The Death of Annie Kelly in Mourne House Women's Unit, Maghaberry Prison, Northern Ireland

Annie Kelly was found hanging in a strip cell in the Mourne House punishment block during the afternoon of 7th September 2002. She was hanging by ligatures torn from an anti-suicide blanket from the diamond steel mesh of a window that should have been fully covered by Perspex to render it ligature-free.

The inquest into her death was held before a jury between 10th and 23rd November 2004. The jury's verdict was unprecedented in delivering a damning indictment of the endemic failures of the Northern Ireland Prison Service. It did not consider that Annie Kelly died 'by her own act' but that 'defects in the prison system contributed to the death'. The defects were:

- A major deficiency in communication between Managers, Doctors and the dedicated team
- No set policies and procedures to adhere to (ie relevant training)
- No consistency in her treatment or her regime from one Governor to the next

These defects contributed to her death primarily because of a 'lack of communication and training at all levels'. The jury continued: 'There was no understanding or clear view of any one person's role in the management and understanding of Annie'.

Reasonable precautions that might have avoided Annie's death were:

- Suicide blankets the blanket used was deficient
- Window an anti-ligature window should have been installed
- Observation given her recent behaviour clearer guidelines on observation and monitoring may not have afforded Annie the opportunity of making ligatures
- If Annie had been searched at some stage of the day ligatures would have been discovered
- Cell inspection should have been carried out more frequently and thoroughly especially regarding the window

Further factors that contributed to Annie's death were: her isolation for long periods; lack of appropriate female facilities; lack of a therapeutic alternative outside prison to meet the complex mental health needs of women and girls in prison; lack of availability of resuscitation equipment; lack of first aid equipment on all landings; the need to update legislation regarding people held in custody diagnosed as personality disordered.

Professor Phil Scraton of Queen's University, one of the co-authors of the Human Rights Commission recent report on women in prison, *The Hurt Inside*, member of INQUEST's advisory group and who gave evidence to the inquest stated:

"This carefully considered verdict by an attentive jury is a damning indictment of the regime and conditions in which Annie Kelly was held. A deeply distressed and disturbed uouna woman. she had been in and out of an adult women's iail since she was 15. At the time of her death she was held in isolation in the Mourne House punishment block in a strip cell. Neither the anti-suicide clothing and blankets issued nor the ligature-free cell were fit for purpose and contributed directly to her death. The detailed verdict considers the defects in the prison system to be so substantial that the jury did not consider that Annie died by her own act. At the heart of the verdict is the jury's identification of the lack of a coherent and co-ordinated management response to Annie's well-documented needs. Our research findings were clear that Annie should not have been in prison but in a therapeutic environment, and the jury endorsed this. However, in terms of international human rights standards, the Northern Ireland Prison Service failed institutionally in its duty of care, the conditions subjected her to inhumane and degrading treatment and, ultimately, her safety was compromised. It is clear from this tragic case that the Coroner's recommendations, after the death in Mourne House of Janet Holmes in 1996, had not been taken seriously by the Prison Service.

Written by Professor Phil Scraton, co-author with Dr Linda Moore of *The Hurt Inside: The Imprisonment of Women and Girls in Northern Ireland* Belfast, Northern Ireland Human Rights Commission, published October 2004. Phil Scraton is a member of INQUEST's advisory group.

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