Analysis

Maternity Provision for Incarcerated Women in the UK: Bridging Gaps in Clinical Care

This analytical paper explores the need for improved maternity provision within the UK prison system, shedding light on gaps in clinical care for pregnant incarcerated women.

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KEY MESSAGES

The challenge is:

- Pregnant women in prison face heightened risks of pregnancy complications. There is a need to address identified gaps in the care provided for incarcerated pregnant and postnatal women and their infants to improve health outcomes.
- All pregnancies in prison are now deemed 'high risk,' however gaps in care provision persist due to barriers to healthcare, particularly within the physical setting of prisons where women are confined.
- Whenever possible, we should strive to avoid incarceration for pregnant women and explore all viable community-based alternatives. *However, in exceptional circumstances* where incarceration is unavoidable, we must ensure adequate, high quality maternity care provisions within the prison system.

The way forward requires:

- Prioritising community-based alternatives to imprisonment for women to enhance rehabilitation efforts and address specific healthcare needs, including pregnancy and motherhood within the criminal justice system.
- Specialised support to help mitigate adverse effects of mandatory separation in the critical 1001 days.

Contributors and sources

The authors of this paper collectively bring a diverse range of expertise and experience to the discussion on pregnancy in the UK prison population. Their backgrounds include academic research, practical experience in women's health, advocacy within the third sector, and firsthand lived experiences. This multidisciplinary approach enriches the analysis by incorporating insights from various perspectives, ensuring a comprehensive examination of maternity care provision for incarcerated women. Additionally, their collaboration allows for the integration of academic research, practitioner insights, and real-world experiences, strengthening the paper's relevance and applicability to policy and practice. This multifaceted approach ensures a thorough examination of the issues at hand and underscores the urgency of addressing the gaps in clinical care for this vulnerable population.

Laura Abbott is Associate Professor [Research] at The University of Hertfordshire and a Registered Midwife with over 24 years' experience, specialising in pregnancy and new motherhood in prison. She is the Principal Investigator for the ESRC funded Lost Mothers Project researching experiences of maternal separation from newborn babies in prison. Laura

co-founded the global network - Pregnancy in Prison Partnership International (PiPPI) and the Prison Midwives Action Group (PMAG).

Kirsty Kitchen is Head of Policy at https://www.birthcompanions.org.uk/ – a leading charity focusing on the needs and experiences of pregnant women and mothers of infants affected by contact with the criminal justice system, children's social care, and/ or the immigration system.

Tanya Capper is an Associate Professor, and midwife with over 26 years of global clinical experience, beginning her career in London, UK. She's held leadership roles in tertiary maternity services and a birth center. Since migrating to Australia in 2006, she's excelled in academia, serving as an editor for PLOS ONE and publishing extensively on midwifery and women's health.

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Lucy Baldwin recently retired as an Associate Professor from Durham University, where she remains a Research Fellow. Lucy has over 35 years' experience in criminal and social justice and is also a qualified social worker and probation officer. Her research with mothers in and after prison has informed policy and practice change nationally and internationally.

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Patient involvement

In this paper, we engaged with individuals who have lived experience of being pregnant in prison. Their perspectives, insights, and concerns were integrated into the narrative of the article, shaping the framing of key issues, and highlighting overlooked aspects of maternal care provision in the criminal justice system. Their contributions underscore the importance of

centring the experiences of women with lived experience in discussions surrounding maternity care in prison.

Conflicts of Interest

We have read and understood BMJ policy on declaration of interests and have no interests to declare.

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Introduction

Between 2019 and 2020, two newborn babies died in British prisons (Aisha Cleary[1] and Brooke- Leigh Powell[2]) and one baby died in transit to hospital in the years preceding. The unique challenges faced by women in detained settings were highlighted in the Corston report in 2007,[3] but these deaths drew widespread attention to the significant shortcomings and substandard care for perinatal women in prison[4]. This emphasised the urgency of addressing existing systemic issues to protect the health of pregnant women, new mothers, and babies whilst in criminal justice settings (CJS).

The decision to incarcerate pregnant women is a political one, with 11 countries, including Spain, Mexico, and Italy, prohibiting, or severely limiting it. Research on this issue is sparse, despite evident similarities in the underutilisation of mother-baby placements in prisons across the world. Women constitute about four percent of the overall prison population in England and Wales and tend to receive shorter sentences than men, usually for non-violent crimes.[3]

Pregnant women in prison face heightened risks of complications such as preterm birth, and hypertension, while also grappling with complex social issues like trauma, substance abuse, and mental health conditions such as anxiety and depression.[5]. It is seven times more likely for a pregnant woman in prison to suffer a stillbirth than if she were not incarcerated[6]. Analysis of hospital data found that as recently as 2017/18, 1 in 10 births by women in prison in England took place outside of hospital[7] and over one in five pregnant women in prison miss midwifery appointments[7]. Furthermore, incarcerated perinatal women are at greater risk than the general population of mental health difficulties[8]. This was highlighted by a suicide of a postnatal woman (Michelle Barnes)[9] in 2015, five days after learning she was to be separated from her baby. Investigations into her death found several failings in her care, including:

> 'The *failure to plan for the post-natal period and a chaotic ad hoc response to an already vulnerable, but now additionally traumatised mother'*. [9]

On 18th March 2024, the Sentencing Council, an independent body in England and Wales that sets guidance for judges and magistrates to use when deciding on the type and length of sentence to be given in a criminal court introduced a new mitigating factor for pregnant and postpartum women, stressing the need to consider their health and avoid imprisonment due

to heightened risks[10]. By providing comprehensive support and healthcare services in community settings, pregnant women and new mothers can receive essential care, significantly reducing the risks and adverse outcomes associated with incarceration during pregnancy. However, when incarceration is unavoidable, it is essential that high quality maternity care provided by specialist midwives is consistently ensured *within* the prison system.

Maternity Care Landscape in Prisons- the current situation

Of the 12 female prisons in England – there are none in Wales or the Isle of Wight - six have Mother and Baby Units (MBU) which are separate from the main population. Data regarding the number of pregnant women in prison and the number of births has only been publicly available since 2021. From April 2023 to March 2024, 229 pregnant women were held in prison and 53 gave birth during this time. One of these births happened in the prison or while in transit to hospital. Ninety-three women applied to a prison Mother and Baby Unit (MBU) – 15 more than the previous year. Fifty-four MBU applications were approved, and 14 were refused [4]. The remaining numbers are unaccounted for, as not all MBU applications proceed to an admissions board; women may withdraw due to changes in circumstances, release on bail, or community sentencing, and some decisions may carry over to the following reporting year. Since data has only been collected since 2021, it is unclear whether the current numbers of pregnant women in prison are typical, higher, or lower than usual.

Currently, specialist Registered Midwives provide maternity care in prisons, typically working 30 hours a week but time allocation varies. However, they are not in the prison overnight or at weekends. Pregnancy Mother and Baby Liaison Officers (PMBLOs), who are prison officers employed by the prison service and not healthcare-trained, work traditional shifts—usually two per prison, often on opposite shifts—to provide additional support for pregnant women and new mothers who have given birth in the past year, serving as a conduit to care but not delivering healthcare themselves.

When attending hospital appointments, women are usually accompanied by two prison officers, and if active labour begins in prison, the woman is transferred to hospital accompanied by officers.[11] Despite guidelines advising against the use of handcuffs and restraints during antenatal appointments, evidence suggests inconsistent application of these recommendations, with some women reporting experiences of restraint use, which exacerbates feelings of stigmatisation. [12] After giving birth, women allocated to a MBU return there with their babies, while those without an MBU place go back into the general prison

population. Analysis of hospital data found that women in prison miss a higher proportion of obstetric and midwifery hospital appointments than women in the general population. Appointments are missed for a variety of reasons, but often the lack of staff to escort prisoners to their appointments is responsible[13]. Staffing pressures in prisons are a long-standing issue, with challenges faced when both recruiting and retaining staff[14].

Following the death of Michelle Barnes, recommendations were made that emphasised the necessity for specialised and tailored support for women that are separated from their babies,[15, 16] and was a core element of the revised His Majesty's Prison & Probation Service (HMPPS) and Ministry of Justice Policy Framework. The need for focus on maternal separation was also emphasised in the findings of the jointly commissioned HMPPS and NHS review of health and social care in women's prisons.[17] Although we do advocate for alternatives to imprisonment, this needs to be balanced with the knowledge that exceptional cases will always exist and therefore maternity care in prison must be of high and consistent quality. In the context of maternity care provision, gaps currently persist, evidenced by inconsistencies in the workforce, lack of care at night[16] and barriers to healthcare, particularly in the physical setting of prisons where women are confined.

In the light of recommendations from recent reports, innovations have been actioned, such as in-cell telephony, assigned Pregnancy Mother and Baby Liaison Officers (PMBLOs), and increased maternity cover. However, they do not match the accessibility of NHS services, where there are no gatekeepers or physical barriers to obtaining maternity care and women have direct access to a midwife / obstetrician should they need assistance outside of regular hours. Whilst pregnancy liaison officers are valuable as a support for women, there has been no formal evaluation, and the officers remain as operational staff first and foremost with no additional professional training.

Addressing Gaps in Maternity Care- the way forward

Pending the realisation of alternatives to imprisonment as per our aspirations, we suggest several actionable recommendations for enhancing maternity care within prison settings. These include ensuring protected time for midwives, thereby preventing their duties from becoming an add-on to existing caseloads, establishing obstetricians' clinics within prisons to minimise missed appointments and unnecessary trips to hospitals. Evidence and our collective expertise suggest that we need to explore enhanced multi-disciplinary clinical training for all healthcare providers in prison settings, particularly addressing issues related to barriers to healthcare and emergency care, especially during the night. There is evidence that hospital

staff may lack awareness of how prisons operate, leading to issues such as prescribed medications being unavailable or confiscated upon a patient's return to prison. [18] Midwives and obstetricians are often inadequately trained in the complex needs facing pregnant prisoners and the complex and time-consuming process of arranging a prisoner's re-entry and escorted return to the hospital when in early labour. Therefore, hospital staff should receive bespoke training on the specific needs and procedures for caring for prisoners. The development of a specific maternal separation pathway akin to those emerging in community services, such as the Giving HOPE project[19] is important to address the care needs of women experiencing compulsory separation from their babies. Additionally, examples of perinatal pathways in prisons necessitate a seamless approach, fostering shared practices and coordination through initiatives like the Prison Midwives Action Group (PMAG) and peer mentoring. Lastly, it is critical to consider the significance of specialist perinatal mental health support, advocating for approaches aligned with the principles of the 1001 critical days [20] framework.

Box 1 outlines the Central and Northwest London NHS specialist prison-based Perinatal Mental Health Service, which provides trauma-informed care for perinatal women in prison, including those involved in care proceedings.

Box 1: Mental health provision for perinatal women in prison

The Central and Northwest London NHS (CNWL) specialist prison-based Perinatal Mental Health Service is commissioned to provide care to women across the perinatal period while in prison. This includes mothers who are subject to care proceedings who may or may not go on to have custody of their baby. The service adopts a trauma-informed, mentalisation-based approach to advocate for both mother and baby's emotional needs and share psychological-based formulations of maternal mental health difficulties and risks with the network of professionals working around mother and child.

Policy Implications

In considering the challenges to improving service provision for incarcerated women, several factors merit attention. Firstly, there may be competing priorities within healthcare systems, where resources are stretched, and numerous issues vie for attention. Policy makers and healthcare providers may prioritise more visible or politically expedient issues over the needs of incarcerated women, particularly when faced with pressing concerns within hospitals

serving the general population. We believe that the voices of women with relevant lived experience must be central to learning, improvement and meaningful change to benefit mothers and babies. [21] Birth Companions, a national charity focused on women facing disadvantage during pregnancy and early motherhood, including those in prison, draws on their Lived Experience Team to improve care for others. The complex nature of the criminal justice system and interagency collaboration presents logistical challenges to improving service provision. Coordination between prison authorities, healthcare providers, policymakers, and third-sector organisations are essential, but may be hindered by bureaucratic hurdles, jurisdictional disputes, and differing priorities.

We must ensure that women entering prison receive healthcare equivalent to that available outside, with the system equipped to address their complex health needs [8,17]. While prisons can provide stability for pregnant women often living in chaotic or traumatic circumstances, short sentences may prevent full engagement in essential treatments like detoxification, perpetuating cycles of harm [16]. Significant investment is needed to support women diverted from custody, alongside enhanced training and specialised support for probation staff working with perinatal women. An example of a recent initiative is a 24-space residential scheme in Southampton, designed and developed by the charity One Small Thing [22]. There are also other more established formally evaluated programs such as Trevi House in Plymouth [23] These initiatives are excellent examples of how, with funding, alternatives to imprisonment can exist and be transformative for women and their babies.

By advocating for legislative changes and empowering healthcare professionals to push for better maternity care in the criminal justice system, positive outcomes for women can be achieved. We make a resounding call to action, urging concerted efforts among healthcare providers, policymakers, third-sector organisations, and prison authorities to effect positive changes. The harrowing accounts of baby Aisha Cleary, baby Brooke Powell, and the tragic loss of Michelle Barnes, demonstrate further why it is essential to address these deficiencies and continue to galvanise our collaborative endeavours to advance maternity care provision in prison while also working to avoid the incarceration of perinatal women in all but the most exceptional of circumstances.

Some countries offer a commitment to more comprehensive and compassionate maternity care, focusing on alternatives that prioritise the health and well-being of both mother and child [12]. For example, countries like Brazil, Mexico and Italy emphasise community-based solutions, which could offer valuable lessons for the UK in improving its approach to maternity care within the criminal justice system. The recent changes to the Sentencing Council guidance,

acknowledging pregnancy and the post-birth period as mitigating factors during sentencing,[10] has the potential to reduce incarceration rates for perinatal women, thereby impacting health and prison systems. Aligning policies to accommodate enhanced maternity care within prisons, including extended postnatal support, is crucial. Collaboration between NHS providers and prison healthcare services can foster compassionate care and address the unique needs of pregnant and perinatal women. The challenge lies in finding or creating alternatives that offer the same level of support for their complex needs. It is important not to view prison as a *place of safety* for pregnant women, but alternatives must be developed to offer comparable support for their needs.

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