas in Hydebank that you have to wear bibs. And apparently there's no contact. Well if they try to move me to Hydebank they will physically have to nail it to my back. I am not wearing a bib and I will not criminalise myself for anybody. I'm a political prisoner not a criminal. If they want to go back to the Armagh situation of women going on hunger strike or women going on dirty protest, by God it will happen. They know, I have spoke to them and I says that the only way of me being moved into this jail – I'll leave here in a box because I'd rather die with respect and dignity than to be treated like an animal." (Republican prisoner)

During the research events moved quickly, both in relation to the women's demands for separation and the move to Hydebank Wood. On 8 April 2004, a telephone call was received at the Northern Ireland Human Rights Commission from one of the Republican women who spoke to the Chief Executive. She stated that she was on hunger strike regarding separation and would like to speak with the researchers. The researchers went to Maghaberry the following day, Good Friday. They were met by the Governor who managed

separation in the male prison and the Governor with responsibility for Mourne House. The governors stated that a decision had been taken to grant separation and it was scheduled for the following Monday. This decision, however, would not be communicated to the woman on hunger strike until she ended her protest. He stated that the official line was not to "negotiate" with hunger strikers. The other woman would be informed of the decision that morning. The researchers indicated their concern and surprise that a woman could be allowed to put her health and, possibly, her life at risk demanding separation when a decision had been taken to accommodate this demand. Why could she not be informed of the intention to grant separation? The reply was that the Prison Service could not be perceived as acquiescing with a prisoner's hunger strike. In reply to a question regarding her immediate future if she remained on hunger strike, one of the governors replied, "She'll die".

It was agreed that the Governor in charge of separation would speak first to the prisoner not on hunger strike while the researchers met with the hunger striker in her cell. She was determined to continue her hunger strike until separation was achieved. She stated that the decision to go on hunger strike had been provoked by disappointment when she realised she had wrongly assumed that separation had been 'informally' granted when other prisoners had been moved off the landing. As a consequence, both Republican women were left alone on the landing. She described her feelings of happiness and relief during this brief period. She felt that she could relax and not worry about association with "ordinary" prisoners or that her conversations were overheard.

On realising that separation had not been granted, albeit informally, she embarked on hunger strike. On Good Friday she had not the slightest inclination that the prison authorities had decided to grant separation from the following Monday. Indeed, she had mentally prepared herself for a long hunger strike, believing that the authorities were not committed to granting women separation in line with male prisoners. Having talked with her, the researchers met with the other Republican prisoner. She had met the separation Governor and been issued with the prisoner compact on separation. She had signed an agreement form and had been informed that she would move to separate accommodation on Monday. She was dismayed that the other Republican woman was not to be informed and would continue her hunger strike unaware that her demand had been met.

Following the discussions, the governors informed the researchers that the initial decision had been revised and 'Mary' would be informed. The Governor in charge of separation conveyed this to her

and issued her with a compact. 'Mary' refused to sign until she had spoken again to the researchers. They assured her they would contact the prison on the following Monday to ensure that separation had been operationalised. They agreed that if separation had not happened they would revisit the prison. Separation did take place on Easter Monday and the women were placed on the YOC landing. The children and young adults were moved to other wings. The woman who had been on hunger strike subsequently undertook a further time limited hunger strike, alleging that a prison officer suggested she had faked the first hunger strike by adding something to her water.

Soon after this unfortunate sequence of events both Republican prisoners were released without charge. At the close of the fieldwork no women sought separation, although it is to be expected that a demand for separation will occur in the future. The Prison Service has stated a commitment to accommodating separated women in Maghaberry rather than accommodating them at Hydebank Wood. While separation is necessary, particularly on safety grounds, there would be serious issues of concern should a woman prisoner be held alone in a high security male prison.

It is recommended that the women's custody unit should provide for women prisoners held under separation arrangements and the plan to hold them at Maghaberry be abandoned. (Recommendation 30) It is recognised however, that given possible safety concerns, Hydebank would be an unsuitable venue for detaining Republican female prisoners.

Chapter 9

TRANSFER OF WOMEN FROM MOURNE HOUSE TO HYDEBANK WOOD

The transfer in context

On 24 April 2004, the Northern Ireland Prison Service announced its decision to re-locate female prisoners (including immigration detainees) from Mourne House, Maghaberry to Ash House, a unit within Hydebank Wood Young Offenders Centre, Belfast.²⁶⁷ In March 2003, the Prison Service Management Board had commissioned a 'feasibility study' into the possible transfer.²⁶⁸ The key terms of reference were: reduction in staffing levels; better use of Hydebank Wood's spare capacity; the creation of an environment less oppressive and security-based than that at Mourne House; and improved regime, particularly health-care and visits. It was suggested that the YOC offered a more pleasant environment closer to Belfast than Mourne House and its regime would enable the identification of the individual needs of women.²⁶⁹

The 'feasibility report', presented to the Prison Service Management Board, concluded that it would be possible to house the women at Hydebank Wood and that the low risk security would not be an issue. The final report to the Prison Service Management Board focused on privacy, decency, mother and baby provision, health-care, disability, gender-specific programmes and enhanced regimes. It was considered by those responsible for the study, that the Inspectorate's 2002 recommendations for change in the Mourne House regime had been adopted and incorporated into the final report.²⁷⁰

While concluding that the transfer of women from Mourne House to Hydebank Wood was feasible, the report also urged that:

'... careful consideration would be required in relation to the way in which the NIPS would undertake its business in delivering services to the female population ... [and that] further consideration be given to the nature of services and

²⁶⁷ Male immigration detainees moved to the 'working out centre' at HMP Belfast, Crumlin Road in June 2004.

²⁶⁸ Information provided during interview with the Governor of Hydebank Wood, April 2004.

²⁶⁹ Above.

²⁷⁰ Above.

facilities on offer to females and the way in which these may impact on them whilst in custody.²⁷¹

On 24 November 2003, the Board ordered an Equality Impact Assessment (EQIA) on the proposed transfer under Section 75 of the Northern Ireland Act 1998. The EQIA document claimed to have used 'both quantitative and qualitative analysis and consultation with other stakeholders' in reaching its conclusions.²⁷² This included age, status and home location of women prisoners, gender of Prison Service staff, views of prisoners, and Inspectorate reports. In considering the situation at Hydebank, the EQIA identified issues that could have a potential adverse impact on women:

- 'no in-cell sanitation provision
- structural changes would be needed to accommodate prisoners with physical disabilities, and
- husband and wife immigration detainees would not be housed in one location.'

However, problems in the current regime at Mourne House were also identified. These included lack of mother and baby facilities, less access to education for women than men and a disproportionate ratio of male to female officers. The proposed transfer was 'founded on the principle of equal and fair treatment for all prisoners and to provide a more cost effective and efficient service delivery through an enhanced regime'.²⁷³ Central to this 'principle' was the provision of 'safe and humane custody', the reduction of re-offending and assistance to women to lead 'useful lives'.²⁷⁴

The Prison Service 'proposed a range of positive measures' to 'eliminate any adverse impact for the categories of persons covered by Section 75'. They included additional programmes, enhanced regime, disability provision, resettlement scheme, video link facilities between establishments, 24-hour access to sanitation, improved health-care, addressing staff ratios and improved gender-related staff training. The Prison Service stated its confidence in establishing and delivering 'an acceptable and socially inclusive regime', that would not only be 'cost effective' but would also be 'innovative'.²⁷⁵ It judged the Mourne House regime 'limited and

²⁷¹ Northern Ireland Prison Service (2003) *Transfer of Women in Custody in Northern Ireland: An Equality Impact Assessment*, 24 November 2003, p 9.

²⁷² EQIA, Executive Summary, point 3.

²⁷³ Above.

²⁷⁴ Above.

²⁷⁵ Above, point 7.

restrictive', with women denied the facilities available to male prisoners.²⁷⁶ It noted high staffing levels and a gender imbalance in staff which had 'result[ed] in an inconsistency in the delivery of services and daily routines'.²⁷⁷

In contrast, Hydebank Wood was presented as offering a refurbished and converted unit and a 'staff focused integrated regime based on programmes such as education, vocational training and gymnasium activities'.²⁷⁸ YOC prisoners were encouraged 'to participate in redressing offending behaviour through a variety of cognitive programmes'. The YOC worked 'in partnership with a variety of community based organisations'. Central to its ethos, in contrast with Mourne House, was the 'high degree of interaction between staff and inmates', giving prisoners 'ownership of the regime, participation and delivery'.²⁷⁹ It proposed the 'delivery of a gender specific health-care programme' and 'more suitable programmes, particularly for those serving long sentences'.²⁸⁰ The assessment concluded that the proposed 'positive measures' would 'eliminate the [identified] instances of adverse impact'.²⁸¹

The Prison Service consulted over 100 groups on its EQIA²⁸². It is difficult, however, to establish a rationale for selection of the potential consultees. For example, given that Hydebank Wood operates as a male young offenders' centre, it is curious that the key children's NGOs and the Northern Ireland Commissioner for Children and Young People (NICCY) were not approached. The consultation period was extended by several months. Approximately 30 responses were received.²⁸³

The EQIA was conducted only in relation to the potential adverse impact on women in prison. No EQIA was carried out regarding the potential adverse impact to the Hydebank Wood young male population, which includes children under the age of 18. However, the possible negative effect of the transfer on the boys and young men at Hydebank Wood was alluded to in the Hydebank Wood Visiting Committee response to the EQIA.²⁸⁴

²⁷⁶ Above, p 12.

²⁷⁷ Above.

²⁷⁸ Above, p 13.

²⁷⁹ Above, p 13.

²⁸⁰ Above, p 14.

²⁸¹ Above, p 21.

²⁸² Above, Appendix 2.

²⁸³ The Northern Ireland Human Rights Commission was among the consultees. Rather than responding to the EQIA document within the allocated timeframe, the Commission preferred to continue to conduct the current research, to enable it to make more informed comment.

²⁸⁴ Visiting Committee, HM YOC Hydebank Wood, letter to Governor, 10 January 2004.

Differential impact on male and female immigration detainees was considered only in terms of married couples. The EQIA noted that weekly contact could be facilitated through video link between Maghaberry and Hydebank Wood.²⁸⁵ The EQIA was based on the presumption that male detainees would continue to be held in Maghaberry. In fact, they were subsequently moved to the HMP Belfast 'working out centre' on the Crumlin Road.²⁸⁶

Although the Prison Service carried out the EQIA regarding the transfer proposal, and consulted accordingly, it did not consider alternative options for the future of women's imprisonment in Northern Ireland. There was no public consultation, for example, on continuing to accommodate women at Mourne House while fully implementing the Prisons Inspectorate's 2002 recommendations.

From the outset it was clear that a transfer to Hydebank Wood was the preferred option of the Prison Service. In June 2003, the Director General wrote to the Chief Commissioner of the Northern Ireland Human Rights Commission:

'I have a small team working on the possibility of locating female prisoners at Hydebank Wood. ... If favourable, the timing of the move will be affected by operational considerations, not least the growing total prison population, which may add pressure to accelerate the transfer.'²⁸⁷

In September 2003, the Director General wrote that 'the feasibility of moving women prisoners from Maghaberry to Hydebank Wood is under active consideration' and that 'it would be more appropriate to undertake the research once a decision on that matter has been taken and, if appropriate, implemented'.²⁸⁸ Once the feasibility study confirmed that such a move would be possible, the Prison Service appeared committed to implementing the transfer as swiftly as possible. In October 2003, before the EQIA consultation had been conducted, the Director General proposed to the researchers that it might be "more appropriate" to delay the Commission's research "until after the move".²⁸⁹ At a meeting with the researchers in February 2004, the Governor of Maghaberry

²⁸⁵ EQIA, p 20. Consultation on the location of male immigration detainees was carried out in December 2003 although the option of using Belfast Prison was not discussed in this document.

²⁸⁶ On the site of the former Belfast Prison, Crumlin Road.

²⁸⁷ Letter to the Chief Commissioner, Northern Ireland Human Rights Commission, from the Director General, Northern Ireland Prison Service, 27 June 2003.

²⁸⁸ Letter from the Director General, 17 September 2003.

²⁸⁹ Meeting with Director General, October 2003.

expressed confidence that the move would “happen within two to three months”.

Reasons for the transfer: the Governors’ views

The EQIA document noted the ‘limited and restrictive’ regime at Mourne House compared with the more open, progressive regime at Hydebank:

‘Hydebank Wood provides a staff focused integrated regime based on programmes such as education, vocational training and gymnasium activities. ... Emphasis is placed on encouraging individuals to participate in redressing offending behaviour ... The Governor encourages a high degree of interaction between staff and inmates, emphasis is placed on all inmates contributing and having ownership of the regime participation and delivery.’²⁹⁰

The commitment to overcoming the existing ‘intransigent’ regime at Maghaberry has been described as one of the main motivations for the proposed move to Hydebank.²⁹¹ The Maghaberry Governor proposed that lack of progress towards meeting the recommendations of the 2002 Inspectorate Report had been due to industrial relations problems with Mourne House POA and its predominantly male staff. He stated that the redeployment of staff from the Maze Prison, accustomed to dealing with paramilitary prisoners, had compounded difficulties already entrenched in the staff culture. It was a culture of disengagement, with few officers prepared to participate in an active and creative regime. The prevailing ethos was one of stagnation in which officers, with few exceptions, did very little beyond the minimum required. Consequently the regime had diminished and prisoners suffered the consequences.

According to the Governor, these problems and those associated with operating a women’s unit within a high security adult male prison, would be resolved by the transfer. He continued:

“Maghaberry is a complex prison. Mourne House is outside the main walls and is different. It would be better served with one perimeter. Hydebank Wood gives this opportunity and provides shared facilities. It is a good opportunity. More can be advanced in a low risk facility. At Maghaberry there’s always

²⁹⁰ EQIA, pp 12-13.

²⁹¹ Meeting with the Governor of Maghaberry Prison, February 2004.

the problem of high security. A good, liberal regime is the objective.”

It was hoped that Hydebank Wood would provide a less harsh and austere environment, bounded by fences rather than walls. The issues of high security at Mourne House and the gender imbalance of staff would be addressed. The Prison Service was committed to a “more open regime for women” and the deployment of “the right kind of staff”.

The Governor of Hydebank Wood YOC supported the assertion that Hydebank Wood had the potential to offer a more open liberal regime for women prisoners.²⁹² At the YOC the “client group” was “very volatile”. During the previous two years, however, a new and effective ethos had emerged and consolidated and there was no reason why the existing young offenders’ regime could not be applied successfully to women prisoners housed in the refurbished Ash House. The recent history of the YOC demonstrated the development of “well motivated and empowered managers” conversant with, and committed to, a progressive regime. The Principal Officer responsible for Ash House, and the officers appointed to work with her, would project the “Hydebank Wood ethos”. There would be extensive and appropriate induction for prison staff, externally purchased “sourced training” and an estimated 60 per cent (female) to 40 per cent (male) staff gender ratio. Hydebank Wood “will not be two separate entities and women will not be the poor relation”.

He recognised the diversity of women prisoners (young offenders, long-termers, immigration/detainees, separation or punishment, remand) but stated that there would be no distinction made between remand and sentenced prisoners. A Prisoner Development Plan would be agreed for, and with, each prisoner including those remand prisoners “who have issues”. The Plan would be tied to the “positive engagement regime” using a mutually agreed compact to ensure progression. All elements of the existing YOC regime would be adopted to meet the needs of women prisoners: drug reduction programme, through-care and key workers, working from home scheme, and positive links with external agencies.

The accommodation would be in Ash House on four landings, two either side of a central pod. Capacity was set at 48 including two converted mother and baby units. On current figures it was expected that there would be approximately six prisoners on each landing, any two of whom could have access to toilets and showers during lock-up. In response to the Commission’s expressed concerns

²⁹² Meeting with the Governor and staff at Hydebank Wood, March 2004.

regarding the arrangements for ablutions, the Director General of the Prison Service later explained that:

'The 'night toilet', which will also be used during the day, is a separate unit equipped with a toilet and wash hand basin.

In addition there is a single toilet and an area with two screened toilets in the ablutions area. The single toilet is self-contained and although it has a half door to ensure that staff are aware that a prisoner is in this area, the screening complies with legislation and does provide sufficient privacy.

All necessary feminine hygiene equipment will be installed in these areas prior to the transfer.²⁹³

The Governor described the projected 'typical day': 7.30am to 8.00am start of day, followed by showers, breakfast; 9.00am-12 noon, education and work parties followed by lunch; 12.20pm lock-up; 1.30pm to 4.15pm education and work parties followed by dinner; 4.15pm to 5.00pm lock-up; 5.30pm to 8.00pm association; 8.30pm lock-up for the night. The policy would be to "maintain workshops and the regime and to get people off the landings". The YOC offered "better education opportunities" with "additional resources" provided on the basis of "individual needs assessment". He expected that eventually workshops would be "mixed sex", including the kitchen. As the grounds were just "one area" he envisaged mixed work parties. Women's "possible access to male dominated workshops" would be subject to "risk assessment". Association on the landings would be "seven nights a week".

The Hydebank Wood Governor recognised that the Inspectorate had recommended "discrete accommodation" for women prisoners. In carrying out the feasibility study he "had to look at making the best move possible" within the limitations of the existing facility and regime. He was confident of staff support: "the POA here are most reasonable and work on the basis of partnership". Hydebank Wood would be a "settled site, a settled prison and a much reduced security culture". The under-18s would have a separate landing governed by "child protection measures". He knew "exactly how many staff I need to run Ash House". In addition to 36 officers, he would require a probation officer, a psychologist, a full-time and two part-time teachers and two physical education staff (including ante natal and post natal work). There would be a new training programme for physical education instructors.

²⁹³ Comments from the Director General of the Northern Ireland Prison Service on the draft of this chapter, correspondence, June 2004.

In commenting on the draft of this chapter, the Prison Service confirmed that 36 officers and several senior members of staff would be supplied. Additional specialists would include six additional nurse officers and a higher psychologist with responsibility for developing gender specific programmes. Existing part-time teachers in Mourne House would transfer as well as the existing Probation Officer and current groundsperson. An additional physical education instructor would be provided.²⁹⁴

While recognising the legitimacy of concerns raised in the consultations, the Hydebank Governor considered that in the main they revealed a “lack of understanding”. The anxiety felt by women prisoners had been “fuelled by misconception”. He accepted that in-cell sanitation was a “big issue”. Given that the cost of converting Ash House entirely to in-cell sanitation was “too great”, the electronic unlock system was a “perfectly acceptable alternative”.

The Mourne House Prison Officers’ Association’s view

In its consultation submission, the Mourne House Branch of the Prison Officers’ Association (MHPOA) stated that the transfer had been inevitable so that officers could ‘be redeployed in a bid to cut costs at the expense of female inmates who will see a massive decline in their accommodation standards and regimes’. While accepting that changes at Mourne House were necessary, the transfer was neither feasible nor desirable as the ‘current standards of regime and accommodation cannot be maintained or enhanced’. The MHPOA questioned whether accommodation ‘designed to be used by short-term young offenders’ could be adapted for use by the range of women prisoners. Lack of in-cell sanitation, communal ablutions, no infrastructure for female work parties, shared gymnasium, education and health-care facilities were each issues of concern.

In a research interview, MHPOA representatives were scathing about management’s role in the diminution of the regimes and conditions at Mourne House.²⁹⁵ When opened in 1986 it had been a “breath of fresh air”, the “flagship of the Northern Ireland Prison Service”. But “whatever the prisoners had when it opened was the best they ever had”. It had been “allowed to deteriorate over the years ... left

²⁹⁴ Above.

²⁹⁵ Interview with Mourne House Prison Officers’ Association, March 2004.

behind in a time warp". The Prison Service regarded it as a "side-show, an irrelevance". It was self-evident from the discussions held between the MHPOA and the Governor of Maghaberry that he wanted "rid of Mourne house". While the Governor considered the staff redeployed from the Maze to be disengaged from prisoners, wanting an undisturbed life, the MHPOA portrayed its members differently: "approximately 40 staff came from the Maze each with 15 to 20 years experience ... over half the staff had jailcraft built in [with] all that experience, skills and commitment to use".

Mourne House had never been managed by a discrete governor and the MHPOA considered that this omission had compounded the under-resourcing of the Unit. Although the raw figures showed the *per capita* cost of women in prison in Northern Ireland to be excessive, the Unit's kitchen and workshops had been mothballed and the potentially excellent health-care facility did not provide round-the-clock care. The post of Principal Officer in the Unit had a high turnover and there was an institutional failure to accept that "the female estate is different and has to be managed differently". According to the MHPOA, the Unit was seen by management "as a thorn in the side of Maghaberry and they want rid of it". What was needed, was acknowledgement that it "is a purpose-built women's prison", that management "had not done a good job" and, that the "Hydebank resources" should have been used to upgrade Mourne House, enabling women prisoners to receive comparable opportunities to those offered to men.

Appended to the MHPOA submission was a letter, dated December 2003, from the Prison Service's Director of Finance and Personnel to Governing Governors in which she stated that the transfer was 'expected to occur in Spring 2004'. She defended the transfer as a cost-effective necessity. Consequently the MHPOA criticised the Director General's "pretence" that the intention was primarily 'to make better provisions for women in custody'.

The Boards of Visitors' views

Such 'pretence' was a concern of the Hydebank Wood Visiting Committee (HWVC) in its response to the consultation:

While the transfer is presented as a move to improve the regime for women prisoners, it has been clear to the Committee since the transfer was first mooted that the reasons behind the proposal are those of efficiency in the use both of staff and the prison estate. The Committee has no quarrel with those objectives, but it would like the move to be

recognised for what it is – a rationalisation in the interests of reducing costs.²⁹⁶

The HWVC noted a 'significant improvement in the regime' at Hydebank Wood. It had been 'achieved against a background of cutbacks and declining resources, and despite the difficulties caused by major refurbishment, a sharply rising inmate population, and the impact of the current breakdown in industrial relations in the Service'. Success had been secured by a 'small and highly committed management team whose resources are stretched to the limit'. The transfer would increase 'managerial complexity'. A key issue was the danger of 'deterioration in the regime for male inmates at Hydebank'.

Following a visit to Mourne House, the HWVC noted the 'understandable anxiety among staff and prisoners alike ... heightened by the lack of hard information about the precise nature of the facilities and regime to be provided at Hydebank'. It concluded that the standard of accommodation at Mourne House, alongside 'dedicated education and recreation facilities' could not be equalled at Hydebank Wood. Cell size was 'an important issue and will become even more so when proposed European standards have to be applied'. Given that facilities would have to be scheduled for joint use, the transfer would constitute 'a move to a physical environment and plant that does not match that of Mourne House'.

The HWVC recorded its concerns about: the feasibility of additional programmes for women 'given the difficulties in recruitment of staff for existing educational programmes'; the capacity within resource allocations to deliver an enhanced regime for women; the 'complex issue of sanitation and personal modesty; loss of privacy and possible verbal abuse from male young offenders; provision of appropriate psychiatric care; adequate training for prison staff'. While expressing 'very real concerns about the effective delivery of measures envisaged in the consultation document', the HWVC concluded, 'if, and only if, the management and staff at Hydebank are given the support and resources they need, they have the commitment and ability to provide an acceptable environment and regime for Northern Ireland's women prisoners'. Finally, the HWVC noted its 'concern that decisions have already been taken ahead of this consultation process'.

The Maghaberry Board of Visitors (MBOV), which had responsibility for the Mourne House Unit, was less equivocal in its response to the consultation document. It 'failed to see how a transfer from a

²⁹⁶ Letter from the Visiting Committee HM YOC Hydebank Wood to the Governor of Hydebank Wood, January 2004.

purpose-built complex less than 20 years old to a single house in a centre built for young offenders' meets the Prison Service's stated ambition to achieve 'better provision for women in custody'. The 'welfare and health (mental and physical) of the prisoners involved' was of 'paramount importance'²⁹⁷. Having conducted extensive consultation with women prisoners in Mourne House, each well known to the Board, the MBV considered it was 'in a position to represent their views and anxieties'. It was concerned that the consultation document failed to consider the baseline requirements for women in custody of 'total physical separation, separate catering, health-care facility, education, visiting, PE, management and staffing', which had been recommended by the Prisons Inspectorate's report, *Women in Prison: A Thematic Review*.

Lack of in-cell sanitation and personal washing facilities had created the 'most anxiety to female prisoners of all ages who are accustomed to having their own facilities'. Having experienced such minimal facilities, their removal would be viewed 'as punitive'. It posed a 'real equal opportunity issue' as 'all adult male offenders in Maghaberry have in-cell sanitation'. The MBOV viewed the reduction in the number of accommodation landings available as limiting the capacity to enable 'special provision for life-sentence prisoners who already feel that their opportunities are very limited in comparison to male long-termers'. While acknowledging the enthusiasm of the Hydebank Wood staff and their commitment to initiating a 'good regime with ample time out of cell' the MBOV was not convinced that appropriate programmes would be provided and that current education and work-party opportunities would be lost. The 'thought of sharing health-care facilities' was a particularly daunting prospect for the women prisoners.

The MBOV considered that the Prison Service would 'undoubtedly face legal challenges on the grounds of lack of equality of treatment of male and female prisoners'. The issue of 'cost effectiveness' cut no ice with the Board. In a clear reference to the costly conversion of two units to house male paramilitary prisoners at Maghaberry, the MBOV concluded, 'the level of recent expenditure on particular groups of prisoners has clearly demonstrated that money can be found, when it is expedient'.

On 4 May 2004 the MBOV visited Hydebank Wood. Members were 'particularly impressed by the dynamic and humane attitude of the Governor'; they noted the 'ethos of personal development in the YOC' and were reassured by the 'Governor's confidence' that his staff

²⁹⁷ Board of Visitors/Visiting Committee HMP Maghaberry (2004) *Response to Equality Impact Assessment on Proposed Transfer of Female Prisoners to Hydebank Wood*, January.

could manage and curb any potential harassment of women prisoners by male young offenders. Yet, they reaffirmed their concerns regarding cell size, the absence of in-cell sanitation, the mixing of remand and sentenced prisoners and the 'complication' of handling 'interactions between the sexes'. While commenting favourably on the 'plan to manage disturbed and troubled females on the residential landing through interaction and intervention' between staff and prisoners, they restated the need for officers and managers to receive 'specific training and monitoring'. Over all, the visit reinforced their initial judgement that the 'physical facilities' were definitely not as acceptable as those in Mourne House. They 'regretted that this move has been put into action in spite of the recommendations ... previously made'. They concluded:

'We sincerely and honestly hope that the decision having, regrettably, been made to move the women, sufficient time will be allowed for all the facilities and training to be PROPERLY completed before the transfer occurs. Rushed and occasionally *ad hoc* administration could have far-reaching repercussions ... These disturbed and often damaged women and children require security and appropriate treatment.' [emphasis in original]²⁹⁸

The women prisoners' views

It was clear from the research interviews that women prisoners had not been provided with information regarding the proposed move: "We just know it's going to happen but we don't know when and we don't know what it will mean for us ... all the girls [women] are uptight".²⁹⁹ The lack of dependable information had led to rumour which had exacerbated their apprehension. It was also evident that rumours had been fed by officers whose motives were not necessarily consistent with the women's best interests. Lack of hard information or consultation, as the research demonstrates, was not confined to the move: "From our arrival onwards, we are the last to find out what's really happening". Several women "wrote to Hydebank, but I don't think they took any notice".

The main concern voiced by all women prisoners was that they would have to live in a predominantly male environment where core facilities would be shared. Their previous experiences of being transported in prison vans with male prisoners had been threatening:

²⁹⁸ Maghaberry Board of Visitors (2004) *Report on Visit to HM Young Offenders' Centre, Hydebank Wood*, 4 May, p 4.

²⁹⁹ Interviews with women in Mourne House conducted between March and May 2004.



"They shout abuse at you and try to get you to tell them your name ... it's awful especially when you're already low or depressed". Shared transport was a practice condemned by the Inspectorate's Report. Women prisoners feared that these experiences would be commonplace at Hydebank Wood: "They'll shout out when you're being moved, on outside recreation or in your cell, whether they can see you or not. That's what they'll do. If they know your name we'll get it all the time". As many women in prison "are victims of domestic violence and are mentally fragile", the view was expressed that living in a male prison would constitute an "abuse" and "demotion of basic rights". The women's appalling experiences of having to share the Maghaberry prison hospital had made them particularly concerned about sharing health-care facilities at Hydebank Wood. Young women were worried that "lots of the boys will know us anyway and just give us a hard time with name-calling and the like".

In-cell sanitation and shared ablutions were major concerns:

"It's awful. We're used to having our own screened toilet and washbasin. Now we're having them taken away."

"In my opinion you don't only need your own toilet; you need your own sink, to clean your teeth, to wash your hands. There's lots of things you do where you need to have a quick wash of your hands."

No sanitation in cells ... that is a big problem because women need sanitation, like, on their monthly cycle. I know myself, I run to the toilet a lot and they're only going to let you out one or two at a time at night. It's demeaning.

"We're all women, yes, but if you're on your period, you're not wanting to be standing next to another woman showering."

"They're trying to move us to something that's basically draconian. No toilets in cells, communal showers ... Females don't like showering together. You've seen on this landing that there's privacy barriers around the showers, the bath and the toilets and we're used to that. We're also used to being able to get up in the middle of the night to wash our hands, use the toilet or whatever."

"They're building cells for the male side where the toilets in cells will have doors ... so why are we being pushed back in time when the men are being pushed forward? Where's the

equality in that? Is it because there are so few women that we're being pushed back?"

"We can't even wash our underwear in our cells and put it on the radiator."

There were also concerns over bouts of stomach sickness when several women at a time might need to access toilets or when individuals might need to use the toilet frequently. Again, every woman interviewed felt that this raised fundamental issues of privacy and dignity. The long-termers and lifers considered that the 'enhanced' regime, to which they were entitled, could not be provided in an environment that did not provide basic facilities. "What are the possibilities of getting a proper lifer wing? I really don't think it's fair to expect lifers to mix with YOs and remands and short-termers." During the 2003 summer, "it was dreadful at Mourne House with the mix on the landing ... sheer hell we lived through".

The long-termers were worried that they would not be able to handle the transfer:

"It took me [a long time] to settle here ... now I'm to be uprooted. How long will it take me to settle there? I'm really used to being here ... it's just not fair and they are taking us back in time. Surely if they're going to move us they should be taking us ahead in time, improving things instead of taking things away."

And the fear of not being able to cope with the transfer was clear:

"I'll be honest with you, if this move takes place I don't know how I'll survive because I'm absolutely no good with confrontation. You might think I'm assertive ... It's got that way that you don't voice anything and I can't see how I could handle the things we'll face with the move."

The impending transfer had "put a dampener on everything" for nearly two years and, according to the women, this had led to a deteriorating regime at Mourne House and a lack of investment in the Unit. The issue was addressed clearly by one of the women:

"Realistically, I am aware there is no more finance available to make changes at Mourne House. But money isn't the problem here as there are already adequate facilities at hand. The problem lies in the lack of motivation to administer fundamental changes that would involve structural management, effort and enthusiasm."

While the women were unrelenting in their criticisms of the Mourne House regime, they did not consider that Hydebank Wood could provide a solution to the problems. The losses regarding personal hygiene, privacy and dignity outweighed any gains that might ensue from being in a lower security prison.

In May 2004, a delegation of staff from Hydebank Wood visited Mourne House to provide information for the women regarding the move. The opportunity to discuss arrangements was welcomed by the women and the more positive attitude of the Hydebank management was recognised. However, none of the assurances provided (for example, that there would be more association time and greater access to education than in Mourne, or that women could decorate their own cells) allayed fears regarding issues of sanitation, privacy and proximity to a young, male population.

The women were perplexed that the regime proposed for Hydebank could not be provided within the Mourne House unit, with the added benefits of physical separation from the male estate and its extensive gardens which the women had worked hard to develop and maintain. However, the women were unanimous that the regime at Mourne House required a fundamental and thorough overhaul.

It is clear from the documentary analysis and the research interviews, that the decision to move women prisoners from Mourne House to Hydebank Wood was taken prior to the Equality Impact Assessment consultation and was based primarily on financial considerations, reinforced by the over all operational imperatives at Maghaberry with its expanding male population.

The climate created by the decision to transfer, led to a further and serious deterioration in all aspects of the regime at Mourne House and to the under-utilisation of key facilities. This process, coming hard on the heels of a critical and negative Inspectorate report, was unacceptable and compromised the health and wellbeing of women in custody. The women moved from Mourne House to Hydebank Wood on Monday 21 June 2004.³⁰⁰

³⁰⁰ Since the transfer the Commission has been refused access by the Prison Service to Ash House to satisfy itself that the women are being treated appropriately. The Commission has established the right to visit prisoners in the legal visits area and has on one occasion been allowed to visit a young women in her cell. The Commission has recently negotiated access to carry out follow-up research with women in Ash House in autumn 2005.

Sex-offenders

One of the most complex and sensitive issues in the management of prisoners concerns the imprisonment of those convicted of sexual and physical abuse offences, particularly in cases where children are involved. The overwhelming majority of those convicted are men, reflecting the gender differentiation in abuse within wider society. Prisoners who have a history of being abused often feel threatened, emotionally as well as physically, by the presence of convicted abusers. Other prisoners pose a real threat to convicted abusers, identifying their offences as beneath contempt. Further, prison officers often bring their own prejudices into this potentially volatile situation. There has been a continual and often heated debate over the integration of convicted abusers into the general prison population. It is clear that for therapeutic regimes to operate, such as at Grendon Underwood in England and the STOP programme at Peterhead in Scotland, significant resources have to be committed in a context of progressive policies utilising highly trained staff. In the Peterhead example, the programme has resulted in significant numbers of prisoners being placed in one geographically remote location. Whatever the successes of this programme, the criticism is made that it places offenders together in an unhealthy reinforcing environment. This is a clear illustration of the dilemma in attempting to create a regime that is free from the threats of an integrated prison yet creating a form of segregation.

As few women are convicted of sexual or physical abuse, less attention has been paid to the creation of appropriate regimes and programmes. Yet, they are often subjected to the worst intimidation and violence, particularly if their offences involved children. It was clear from the research that the Northern Ireland Prison service had no policies or plans in place for receiving into prison women convicted of physical or sexual abuse. During the course of the research a major trial was being conducted which eventually led to the conviction of a woman for offences committed against children in a residential home 20 years earlier. It was clear at the time that if convicted she would be located on general association with other women prisoners. This case serves as a particularly pertinent example of how women's imprisonment in Northern Ireland is managed.³⁰¹

³⁰¹ The woman was convicted and sentenced to Hydebank Wood but at the time of publication, June 2005, was in the process of appealing this conviction.

The lack of specific and well considered policies results in ad hoc responses which have consequences for all women and girl prisoners. For some women in Ash House at Hydebank Wood, the arrival of a woman convicted of institutionalised abuse of children will have brought back all-too-vivid and damaging memories. Yet again, the Prison Service failed to provide appropriate preparation for such an event because it lacked appropriate policy provision.

Findings of Equality Impact Assessment consultation process

In October 2004 the Prison Service published its findings of the consultation process on the transfer. It lists 21 individuals or organisations as respondents to the consultation. No children's sector organisations are listed. The values underpinning the findings are evident in the Executive Summary:

'It was clear from the consultation that the majority of female prisoners had been misinformed as to the potential benefits of the transfer and the improved regime delivery. However, in comparison associated organisations understood the potential of the policy opportunity and see it as being of positive benefit to women in custody.'³⁰²

The Findings document provides no evidence in support of this. Only ten paragraphs are written on 'key findings' and no data is presented to validate the claim of misinformation, either in source or in substance. There is no identification of the 'associated organisations' which considered the transfer a 'policy opportunity'. Criticisms of the lack of in cell sanitation, of cell accommodation and amenities, of perceived deterioration in the regime and of inferior visits are simply dismissed or covered by reassurances. For example, concern over accommodation brings the response that '[a]ll cells conform to the United Nations Standard Minimum Requirements for the Treatment of Prisoners'.³⁰³ Concern over perceived deterioration of regime brings the reassurance that there 'will be a lengthening of the time out of cell through increased association and with exercise periods being programmed during the working day'.³⁰⁴ Details of the proposed regime and its associated programmes are conspicuous by their absence.

³⁰² Northern Ireland Prison Service (October 2004) *Transfer of Women in Custody: Maghaberry to Hydebank Wood: Findings of Consultation Process* NIPS, Belfast.

³⁰³ Above, p 5.

³⁰⁴ Above, p 6.

On holding under-18s within the Ash House unit, 'NIPS are [sic] fully aware of their responsibilities under Child Protection legislation'. The document continues:

'Hydebank Wood complies with NIPS policy and when operationally practical and in the best interests of the child, will accommodate persons under 18 years of age on separate landings. Similar provisions will be made for those females under 18 years old within Ash house.'³⁰⁵

What this statement fails to acknowledge is the persistent criticism of the Prison Service, including statements made by the Visiting Committee, for allowing boys under 18 years of age to be located or have association with male prisoners over 18. Further, the Prison Service made no assessment of the 'equality impact' of the women's transfer on boys under 18 held at Hydebank Wood. Such a significant policy change required that the EQIA should have taken cognisance of the potential impact on boys. This failure to comply with Section 75 of the Northern Ireland Act is reflected in the Prison Service's omission to invite submissions from children's sector organisations. While the Prison Service states a commitment to training its staff in the 'nature of adolescence', 'race and cultural awareness', 'gender specific issues' and 'induction on transfer to Hydebank Wood',³⁰⁶ there is no detail given as to the depth or quality of this 'training'. Child protection training is not mentioned.

Finally, in response to the criticism that the transfer was a 'cost saving exercise', the document concludes:

'The NIPS do [sic] not accept that the principal objective for the proposed transfer was purely financial. The findings of the Feasibility Report concluded that the transfer to Hydebank would allow for the provisions of an enhanced regime for women in custody. It is however accepted that as a result of the transfer the regime can be delivered by a reduced number of staff and that NIPS can also make much better use of the present prison estate. It is acknowledged that savings will be made in these areas but this will not be to the detriment of prisoners, staff or service delivery.'³⁰⁷

The Findings document is thin in content, short on detail and significant in omission. Given the criticisms within the Chief Inspector's report on Mourne House, and its core recommendations, it is evident that Ash House, in a male young offenders' centre, falls well short of the basic standards recommended in that report. As at

³⁰⁵ Above, p 7.

³⁰⁶ Above, p 8.

³⁰⁷ Above, p 9.

October 2004 there is no Prison Service policy, no strategic plan, no discrete prison, no dedicated governor, no gender-specific regime, no separate healthcare facility and no appropriate child protection measures or sex offender policy regarding women in prison in Northern Ireland. Whatever claims are made and reassurances given concerning the transfer, Ash House cannot resolve the endemic problems that were allowed to consolidate at Mourne House.

The Northern Ireland Prison Service should declare the current use of Hydebank Wood, the male young offenders' centre as a temporary and time-limited location for imprisoning women in Northern Ireland. (Recommendation 31)

It is recommended that a women's custody unit be developed, either on the site of Mourne House or at another appropriate location. It should be low security and entirely self-contained, offering discrete healthcare and visiting facilities, kitchens and laundry, education, employment and gymnasium. (Recommendation 32)

The women's custody unit should offer minimum acceptable standards of accommodation for women. These include: in-cell sanitation and ablutions screened off from the cell; in-cell television and radio; daily access to bath and constant access to showers during unlock; comfortable and well-equipped recreation and kitchen areas; and access to telephones. (Recommendation 33)

A 'needs assessment' should be carried out with long term prisoners to establish their priorities for accommodation and effective programmes while in Ash House. (Recommendation 34)

Whenever possible, healthcare provision, including counselling, should take place in Ash House. (Recommendation 35)

A minimum level of nursing provision based on 24 hour nursing staff availability should be established for Ash House. Women prisoners should have access to a female doctor. (Recommendation 36)

Women prisoners should not be placed on association, whatever the circumstances, with male prisoners. (Recommendation 37)

The Northern Ireland Prison Service should urgently carry out an assessment of the situation relating to the holding of women convicted of sex offences, taking into consideration the safety of these women and the needs of other women prisoners, and publish for consultation the resultant policy. (Recommendation 38)

The Northern Ireland Human Rights Commission should be granted access to Ash House, Hydebank Wood, to the facilities used by women prisoners and to those women who want to be interviewed, to monitor independently the current situation. (Recommendation 39)

As a matter of urgency, the Prison Service in consultation with relevant statutory and non-government organisations (NGOs) should develop a strategic plan, including guidelines for operational policies and practices, for the treatment of women in custody. As part of the consultation process, seminars should be held with representatives of the Criminal Justice and Prisons Inspectorates, the Equality Commission, the Northern Ireland Human Rights Commission, the Social Services Inspectorate, relevant NGOs, established academic researchers and advocacy groups. (Recommendation 40)

Chapter 10

FINDINGS AND RECOMMENDATIONS

Mourne House

The report of the Chief Inspector of Prisons, following the Inspectorate's 2002 full inspection of Maghaberry, was highly critical of the Mourne House regime and the day to day routine under which women and girl prisoners are held in Northern Ireland. In a press release the Chief Inspector, Anne Owers, commented that there was "some way to go before the prison fully met our expectations".³⁰⁸ In reply the Director General thanked the Chief Inspector for acknowledging "the progress that has been made" while "taking a realistic view of the challenges ahead". The inspection had assisted "in developing Maghaberry and focusing our efforts on the healthy prison agenda".³⁰⁹ Given the severity of the criticisms over Mourne House, and the revelation that the Northern Ireland Prison Service had no policy or strategic plan for the treatment of women in custody, it was to be expected that the Inspectorate's 49 recommendations would have been a priority.

It is a matter of profound concern that the researchers experienced the operation of a regime that neglected even the identified needs of women and girl prisoners, that lacked creative or constructive programmes to assist their personal or social development, that compromised their physical and mental health and failed to meet the minimum expectations of a 'duty of care'. The reassurance given by the then Director General in an interview for television in June 2004,³¹⁰ that "conditions" in Mourne House "are decent and humane and they are caring", suggests complacency in the face of much evidence to the contrary. While accepting that the Northern Ireland Prison Service, and Maghaberry in particular, is emerging from a prolonged period of poor industrial relations, has been negotiating and planning for separation in the wake of the Steele Report and has a complex 'mix' of prisoners, the stagnation of the Mourne House regime has caused considerable suffering for the women and girls held there in recent years. That is clearly evident from the case material and the interviews with prisoners.

³⁰⁸ Northern Ireland Prison Service press release, 26 February 2003.

³⁰⁹ Above.

³¹⁰ Pre-recorded interview, 10 June 2004, for BBC Northern Ireland *Spotlight* programme, broadcast, 12 October 2004. Transcript obtained from NIO Media Monitoring Unit.

It is important to return to the Inspectorate's concerns, not least because they provided a baseline accepted without qualification by the Northern Ireland Prison Service. At a broader policy level the Inspectorate was concerned to find a lack of strategic planning for women in custody and that Mourne House was not operational, either in facilities or management, as a discrete facility for women. As a consequence, women and girls were put in vulnerable and potentially damaging situations through shared healthcare facilities in the male prison hospital and shared transport. High security, including the oppressive staffing levels, was considered inappropriate as was the male to female staffing ratio. The lack of training of prison officers in working with women or girls, particularly in the aftermath of redeployment from the Maze prison, was considered unacceptable. Opportunities to participate in programmes central to contemporary sentence management or to develop workshop skills were denied. The Inspectorate stated its opposition to age mixing and was 'firmly of the opinion that prison establishments should not be used to hold juveniles'.³¹¹

In assessing Mourne House against the 'healthy prison' standards the Inspectorate criticised: the lack of occupational opportunities; a closed management style; the lack of an induction programme; the failure to adopt a co-ordinated multi-disciplinary approach to de-medicalising suicide and self-harm; the level of inconsistency in the regime; the decision to close the Mourne House kitchens, workshops and healthcare centre; the absence of strategic direction and planning for release and resettlement; the limitations of child protection procedures, which 'fell far short of the standard required for staff working with very needy and damaged children in a custodial setting';³¹² the apparent lack of awareness of the need to develop gender-specific programmes for women; and the lack of a pre-release programme or a drug and alcohol programme. It is ironic that while there has been minimal strategic or regime development in response to these criticisms, the two areas that received praise, sentence planning and education, virtually collapsed during the two years following the inspection.

The Inspectorate made many detailed recommendations on each aspect of the regime. Key recommendations included: Mourne House should be declared a discrete female facility, under the auspice of Maghaberry management; the Prison Service should produce a policy and strategic plan for the treatment of women in custody to be delivered in Mourne House; all staff and managers should receive training to prepare them for working with women in

³¹¹ *HM Inspector of Prisons, Report of a full announced inspection of HM Prison Maghaberry, 13-17 May 2002 (Maghaberry Inspection 2002), 18:162.*

³¹² Above, 105: 179-180.

custody and responding to their needs; Mourne House should be operated as a low security facility within a secure perimeter and with significantly reduced staffing levels; and the healthcare facility in Mourne House should be reopened and all healthcare be delivered either in the unit or in the community.³¹³

The research found a regime in which it was usual for women to be locked in their cells 17 hours a day, the workshops closed and education classes rarely held. The only available organised outdoor activity was horticulture offered to sentenced women only. Given that the researchers were able to walk around the Mourne House grounds unescorted and talk freely with women, it was clear that neither management nor staff regarded the women to be a threat to personal safety. Yet, they were not permitted to attend education classes, a short distance from their cells unless escorted by prison officers.

Women received little or no support on their reception on to the prison landings and there was no structured induction programme or adequate information provision. Neither had the need for structured sentence management or resettlement programmes been addressed. The right of women in prison and their children to a meaningful family life was not respected. Women were restricted to brief periods of unlock during which they could make telephone calls to their children and there were no special arrangements for family visits. Women complained that they were often only able to see their children for 45 minutes each week. This lack of support for family relationships was damaging to the women and their children during their sentence and clearly had a deleterious impact on relationships following release, particularly after substantial sentences.

The treatment of children and young adults in the prison was particularly alarming. When the research began there was a YOC, albeit on a separate landing, with no special provision made for the children and young people. Following separation of the Republican prisoners from other women prisoners, they were relocated to this landing and young prisoners were moved. Consequently, there was no separate provision for children and young people, thus breaching international human rights standards.

The inspectors were highly critical of the treatment of suicidal and self-harming women, especially young women. In particular, they were concerned about the use of the main male prison hospital for distressed women prisoners and of the use of the punishment block for these women. The research found that healthcare for women

³¹³ Above, MH 06-11.

prisoners was dire. Other than for basic day support, the Mourne healthcare centre remained closed and women attended the male prison hospital for treatment. Women prisoners were critical of the lack of available counselling and therapeutic provision. The situation was particularly bleak for those women identified 'conduct disordered' rather than diagnosed as having an identifiable mental illness. They were generally unable to access treatment in the prison hospital as they were not deemed to have a recognised psychiatric condition. Yet, staff in Mourne House felt unable to cope with their mental health needs. Prison officers voiced their concerns regarding the lack of training in this area.

Since the 2002 inspection report two women, Annie Kelly (in September 2002) and Roseanne Irvine (in March 2004) have died in Mourne House. It is clear from Chapters 5 and 6 that their deaths, as with the death of Janet Holmes in 1996, are at the sharp end of a continuum of self-harming and parasuicidal behaviours. Clearly, the issues raised by Janet Holmes' solicitor and by the Belfast Coroner following her inquest were not incorporated into any coherent strategy for dealing with vulnerable women prisoners. That Annie Kelly could make ligatures from protective clothing and find a ligature point in what was supposed to be a specially adapted ligature free cell is a matter of profound concern. That Roseanne Irvine was left with access to ligatures in a standard cell with multiple ligature points while known to be suicidal and on an IMR21 is also a matter of profound concern.

The punishment block, or special supervision unit, was a wholly inappropriate environment in which to hold distressed and self-harming women and girls. The two cases discussed in Chapters 5 and 6 raise serious concerns about the punitive context in which physically ill and mentally disturbed women and girls were treated. Holding women prisoners, particularly girl children, for 28 days in bare cells with nothing to read, listen to or look at amounted to real and serious deprivation. The use of the strip cell with no mattress, no pillow, a heavy duty blanket, a potty for a toilet to be slopped out and no in-cell access to a sink was degrading and inhumane and, possibly in breach of Article 3 of the European Convention on Human Rights and of Article 3 of the Human Rights Act. Indeed, the holding of a 17-year-old in these conditions was challenged in an application for leave for a judicial review in the High Court and the judge ordered that the child be moved immediately to the prison hospital. Yet, only weeks later following her re-admission to prison, the Prison Service returned her to the same punishment cell disregarding the court's ruling. On this occasion she was denied access to underwear.

The research did not confirm the Inspectorate's finding that relationships between staff and prisoners in Mourne House were 'relaxed' and 'respectful'. On the contrary, the research found only a small minority of staff committed to engaging in a constructive, creative and caring regime. Their commitment placed them in a difficult position as the dominant attitude among prison officers to the women and girl prisoners was, at best, disinterested and, at worst, disrespectful and abusive. The evidence from the interviews with prisoners was supported by that derived in interviews with other professionals and with a few officers. The proposition, put to the researchers on the first day of the research by the Mourne House Prison Officers' Association (MHPOA), that the officers in Mourne were highly experienced, dedicated and committed to the well-being of women in their care was not substantiated by the research or by the researchers' observations of the regime in practice.

The management holds prison officers and their representatives responsible for the sorry state of affairs at Mourne House while the MHPOA points to an abdication of managerial responsibility. Whatever the circumstances of recent industrial relations disputes, it has been women prisoners who have suffered. In the final analysis the responsibility for providing a positive and constructive environment, adequate and appropriate care, rehabilitative and supportive programmes for women in custody rests with the Director of the Prison Service and the Prison Service Management Board. While the working practices adopted by many, but not all, prison officers fall short of minimum professional standards, the Prison Service HQ should have resolved the worsening situation at Mourne House. That they failed to do so is an indictment of their approach towards the women and girls in their care and has had serious consequences.

The findings of the research project are the product of an intensive and focused period of investigation recording the accounts and experiences of many individuals involved directly at Mourne House. Most significantly, it draws on in-depth interviews with women prisoners who were keen to participate. These interviews were not supervised by Prison Service staff. While the Northern Ireland Human Rights Commission negotiated access to Mourne House, its powers to conduct a full-scale inquiry are limited. It can request, but cannot compel co-operation. Nor, can it insist on the disclosure of relevant documentation.

Given the seriousness of the findings it is essential that further inquiry into the key issues is pursued. In this context, serious consideration should be given to holding an

independent public inquiry. Its focus should be the deterioration in the regime and conditions, in which women and girl children were held in Mourne House following the inspection carried out by the Chief Inspector of Prisons in February 2002. It should enable disclosure of all available documentation regarding the administration and management of Mourne House. It should call oral evidence from senior managers which should be tested through cross-examination. It should also request written submissions from all interested parties. Its terms of reference should include:

- **the failure by the Northern Ireland Prison Service to implement the Inspectorate's recommendations and the consequences for women and girl children prisoners held at Mourne House from 2002 to 2004**
- **the circumstances surrounding the deaths in custody of Annie Kelly in September 2002 and of Roseanne Irvine in March 2004**
- **the use of the punishment and segregation unit as a location for the cellular confinement of self-harming and suicidal women, including girls, and**
- **the circumstances in which prison officers were suspended and dismissed following allegations of inappropriate conduct.**

(Recommendation 41)

The transfer to Hydebank Wood

In proposing the move of women and girl prisoners from Mourne House to Hydebank Wood, the Equality Impact Assessment consultation document made reference to the *Thematic Review of Women in Prison* (2001), stating that this 'offers a template of how women should be managed in a mixed gender facility and highlights best practices in relation to accommodating both males and female in one establishment'.³¹⁴ But there is no acknowledgement of the Inspectorate's view that at present, the sharing of sites does not work to the benefit of the female prisoner population.³¹⁵ In England and Wales, the decision to situate some female establishments within male prisons is endorsed by the Inspectorate only to ensure 'as wide

³¹⁴ Northern Ireland Prison Service (2003) *Transfer of Women in Custody in Northern Ireland: An Equality Impact Assessment*, NIPS, Belfast, 24 November 2003, p 12.

³¹⁵ HM Inspector of Prisons (2001) *Follow up to Women in Prison: A Thematic Review by HM Chief Inspector of Prisons for England and Wales* HMIP, London.

a geographical provision of accommodation as possible' so that women can be held close to their homes. However:

'There is an inevitable tension between the two options: on the one hand, attempting to locate women as close to home as possible but thereby marginalising them because they represent tiny groups in male prisons; on the other hand, concentrating them in a few prisons dedicated to women only, thereby placing them far from home.'³¹⁶

The need to situate women as close as possible to their homes was not identified by the Northern Ireland Prison Service as a significant factor in the decision to move from Mourne House to Hydebank, thus lessening any possible justification for situating the proposed female unit within a male young offenders' institution.

Nor, does the Northern Ireland Prison Service acknowledge the Inspectorate's specific safeguards to be adopted where a women's unit is situated within a male establishment:

- total physical separation
- a separate identity reinforced by distinct management and staffing team
- separate costing arrangements and management accounting systems to attribute costs of shared services
- discrete objectives
- separate visiting facilities
- separate catering facilities
- separate healthcare, and
- separate education, employment and physical education facilities.

In contrast, the Northern Ireland Prison Service has demonstrated little understanding of the 'blinding glimpse of the obvious' that 'women in prison should be treated differently than men'.³¹⁷ Consider its responses to issues regarding women's treatment, raised by the Maghaberry Board of Visitors in their Annual Report:

[on a request for women to be allowed to cook all their own food] ... 'it would not be appropriate to allow female prisoners to cook their own food while males are not permitted to. It is essential that we have transparent fairness across the board.'

[on concern about the high proportion of male to female staff in Mourne House] 'the proportion of male to female staff is

³¹⁶ Above, 3.10.

³¹⁷ Above, Sir David Ramsbotham, former Chief Inspector of Prisons, in preface.

based on a Genuine Occupational Qualification (GOQ). The current ratio is well within the GOQ for Mourne House.'

[on a recommendation to create a prison 'entirely geared to the needs of female prisoners'] ... 'The feasibility study reviewing the proposal to transfer female prisoners from Mourne House to Hydebank Wood had a clear brief to ensure that the regime available to females is similar to that available to male prisoners in so far as this is practicable given the number of females in custody and the range and types of sentences being served.'³¹⁸

The Northern Ireland Prison Service failed to provide the necessary safeguards for female prisoners in a male prison in the Mourne House context and has not demonstrated that it can meet them at Hydebank Wood. In deciding to transfer women and girl prisoners to Hydebank Wood, little consideration appears to have been given to the central issues of concern raised by the Inspectorate and its recommendations.

A comprehensive and strategic review of women's imprisonment has not taken place. The lack of a senior manager and governor dedicated solely to identifying and assessing the needs of women and girls compounded their marginalisation within the over all prison population.³¹⁹ At Hydebank Wood there is a single healthcare facility, and mixed sex facilities in the kitchen and visiting areas. The Director General noted: 'Everything else will be timetabled so that all contact will be kept to a minimum if at all'.³²⁰

The installation of in-cell sanitation was a main recommendation of the Woolf report, published in 1991, after the Strangeways riots. Yet, the Northern Ireland Prison Service has moved women prisoners from cells with in-cell sanitation to cells with no such amenities. On the lack of in-cell sanitation the EQIA simply noted that 'the proposed accommodation does however have sufficient sanitary provisions, identical to those provided to the majority of inmates in Hydebank Wood and similar to those in other prison establishments'.³²¹

³¹⁸ Northern Ireland Prison Service *Response to issues raised by Maghaberry Board of Visitors in their Annual Report (2002-2003)*.

³¹⁹ Since the publication of the first edition of this report, a female Governor was transferred from Maghaberry with responsibility for the management of Ash House.

³²⁰ Comments received from the Director General of the Northern Ireland Prison Service about the draft chapter on the transfer, June 2004.

³²¹ Northern Ireland Prison Service (2003) *Transfer of Women in Custody in Northern Ireland: An Equality Impact Assessment*, 24 November 2003, p 17.

At Bulwood Hall women's prison in Essex, cells have no internal toilets and at night women are automatically unlocked if they wish to use the toilet. Security procedures dictate that they are unlocked one at a time and 'in practice long delays are inevitable and some inmates, including juveniles and pregnant women, are reduced to using "potties"'.³²² The most recent inspection at Cornton Vale, Scotland's only dedicated women's prison, comments on the 'difficulties of toilet access in some parts of the prison at night and sometimes during the day'. Over '25% of women who seek access to a toilet at night will have to wait for more than thirty minutes; and some have to wait considerably longer'.³²³ For those in shared cells the lack of 'integral sanitation ... can be humiliating and degrading' and 'some women often used their sink as a toilet'.³²⁴ While the Hydebank Wood arrangement allows two women on any landing to be let out at once, there are no guarantees that women will not have to wait for access to the toilet and washing facilities at night or early morning.

The Prison Service has shown no perception of issues regarding personal hygiene, shared ablutions and the significance of privacy, especially regarding menstruation. In interviews with senior managers the focus, when questioned about these issues, seemed entirely on where women would go to the toilet. The then Director General's response to the Commission's concerns was that 'We are fully aware of the issues in this area [privacy and menstruation] and arrangements are in place to provide privacy for such individuals'.³²⁵

It is extraordinary that the problems stemming directly from holding women and girls in a discrete unit, within the outer walls of a high security adult male prison, have been tackled by a transfer to a house within the fences of a lower security male young offenders' institution. While a reduction in security levels was long overdue, the house in which the women are held is adjacent to a house accommodating young men. There are profound implications in this decision for the women and girls and also for the boys and young men. No evidence was provided to suggest that these implications were explored and translated into operational policies and anticipated practices. It is to be expected that women prisoners, several of whom are high profile cases, will receive abuse from young male prisoners housed close by. Girls and young women often will be

³²² Alison E (2004) 'Women inmates forced to slop out', *The Guardian*, 5 May 2004.

³²³ HM Inspectorate of Prisons (2004) *HMP and YOI Cornton Vale: Inspection 4-6 February 2004*, 30 June 2004, para 2.5.

³²⁴ Above, para 15.3.

³²⁵ Comments received from the Director General of the Northern Ireland Prison Service about the draft chapter on the transfer, June 2004.

known to male young offenders. Again, intimidation and harassment will be difficult to regulate and police.

The enthusiasm and commitment of the Hydebank Wood Governor is well-documented and was clearly evident in interview. His belief, however, that the Hydebank Wood ethos, regime and programmes can be operationalised for women and girls takes no account of the particular needs of women and offers scant reassurance that an assessment of those needs has been fully understood and taken seriously. While the reasons behind his intention to aim for mixed education, mixed work parties and other mixed facilities are positive, they appear naïve. They also fail to address the important issue of women-only space particularly in circumstances of high vulnerability.

It appears that Hydebank Wood, with spare capacity, provided an 'easy way out' of the industrial relations problems at Mourne House – reducing costs while ending the added complication that Mourne House had become for Maghaberry. In terms of penal policy and best practice, no convincing case was made to support the choice of Hydebank Wood.

A consequence of the proposed transfer was the refusal of two Republican women prisoners to make the move. They threatened to go on hunger strike rather than relocate to Hydebank Wood. Arrangements were in place for their transfer but a decision was made to accommodate them in separation at Maghaberry, although they were released without charge before the move went ahead. While it is appropriate that women should receive equal treatment to male prisoners regarding separation their accommodation in a high security male prison is not a satisfactory solution. Neither would be their imprisonment at Hydebank Wood.

It is instructive that when asked the question: 'If a women's prison was purpose-built to meet the standards required would Ash House at Hydebank Wood be acceptable', each senior manager replied, "Of course not". The Prison Service's response to this statement is that 'very little of our residential accommodation is anywhere near ideal'.³²⁶

The Hydebank Wood Governor is confident that the staff necessary to meet the needs of the transfer will be provided. The criteria used to deploy staff were not clear and there are serious issues regarding staff selection and training. Although the Inspectorate recommended the appointment of a dedicated governor for women, Ash House is managed by a female principal officer.³²⁷ There appeared to be an

³²⁶ Above.

³²⁷ Since the publication of the first edition of this report, a female Governor was transferred from Maghaberry with responsibility for the management of Ash House.

assumption that certain staff were suited to work with women prisoners, rather than establishing a well conceived programme of recruitment and training in the context of a gender-specific strategy. As discussed above, this issue is most apparent in dealing with vulnerable and troubled women. Responding to their complex and challenging needs, both on the landings and in the health-centre, requires carefully planned policies and practices within a framework that reflects an understanding of self-harm and suicide. This was not addressed at Mourne House and a recently published *Howard League* report raised concerns about difficulties in Hydebank Wood regarding healthcare, particularly relating to prisoners who were suicidal and self-harming.³²⁸ The Prison Service disputes the Howard League's findings.

While the research demonstrates the unacceptability of the regime at Mourne House, the suggestion that the transfer to Hydebank Wood offered an adequate resolution to the complex and deep-seated problems identified was disingenuous. It is evident from the documentation presented here that the primary driver behind the transfer was cost efficiency and not the advancement of a humane regime appropriate to the assessed and acknowledged needs of women and girls. It was clear from interviews with the Board of Visitors, the Prison Officers' Association and prison officers, that the transfer was a foregone conclusion regardless of the results of the EQIA. An alternative approach would have been for the Prison Service to have conducted a more comprehensive public consultation than that provided by a Section 75 EQIA.

While women prisoners had endured the deterioration of the Mourne House regime, it was clear that they feared the transfer to Hydebank Wood. Despite reassurances to the contrary, on their arrival essential facilities were not in place. The physical environment was under-developed, building work was incomplete and appropriately trained staff had not been appointed. Soon after the transfer, the Human Rights Commission supported a judicial review taken by a female prisoner regarding the adequacy of conditions in Ash House. She challenged the lack of in-cell sanitation, strip searching and harassment of the women by young male prisoners. The judge, Lord Girvan ruled that random strip searching contravened the women prisoners' human rights, yet did not find the arrangements regarding access to sanitation to be in breach of their rights. In May 2005 the Human Rights Commission agreed access with the Prison Service to conduct follow-up research in Ash House in the autumn.

³²⁸ Howard League (2003) *Suicide and self-harm prevention: A Strategy for Northern Ireland* Howard League, London, p 9.

Recommendations

The Northern Ireland Human Rights Commission will monitor the extent to which the following recommendations are adopted.

1. The investigatory powers of the Northern Ireland Human Rights Commission (the Commission) should be enhanced by the Government, to bring the Commission into compliance with the UN's Paris Principles and to ensure that it can effectively carry out investigations. (Chapter 1)
2. Government policy should prioritise alternatives to custody and funding should be made available for viable alternatives, including those run by state and non-governmental organisations. (Chapter 2)
3. Gender-specific programmes should be developed in consultation with relevant state agencies, NGOs and women prisoners. Programmes should be an integral part of a broader framework of care through which women's mental and physical needs are adequately and appropriately identified and met. Gender-specific needs include: separation from children; menstruation; pregnancy; post-natal provision; menopause; and the consequences of sexual, physical or mental abuse. (Chapter 2)
4. The women's custody unit should establish a distinct, gender specific identity supported by a discrete management structure. The majority (baseline 80 per cent) of management staff, prison officers and professional service providers in the unit should be female. At all times, women prisoners should be guaranteed access to women staff regarding any aspect of service provision. (Chapter 2)
5. Each prison and place of detention, and the government department to which it is responsible, should be required to detail its strategy and policies, demonstrating compliance with all relevant and applicable human rights standards and establish implementation baselines for the operational practices of their regimes. (Chapter 2)
6. Fine defaulting should not be grounds for imprisonment and alternatives should be found. Legislation should be amended accordingly. (Chapter 2)
7. The Prison Service's response to the 2002 inspection on Mourne House, and the circumstances in which prison officers were suspended and dismissed following allegations of inappropriate conduct, should be the subject of further inquiry. (Chapter 3)

8. There should be an evidence-based review of the current framework of regime progression, with the intention of establishing a higher baseline level of service provision. Unlock time, length and frequency of visits, and telephone access should not be determined by regime progression. (Chapter 4)
9. While the current policy of regime progression remains, it is imperative that women prisoners on the 'enhanced' regime receive their full entitlements. (Chapter 4)
10. A comprehensive programme should be developed for long-term prisoners from reception, induction and assessment through accommodation, sentence planning and programmes, to pre-release and throughcare. (Chapter 4)
11. Detailed information packs should be provided to all women prisoners on reception outlining, in accessible and informal language, the expectations and practices of the regimes, the rights of prisoners and the procedures for seeking help and support during the first days of imprisonment. Care should be taken regarding literacy and language. The pack should be developed in consultation with women prisoners. (Chapter 4)
12. A structured induction and risk assessment programme should be developed and implemented. A discrete and extended programme should be provided for long-term prisoners. The induction programme should be developed in consultation with women prisoners. (Chapter 4)
13. Family-friendly policies should be developed and visiting arrangements introduced to maximise children's contact with their mothers. This should include extended child-centred visits in the privacy of family rooms. (Chapter 4)
14. The current telephone arrangements based on a 'PIN number' system should be abandoned and a system put in place which respects women's right to privacy and which maximises the potential for contact with family and friends. Access to telephones, including lock-up periods, location and cost should be reviewed. (Chapter 4)
15. Women prisoners should be provided with a full range of education, work and rehabilitative programmes, including preparation for release and the 'working out' scheme. (Chapter 4)
16. The regimes within the women's custody unit should emphasise constructive and creative engagement with prison officers

- spending much of their time interacting with prisoners. There should be effective sentence planning administered by trained officers with specific responsibility for initiating sentence plans and monitoring their progress. (Chapter 4)
17. Extended periods of lock-up and cellular confinement should be ended. Women prisoners should not be compulsorily confined to their cells for more than 12 hours in any one day, including Sundays. (Chapter 4)
 18. 'Immigration detainees' should not be held in Prison Service custody and legislation should be amended accordingly. (Chapter 4)
 19. As a matter of urgency, relevant Government departments and agencies must develop a coherent and multi-agency strategy on women and girl 'offenders' who are diagnosed mentally ill and 'behaviour' or 'personality' disordered. The primary objective of this strategy being to ensure that most will not be sentenced to prison but will have their needs identified and met in therapeutic facilities that offer age-appropriate and gender-specific programmes. An age-related, gender-specific and multi-agency strategy should be developed to identify and meet the mental healthcare needs of the few women whose offences require a prison sentence. (Chapter 5)
 20. An individual mental and physical health risk assessment should be conducted on all women and girls currently in custody and the outcomes discussed at multi-disciplinary case conferences. The women and girl prisoners should participate in this process and be fully aware of the outcomes. (Chapter 5)
 21. Without exception the unit's management, prison officers and professional service providers should receive significant training, supported by a training 'tool-kit', for working with women in custody. Key training curriculum issues include: mental health; suicide prevention and awareness; self-harm; physical and sexual abuse; young prisoners; and human rights. (Chapter 5)
 22. A distinction should be made between the use of anti-ligature cells and a restricted regime for protection against self-harm and suicide and the use of punishment cells. There should be at least one cell on each landing that is ligature free so that women on observation can remain on general association. (Chapter 5)
 23. Women prisoners should not be transported in vehicles with male prisoners. (Chapter 5)

24. The circumstances of the deaths of Annie Kelly in September 2002 and Roseanne Irvine in March 2004 should be subject to further inquiry. This should include analysis of the extent to which lessons from the death of Janet Holmes, including the recommendations of the coroner, were taken on board by the Prison Service and changes made accordingly. (Chapter 6)
25. Children under the age of 18 should not be held in Prison Service custody. (Chapter 7)
26. A separate young prisoners' centre for young women should be established, providing age-specific regimes and programmes. Its use should be a matter of last resort and relate only to grave offences. (Chapter 7)
27. Age-appropriate reception and information packs and induction programmes should be provided for young prisoners. (Chapter 7)
28. Whatever the circumstances, children should not be held in segregation or 'punishment' cells. (Chapter 7)
29. Whatever the circumstances, the practice of 'slopping out' should be ended. (Chapter 7)
30. The women's custody unit should provide for women prisoners held under separation arrangements and the plan to hold them at Maghaberry must be abandoned. It is recognised however, that given possible safety concerns, Hydebank would be an unsuitable venue for detaining Republican female prisoners. (Chapter 8)
31. The Northern Ireland Prison Service should declare the current use of Hydebank Wood, the male young offenders' centre, as a temporary and time-limited location for imprisoning women in Northern Ireland. (Chapter 9)
32. A women's custody unit should be developed, either on the site of Mourne House or at another appropriate location. It should be low security and entirely self-contained, offering discrete healthcare and visiting facilities, kitchens and laundry, education, employment and gymnasium. (Chapter 9)
33. The women's custody unit should offer minimum acceptable standards of accommodation for women. These include: in-cell sanitation and ablutions screened off from the cell; in-cell television and radio; daily access to bath and constant access

to showers during unlock; comfortable and well-equipped recreation and kitchen areas; and access to telephones. (Chapter 9)

34. A 'needs assessment' should be carried out with long-term prisoners to establish their priorities for accommodation and effective programmes while in Ash House. (Chapter 9)
35. Whenever possible healthcare provision, including counselling, should take place in Ash House. (Chapter 9)
36. A minimum level of nursing provision, based on 24-hour nursing staff availability, should be established for Ash House. Women prisoners should have access to a female doctor. (Chapter 9)
37. Women prisoners should not be placed on association, whatever the circumstances, with male prisoners. (Chapter 9)
38. The Northern Ireland Prison Service should urgently carry out a review of the holding of women convicted of sex offences, and develop policy accordingly. Such policies developed should be put out for consultation to a wide range of relevant bodies. (Chapter 9)
39. The Northern Ireland Human Rights Commission should be granted access to Ash House, Hydebank Wood, to the facilities used by women prisoners and to those women who want to be interviewed, to monitor independently the current situation. (Chapter 9).
40. As a matter of urgency, the Prison Service in consultation with relevant statutory and non-government organisations (NGOs) should develop a strategic plan, including guidelines for operational policies and practices, for the treatment of women in custody. As part of the consultation process, seminars should be held with representatives of the Criminal Justice and Prisons Inspectorates, the Equality Commission, the Northern Ireland Human Rights Commission, the Social Services Inspectorate, relevant NGOs, established academic researchers and advocacy groups. (Chapter 9)

Further inquiry

41. The findings of the research project are the product of an intensive and focused period of investigation, recording the accounts and experiences of many individuals involved directly at Mourne House. Most significantly, it draws on in-depth interviews with women prisoners who were keen to participate. These interviews were not supervised by Prison Service staff. While the Northern Ireland Human Rights Commission negotiated access to Mourne House, its powers to conduct a full-scale inquiry are limited. It can request, but cannot, compel co-operation. Nor can it insist on the disclosure of relevant documentation. Given the seriousness of the findings it is essential that further inquiry into the key issues is pursued. In the circumstances it is appropriate to call for independent, public inquiry. Its focus should be the deterioration in the regime and conditions in which women and girl children were held in Mourne House, following the inspection carried out by the Chief Inspector of Prisons in February 2002. It should enable disclosure of all available documentation regarding the administration and management of Mourne House. It should call oral evidence from senior managers which would be tested through cross-examination. It should also request written submissions from all interested parties. Its terms of reference would include:

- the failure by the Director General and the Governor of Maghaberry to implement the Inspectorate's recommendations and the consequences for women and girl children prisoners held at Mourne House from 2002 to 2004
- the circumstances surrounding the deaths in custody of Annie Kelly in September 2002 and of Roseanne Irvine in March 2004
- the use of the punishment and segregation unit as a location for the cellular confinement of self-harming and suicidal women, including girl children, and
- the circumstances in which prison officers were suspended and dismissed following allegations of inappropriate conduct.

Appendix 1

METHODOLOGY

The field research took place in Mourne House Women's Unit, Maghaberry Prison between March and May 2004. Following meetings with the Director General of the Northern Ireland Prison Service and the Governor of Maghaberry Prison research access was granted under the over all direction of the Governor with responsibility for Mourne House. Daily access was under the supervision of the Principal Officer who managed Mourne. During the course of the research a new Principal Officer was appointed. Arrangements for visiting Mourne were made and agreed in advance. On several occasions, due to unforeseen changes in plans, the researchers telephoned to arrange a visit for that day. Throughout the research the access granted was excellent, the accommodation provided was comfortable and the arrangements went according to plan. The researchers went through the usual security checks on arrival and were issued with palm-activated passes. Their passage through the prison was unencumbered and access was granted immediately to all parts of Mourne House including the punishment block (special observation unit). At all times prison officers were courteous and helpful and respected the need for confidential interviews with prisoners. Documentation available on the landings, such as IMR21s, was made available on request.

It was not possible to conduct interviews during lock-up which proved to be restrictive. Following the death of Roseanne Irvine, access was denied to the cell in which she died as it was subject to police investigation. Access was granted, however, to an adjacent cell to demonstrate the physical conditions under which she had been held. Two interviews were held with the 17-year-old child held in the punishment block but a third interview on the landing, to which she had been relocated, was denied by the Governor in June. In fact the interview eventually took place in the closed visiting area.

Documentary analysis

On the first visit the researchers requested that all policy documentation concerning women's imprisonment currently in use at Mourne House be provided. It was several weeks before this documentation was made available. It consisted of the following: a four-page introduction to Mourne House with brief descriptions of accommodation, landing routine, tuck shop, visits, parcels and wages; a two-page guide for prisoners to 'progressive regimes'; a two-page guide to 'booking a visit at Maghaberry Prison'; a two-page

description of the daily routine for the committal and assessment landing; the Committee on the Administrative Justice's (CAJ) brief guide to prisoners' rights; a card introducing the Board of Visitors; and the Maghaberry Prison *Health and Safety Policy*. In fact, the latter document was the only policy statement provided by the prison authorities. The researchers were informed that the Prison Service did not have policy documentation on the custody of women or girls.

Relevant Prison Service documentation, accessed from other sources, included: *Life Sentence Prisoners in Northern Ireland: an explanatory memorandum* (July 2000); *Review of Prison Healthcare Services* (April 2002); the draft *Policy on Self Harm and Suicide Prevention Management* (March 2003); the Maghaberry Prison Board of Visitors *Annual Report 2002-2003*; and the explanatory guide *Compact for Separated Prisoners* (February 2004).

Focus Groups

Focus groups were held with representatives of the Mourne House Branch of the Prison Officers' Association (two occasions), with members of the Maghaberry Board of Visitors and with members of the education staff. Other meetings were also held with members of the Board. It was considered appropriate to retain personal anonymity in presenting views given in the course of focus groups.

Interviews

Semi-structured interviews were held with women prisoners who wished to participate in the research. Prior to the research, all women prisoners received a letter announcing the research and offering the opportunity to participate. The majority of the women – 18 – participated, several on more than one occasion. Wherever possible, and with their agreement, these interviews were taped. Given the sensitivity of the research and the vulnerability of women prisoners, anonymity was guaranteed. In evaluating the research evidence, and establishing its reliability, wherever possible triangulation has been used. Verification of accounts has been achieved through cross-referencing. In addition to representatives of the Mourne House Prison Officers' Association, a number of prison officers were asked or agreed to be interviewed. Individual interviews were also held with staff from healthcare, probation and the clergy. A meeting was also convened with the Governor of Hydebank Wood and his staff, at which contemporaneous notes were taken regarding the proposed move of women prisoners from Mourne House. A meeting was held with two Maghaberry Governors in the course of the visit regarding the hunger strike of a Republican

prisoner. Contemporaneous notes were used to record this meeting and the events that followed. Again, wherever possible, anonymity has been preserved in presenting evidence gathered in the course of these interviews and meetings.

Field notes

In conducting qualitative research within institutions, researchers witness the operation of the daily routine. Field notes provide the appropriate method of recording events that occur as part of that routine. These were written at the time or in the immediate aftermath of each visit to the prison

Mourne House research: interview schedule

Who we are

What the project is about

Tell us about yourself (been inside before? first time?)

Mourne House ... A typical day?

Routines

Lock-up

Association

Food

Showers/Bath/Privacy

'Dead' time

Arrival and Admission

Reception

Induction

Settling-in

Opportunities

Work

Education

Recreational facilities (TV; Gym; Swimming)

Relationships

Other prisoners

Officers (Men; Women)

Governor

External (Clergy; Social Workers; Teachers; NGOs; BoV)

Family

Visits
Children
Letters
Phone
Privacy

Health Care

Requests/Referrals
Doctor/Nurse visits
Prison Hospital
Self-harm/Suicide

Discipline

Formal rules/Informal rules
Punishments
Drugs

Appendix 2

RESEARCH INFORMATION FOR WOMEN AND STAFF IN MAGHABERRY

Dear friend,

We are writing on behalf of the Northern Ireland Human Rights Commission to seek your help with the above research. The Human Rights Commission has a statutory duty to protect and promote human rights. Research plays an important part in the Commission's work as it helps us to better understand the extent to which human rights are being observed, and to make positive recommendations for improvement.

We will be visiting Maghaberry next week (starting on Monday 1 March) to talk to staff and women in Mourne House and to observe the prison in operation. We are keen for as many staff and women as possible to talk to us so that we can get as full a picture as possible of the unit.

The research will document the human rights standards which govern the care of prisoners especially standards referring specifically to women and girls in prison. We will look at the law and policy relating to the detention of women in Northern Ireland. Central to the research will be the documentation of the views and experiences of those working and living in Mourne House.

The main aim of the research is to make recommendations for improving the system so that women and girls can best achieve the human rights to which they are entitled.

We are aware that the Prison Service has plans to move female detention from Maghaberry to Hydebank. We are keen to talk to staff and women prior to the move taking place and to reflect their views in our report. We hope that the work will be constructive in providing guidance to the Prison Service about human rights standards and will feed positively into the planning process for the move.

We would really value your co-operation and we look forward to meeting you next Monday and will be able to talk to you in more detail than about our proposed work.

Yours sincerely

Linda Moore
Investigations Worker
Human Rights Commission

Phil Scraton
Professor of Criminology
Queens University of Belfast



