

For Immediate Release – 2nd December 2005

DAMNING VERDICT RETURNED INTO WENDY BOOTH'S DEATH IN CONDEMNED DURHAM PRISON

Today the jury returned a highly critical narrative verdict at the inquest into the death of 35 year old Wendy Booth before HM Coroner Mr A. Tweddle sitting at Chester-le-Street Magistrates' Court.

Wendy Booth was found hanging in her cell in 12 November 2003. She had been placed on suicide watch on numerous occasions since arriving at the troubled prison in February 2002. Wendy had been described as withdrawn and very down and had not been eating properly. Despite her clear vulnerability the observations by prison staff on her were reduced on the day of her death. She was the fifth woman to take her own life at the Women's Unit in HMP Durham between August 2002 and November 2003. Prior to August 2002 there had been no recorded deaths there for twelve years.

In their verdict, the jury explicitly criticised the failings of the prison and made comments relating to not only the death of Wendy but also the care of vulnerable prisoners held in prisons across England and Wales:

- The F2052SH (suicide and self-harm form) review panel sitting on the morning of Wendy's death had insufficient information before it to make an informed decision about her care, particularly : access to relevant information contained in medical records; all previous FS2052SH reports for the prisoner concerned; access to all recent relevant written correspondence including details of all recent evaluations, documented or otherwise
- The decision to reduce the levels of observations from intermittent to half hourly had contributed to Wendy's death as: more frequent and irregular inspections would have reduced the opportunity for her to kill herself; an intermittent watch signifies a higher state of concern and would motivate a higher level of care from staff in general; a reduced level of care would give more confidence to the prisoner of success
- The Prison Service did not take adequate steps to prevent her death and the jury held that the following further steps should have been taken:
 - i) a more robust 2052 review procedure should have been in place as standard practice;
 - ii) a reinforced staffing establishment should have been in place to cope with local situations and conditions reported in feedback from prison staff;
 - iii) a method of promptly expediting the recommendations of previous investigations and reports;
 - iv) the provision of an appropriate counselling service easily accessible to prisoners;

- v) a review of the training requirements for all prison staff in connection with the specialist care required for vulnerable/at risk female prisoners;
- vi) actions to make ordinary cells safer;
- vii) actions to ensure the best emergency procedures were available at all times and fully understood by staff;
- viii) communications within the service should have been strengthened;
- ix) an investigation in to the structure and mechanisms of the entire prison review process.

David Booth, Wendy's father commented:

"I am absolutely delighted with the verdict. It highlights the failings that appear to have been present within HMP Durham at the time of my daughter's death."

Deborah Coles, co-director of INQUEST said:

"Once again an inquest jury have highlighted gross failings in the treatment and care of a vulnerable woman prisoner. Sending women to prisons which can't protect a woman's right to life is a damning indictment of the prison system. Once again there was a serious delay from death to inquest which has frustrated the opportunity to learn the lessons and allowed two more women to die before Durham prison was closed and for which the prison service must be held accountable."

Fiona Borrill, solicitor for the family, said:

"It is highly regrettable that two more women have had to die in Durham prison before the women's wing was finally closed in September 2005 despite the earlier recommendations by the chief inspector of prisons."

The family was represented by INQUEST Lawyers group members Nick Stanage from Garden Court North Chambers, instructed by Fiona Borrill of Lester Morrill Solicitors

Notes to Editors

Deaths of women in HMP Durham from 1990 to 2005

Name	Date of Death	Ethnicity	Age	Status	Cause of death
Louise Giles	21/08/2005	UK White	20	Sentenced	Hanging
Sharon Miller	08/05/2004	UK White	45	Sentenced	Hanging
Wendy Booth	12/11/2003	UK White	35	Sentenced	Hanging
Jayne Buck	01/05/2003	UK White	28	Sentenced	Hanging
Sue Stevens	21/02/2003	White	48	Sentenced	Hanging
Beverly Fowler	02/10/2002	Black Caribbean	32	Sentenced	Hanging
Diana Schooling	19/08/2002	UK White	52	Sentenced	Hanging
Linda Tandy	04/06/1990	UK White	35	Sentenced	Hanging

Source: INQUEST Casework and monitoring

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INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the Coroner's Courts.