How can women's healthcare environments do more to aid them in the birthing process, both physically and mentally?

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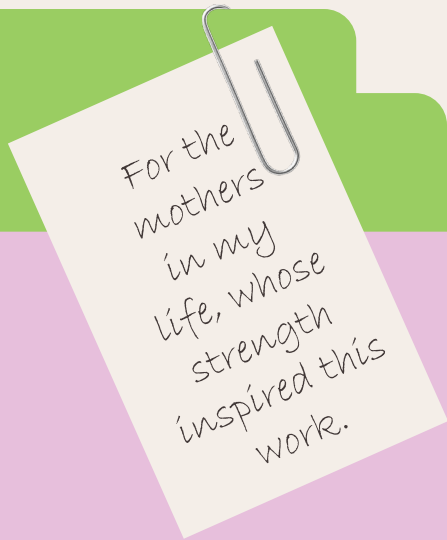

Women's healthcare enviroments

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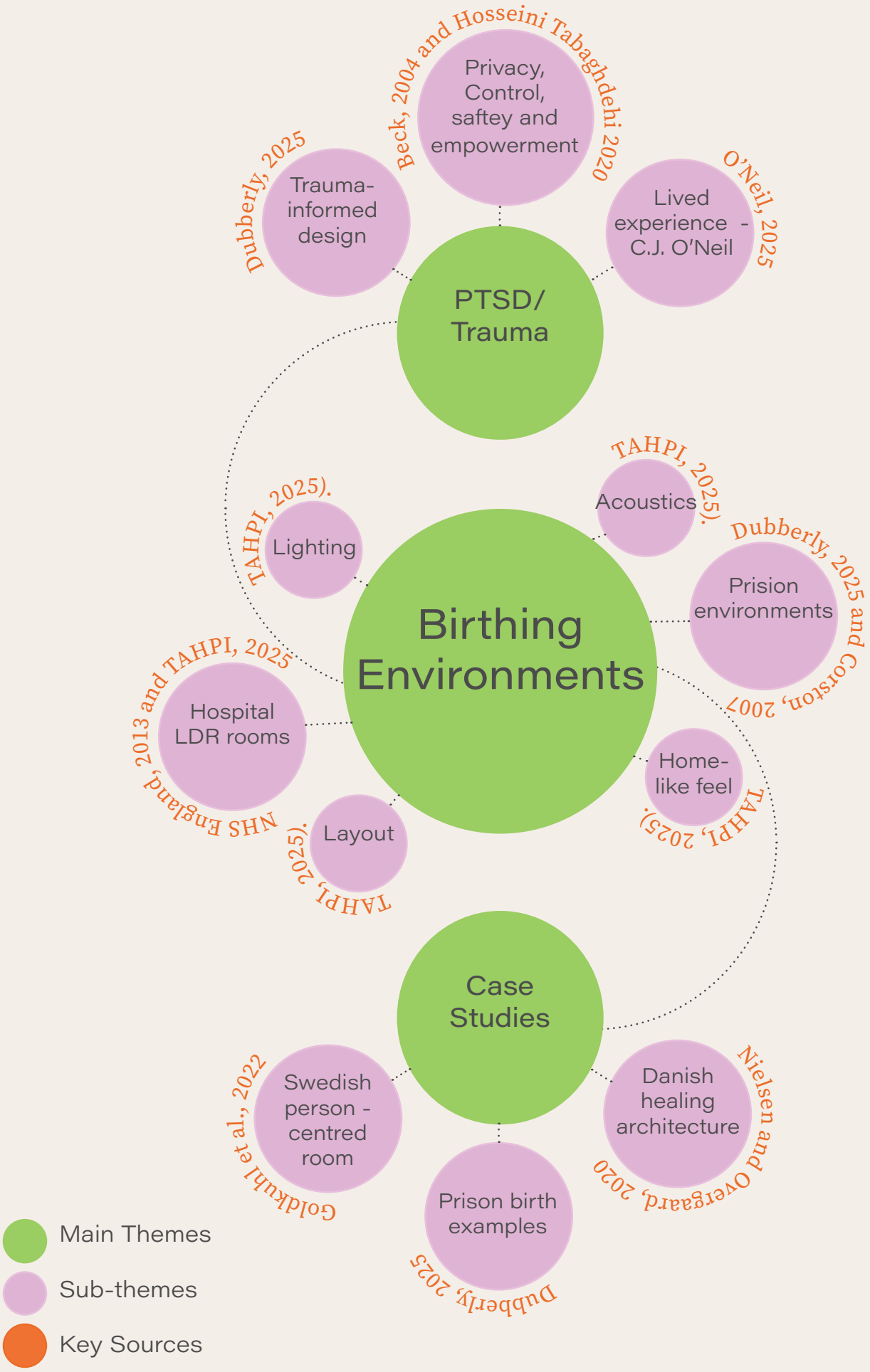
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1: Glossary

In this essay, I will use the following terms as defined in the glossary below. These definitions have been developed through my research to reflect the precise meanings intended for this study.

Women - refers to an individual with the biological capacity for pregnancy and childbirth. This definition focuses on physiological aspects relevant to maternity care, while acknowledging that not all women give birth and not all people who give birth identify as women (World Health Organization, 2024).

Gender Data Gap - Refers to the absence or lack of data representing women's bodies, needs, and experiences. This missing information leads to incomplete evidence used in design, policy, and healthcare decisions, resulting in environments and systems that fail to account for women equally (Criado Perez, 2019).

Gender Data Bias - Refers to the distortion or skewing of data caused by male-centred assumptions. Unlike the data gap (which highlights what's missing), gender data bias describes how existing information is collected, analysed, or interpreted in a biased way, reinforcing unequal outcomes in healthcare and design (Criado Perez, 2019).

LDR room- a single maternity care room where a woman is admitted to labour, give birth, and recover immediately afterwards. After the period of immediate recovery, the mother (and baby) are typically transferred to a separate postnatal ward or unit for ongoing postnatal care. (NHS England, 2013).

Trauma informed - is an approach which recognises the prevalence and impact of trauma, understands how trauma affects individuals, and integrates this understanding into every aspect of service delivery in ways that avoid re traumatisation while promoting safety, trust, choice, collaboration and empowerment. (Fallot and Harris, 2009).

Obstetric units – situated in hospitals where diagnostic and medical treatment services are available on site. Care is provided by midwives and doctors. Obstetric units provide care to low and higher risk women. (NMPA, 2025)

2: Preface

This report examines the ways in which women's healthcare environments fail to support them and identifies design flaws that often go unnoticed within female-focused spaces. My motivation for this project stems from the experiences of my female friends — pain being dismissed, misdiagnoses, a lack of trust in the NHS, and trauma resulting from healthcare encounters.

Engaging with research on gender bias in medical data revealed how deeply embedded these inequalities remain within contemporary healthcare systems. This prompted me to question why spatial design is rarely discussed as a contributing factor to inequality in women's care. While I am not a medical professional, my position as an interior design student allows me to explore how healthcare environments can better support women through spatial strategies relating to ergonomics, lighting, materiality, layout and privacy.

In an ideal scenario, designers and healthcare professionals would collaborate to embed human-centred design principles within maternity environments, creating a more holistic approach to care. By comparing hospital and prison birth settings, this report investigates how interior architecture can either support or undermine women during labour and delivery.

3: Methodology

This report adopts a qualitative research approach, using semi-structured interviews with experts in relevant fields to investigate women's experiences of labour and delivery within hospital maternity units and prison settings. Hospitals are used as the primary areas for improvement, while prisons function as an extreme comparison to reveal the impact of environment on the birth experience.

Dr Sarah Dubberley provides insight into how prison environments affect pregnant women, as well as trauma-informed policy. Dr C. J. O'Neil contributes a mental health perspective through her work with the Maternal Mental Health Team in Manchester, focusing on postnatal PTSD.

Secondary research methods, including analysis of academic literature, audio and visual sources, are used to strengthen these findings, with particular focus on PTSD, healthcare design requirements and gender-based disparities in healthcare.

This study is limited by not being rooted in a medical understanding of the delivery process. The opinion of a medical professional – midwife – would strengthen this argument, however the report is approached from an interior design perspective. The aesthetics changes I will be discussing would need to be implemented in accordance with safety requirements.

4: Introduction

Childbirth is both a medical event and a deeply spatial experience. While some women choose to give birth at home, most plan to give birth in hospitals (Coxon et al., 2017). However, in doing so, they often lose the comfort, agency, and familiarity that a home birth can provide. Therefore, how can we reassess the design of UK hospital birthing rooms, asking how design can better support positive birth experiences while reducing medical complications and emotional distress: ultimately lowering the number of mothers who leave childbirth with trauma or PTSD. Many birthing environments are clinical and cold, designed around efficiency and observation rather than emotional or sensory wellbeing (Davis-Floyd, 2001). Essentially, they are environments designed by men, for men. This lack of empathy in design can heighten stress and anxiety, and poorly considered environments can even affect the progression of labour.

This report focuses primarily on hospital births, using prison births as a comparative study. This acts as an extreme example of how space can influence the mother and child when design neglects emotional and gendered experience. When interviewing Dr C.J. O'Neil - lived experience representative for the Maternal Mental Health team, who support women processing trauma and loss - she explained that:

> "There's two pathways [...] which are loss and trauma. If you've lost a baby, you're in a completely different place than someone who's had a traumatic experience and still has a baby. And if you use design to try and speak to those two different groups of people, it's just not going to happen."
> (O'Neil, 2025, 00:02:48).

It is because of this that the report will focus on women who have experienced trauma and still have the baby, as their trauma isn't accompanied by grief. This allows the research to focus on the design elements that may have contributed to the experience. The aim is to demonstrate the importance of women's healthcare environments that actively support labouring women, helping to make childbirth safer and less trauma-inducing.

5: The Role of Space on the Birthing Process

The physical environment strongly impacts the experiences, health, and wellbeing of women during childbirth. Spaces that reduce anxiety, support physical comfort, and allow positive interaction between the mother and her support system help create a positive experience (Nielsen & Overgaard, 2020). Buckley (2015) found that women are more likely to have physiologically normal births when they perceive an environment as private, safe, and undisturbed. These conditions also reduce the likelihood of medical interventions.

Safe, familiar birth environments encourage oxytocin release, supporting stronger contractions and reducing fear and pain. Stressful or unfamiliar spaces, however, can suppress oxytocin and increase the need for intervention (Uvnäs-Moberg et al., 2019). This is important not only for the immediate health of mother and baby but for the mother's psychological wellbeing after birth. Overwhelming fear, panic, and anxiety during labour, as well as feelings of loss of control and helplessness, are directly linked to the development of post-traumatic stress disorder (Beck, 2004).

These findings demonstrate that the design of the birthing environment affects both the physiological processes of labour and the psychological wellbeing of the mother. When women perceive spaces as safe and controllable, hormonal responses are ideal, and the likelihood of subsequent trauma or medical intervention is greatly reduced. Hosseini Tabaghdehi et al. (2020) further support this, identifying control and empowerment as key themes underpinning positive childbirth experiences. This provides a foundation for considering trauma-informed design.

Trauma-informed design recognises how trauma impacts individuals and uses this knowledge to create spaces that minimise re-traumatisation. Such designs encourage safety, trust, choice, collaboration, and empowerment—all crucial during labour and birth (Fallot & Harris, 2009). According to a UK survey of postpartum women, 45% of women considered their childbirth traumatic, with 15% meeting full or partial criteria for postnatal post-traumatic stress disorder (PTSD). The most common contributing factors were feeling out of control, unsupported, or highly fearful or distressed (Baptie et al., 2020).

6: Prison Births: The Extreme Environment

To support the argument that the environment can have a detrimental effect on successful, non-trauma-inducing pregnancy and labour, I interviewed Dr Sarah Dubberly, who is the Principal Lecturer and Professional Lead in Criminal & Youth Justice at Wrexham University. The intention of this interview was to determine why women who give birth in the prison environment experience, on average, more negative outcomes.

A limitation of comparing prison births to hospital births is that many women in custody experience poor mental health, with self-harm and suicide commonly used as coping strategies (S. Dubberly, 2025). Therefore, we cannot, with real validity, examine the correlation between environment and emotional state. However, the prison setting still allows analysis of how space contributes to negative medical outcomes and trauma, with acknowledgment that women in this setting may be more susceptible to poor outcomes as they are described as "the most vulnerable women within the UK" (Dubberly, 2025).

There is a significant gap between Ministry of Justice policy regarding the care of pregnant women in UK prisons and what is delivered in practice. During the interview, Dr Dubberly said, "whatever you read with regards to Ministry of Justice policies and statutory policies will be different to what's delivered in practice," going as far as to say she would "put her life on it." She explained that there are so few women in prison in comparison to their male counterparts that "that in itself is a disadvantage," as they are overlooked when it comes to resources. This is of relevance because it means that female prisoners are living in a system shaped around male needs. As Dubberly states,

> "criminal justice has always been built and delivered for men, always" (Dubberly, 2025, 00:07:26).

Prisons are fundamentally not designed for women, let alone for childbirth. This systemic failure is evident in examples of women giving birth in shackles, despite government guidelines disallowing it: "babies are dying because of it" (Dubberly, 2025). Labouring women are forced to navigate spaces that ignore their biological and emotional needs, reflecting a wider gender gap in design that is amplified in prisons due to the overwhelming male population (Dubberly, 2025). The Corston Report documents how women find prison spaces stressful, unpredictable, and threatening (Corston, 2007). Spatially, this results in disempowerment at a time when control, privacy, and dignity are crucial, highlighting the urgent need for trauma-informed, rights-based design in women's prisons to support both maternal wellbeing and safe birth outcomes.

These policies are in place for a reason. Research shows that pregnant women in English jails are seven times more likely to suffer stillbirth, highlighting severe health inequalities (Prison Reform Trust, 2025 briefing). Stillbirths increase in areas of social deprivation (SANDS & Tommy's, 2025), emphasising the importance of community and a good support system, which Dr Dubberly drew attention to in her areas of concern. Due to the fact that there are very few Mother and Baby Units in the country, "those that are sentenced are often sent really far from home. You can be sent 200 miles away. If not more, [...] No support system at all." Dr Dubberly's recommendation aligns with that of Baroness Corston, and is in favour of community environments (Corston, J., 2007) and community sentences (Dubberly, 2025), as they allow for rehabilitation, punishment, and maintenance of a family environment. This illustrates how sentencing practices remove women from essential family and social networks at a time of heightened vulnerability. This displacement of pregnant women contributes to poorer birth outcomes and more traumatic experiences, reinforcing cycles of inequality rather than supporting rehabilitation. These findings reinforce the argument for community-based maternity

environments as safer alternatives, leading me to explore spatial models that encourage interaction with support systems and a community feel.

Prison pregnancies and births emphasise the importance of environment on women and babies and help pinpoint areas of concern: lack of control and comfort. This understanding can be applied to the design of other birthing environments to create safer, less traumatic experiences for the mother. When it comes to the design of prison births, there is far greater work to be done, which is deeply rooted in the judicial system, its distribution of funding, and its ability to comply with government policy. However, experts appear aligned in the belief that community environments are the way forward, not only for pregnant women but for all convicted women. Prison design needs to start acknowledging the differences between female and male prisoners for female prisons to be safe.

Only 13% of women in England currently give birth in settings other than obstetric units (Coxon et al., 2017). Therefore, when designing obstetric units, we are designing for the majority of women in the UK, requiring an understanding of, and responsiveness to, the varied needs, values, and personal circumstances of individual patients. For this report, I focus on the LDR model of care – which sees a single maternity care room used for labour, birth, and recovery (immediately after), before the patient is moved to a separate postnatal ward (NHS England, 2013). Regardless of setting, these types of environments must comply with essential safety standards and operational requirements. Within these requirements, what is being done to try to create a positive, non-trauma-inducing birthing experience? According to the International Health Facility Guidelines, the birthing unit should also incorporate design elements such as acoustics, privacy, natural light, and home-like environments to support patient experience (TAHPI, 2025).

What does this look like when designing for optimal birthing environments?

7.1: Enabling Control – Lighting

Firstly, LDR rooms require access to clinically appropriate, colour-correct lighting to allow staff to accurately observe skin colour; however, this lighting does not need to be on at all times. The International Health Facility Guidelines state that lighting should be dimmable and colour adjustable depending on the individual's preference (TAHPI, 2025). This highlights an opportunity for layered lighting strategies that support both medical safety and emotional comfort. Each individual will respond differently to light during labour. For example, Camilla Thurlow recounts that during birth she needed lots of light and open windows, stating,

> "I need light to feel... safe" (Thurlow, 2025, 00:51:17)

For many women, bright lighting has the opposite effect, increasing anxiety and physical discomfort. Jane Hyldgaard Nielsen and Charlotte Overgaard conducted a study into alternative birthing environments and found that warm, dimmed lighting contributed to women feeling comfortable and safe, overall providing a more positive experience (Nielsen and Overgaard, 2020). During labour, the nervous system is already in a heightened state, meaning exposure to intense light can increase sensory sensitivity and even become painful. In this context, light sensitivity functions both as a trigger for anxiety and as a response to it, creating conditions that are counterproductive to a non-traumatic labour and, in some cases, can lead to emergency medical intervention. To combat these contrasting preferences, a bedside lighting system which can be controlled by the individual—depending on their preferences—and only altered when medically necessary would help provide the ideal environment for women to give birth.

LDR rooms are required to have windows for access to natural light; however, the placement of these rooms is often determined by the need for observation and access routes rather than experiential considerations. From a design perspective, this can be personalised by including a dual-layer curtain with a sheer option and a blackout option. This gives women the choice between full light, diffused light, and darkness, creating agency over the environment, which we know to be important due to control being one of the crucial factors for a positive birth experience, as outlined by Hosseini Tabaghdehi (2020). Camilla Thurlow also mentions the difficulty she faced when she gave birth at night (Thurlow, 2025)—meaning no access to natural sunlight—which highlights the potential value of circadian-responsive artificial lighting, which mimics natural light patterns, providing orientation and reducing sensory deprivation. Together, these lighting approaches demonstrate how interior design can actively reduce anxiety, promote emotional regulation, and support physical labour processes rather than simply meeting medical requirements.

7.2: Enabling Control – Acoustics

Noise levels in hospitals are said to have increased over the past 20 years. This is concerning, as excessive noise can be a trigger for PTSD in some patients. Integrating acoustic design strategies into healthcare design using a human-centred approach to care has been shown to improve patient outcomes and support healing. It is also important to note that complete silence can be just as unnerving for some patients (Goldfarb and Macpherson, 2025).

Therefore - similarly to the lighting approach - using a thoughtful acoustics system to filter out excess noise, while providing women with the opportunity to play music or white noise, helps them have complete control over the environment they are in. This may include acoustic ceiling panels, wall absorbers, or cushioned flooring to dampen sound, as well as soft furnishings to reduce echoes. Dr O'Neil recounts listening to music while she was in labour, emphasising the immense difference this made to her experience. Dr O'Neil also describes being left alone in a critical care room after a haemorrhage: the door was closed, her husband had taken the children home, and she could hear other labouring women through the walls. She explains that acoustically, the space felt overwhelming and "hard to take" (O'Neil, 2025).

The functional needs of the unit should take priority over location; however, where possible, consideration should be given to locating louder spaces further away from LDR rooms, as well as minimising road noise, such as cars and sirens. The International Healthww Facility Guidelines also state that delivery sounds must not be audible outside the confines of the space, which was not the case for lived experience representative Dr O'Neil (TAHPI, 2025). The impact acoustic design can have on patient experience should be enough to encourage greater focus on the importance of good acoustic design.

7.3: Establishing Privacy – Space Planning

Privacy in LDR rooms is important because it is a time when women are physically exposed and emotionally vulnerable. Privacy is one of the main factors Buckley identified in 2015 as important for physiologically normal births. Guidance from the International Health Facility states that privacy can be accounted for with design implications such as: not facing the foot of the bed towards the door, providing privacy curtains, and ensuring doors do not include windows or viewing panels, to avoid people in the corridor being able to see in. Some of these features are not standard in hospital care, mainly because the design of hospitals prioritises observation over patient experience (TAHPI, 2025). While observation is important, this can make women feel exposed, intensify feelings of loss of control, and position the woman as a patient rather than an active participant (the other key factor this report focuses on).

Re-thinking the position of the bed in LDR rooms—current research indicates the bed should not be the focal point in the room (TAHPI, 2025)—for example, puts focus on the patient's psychological wellbeing, which also increased the chance of a medically normal birth. This supports trauma-informed birth experiences and acknowledges the importance of dignity and privacy, even in a medical environment where observation is important.

7.4: Creating comfort – Home-like environments/ finishes

In America, the consensus seems to be that hospitals and birth centres are the safest place for women to give birth (ACOG Committee on Obstetric Practice, 2011; American Academy of Paediatrics, 2013). However, this is a highly debated topic. In 2007, the United Kingdom's Royal College of Obstetricians and Gynaecologists and Royal College of Midwives issued a joint statement in support of home births for women with uncomplicated pregnancies. In the UK, the majority of women opt for obstetric units; however, a study which tracked over 16,924 planned home births reported notably lower rates of birth trauma (1.2% vs 2.9%) (Labors of Love Birth Center, 2025). Using this knowledge, what can we learn from home births to make hospital births less trauma-inducing?

It is suggested that women choose home births because their home environment is perceived as comfortable and safer than a hospital, as well as because they want to be in control of their environment and birth-related decisions (Descieux et al., 2017). This aligns with the previous factors discussed, which contribute to lower PTSD/trauma rates. Therefore, introducing more home-like design choices into LDR rooms should, in accordance with the stated research, help to increase positive birth experiences without sacrificing the safety of medical care provided in a hospital. Previously mentioned interventions such as intentonal lighting, acoustic, and privacy choices will contribute to this significantly.

In addition to these, designers might locate medical equipment and services behind accessible but concealed joinery or screens and select interior décor that aims to create a calming, non-threatening environment through the use of colour, textures, surface finishes, fixtures, fittings, furnishings, and artworks (TAHPI, 2025). This is further complicated by the fact that everyone will perceive spaces differently; what one person likes, another may not. However,

"it's about being aware of what makes people [typically] feel safe" (O'Neil, 2025, 00:19:23)

and, where possible, providing opportunities for personalisation, thereby supporting empowerment and control. Another home-like amendment would be to implement alternative seating areas into an LDR room, providing choice and comfort (TAHPI, 2025).

7.5: Eliminating gender bias – Designed for observation, not experience

'The male default' is a term Caroline Criado Perez uses in her book Invisible Women to describe an underlying issue that is still prevalent today: the male body, experience, and perspective are taken as societal norms and averages. This is because the data which forms the foundation for our daily lives is riddled with gender bias; we work on a "male-unless-otherwise-indicated" way of thinking. It would be easy to dismiss this bias as old and outdated; however, modern-day data is flawed, resulting in a world where women's experiences are determined by the male standard.

This bias has tangible consequences. Car safety systems are still calibrated to the average male crash-test dummy, making women 17% more likely to die and 73% more likely to be injured in a collision, equating to over 1,300 preventable deaths annually in the US alone. In healthcare, over 8,000 women in England and Wales died between 2002 and 2013 after not receiving the same standard of care as men, a disparity attributed to a persistent gender data gap in medical research (Criado Perez, 2022). Historically, medicine has been dominated by male clinicians and researchers; therefore, the design of hospitals focused on their needs, creating a technocratic model of birth that prioritises surveillance, efficiency, and intervention over maternal wellbeing (Davis-Floyd, 2001).

Birthing rooms which prioritise observation and efficiency suppress oxytocin release, increasing the likelihood that medical intervention will be necessary (Buckley, 2015). This demonstrates that maternity design is male-focused due to inherited data, professional power, and institutional priorities—reinforcing gender-biased design and embedding inequality into the built environment itself.

8: Case Study - Swedish Birthing Room Designed with Person-Centred Considerations

Fig. 1. Pictures of A) the Regular birthing room and B) the New birthing room.

Figure 1 shows the setting for a Swedish randomised controlled trial conducted by Lisa Goldkuhl et al., where they compared a person-centred birthing room with a standard hospital birthing room. The "new room" included many of the features discussed in this report, such as dimmable lighting, nature projections, adjustable audiovisual stimuli, hidden medical equipment, and adaptable furnishings. From the imagery, the birthing room has a more welcoming and homely feel while still complying with hospital regulations for safety. This trial also embodies the psychology of space planning: by repositioning the bed, the room automatically looks more inviting, encouraging women to sit where they feel most comfortable rather than where the layout dictates. The layout of Room B supports the reframing of the woman as a participant rather than as a patient, which has connotations of weakness (Davis-Floyd, 2001). Women in Room B reported that the environment made them feel safer, more in control, and better able to maintain personal integrity, and they felt the room could be adapted to meet their needs. This study emphasises the value of designing with a human-centred approach and strengthens the argument that thoughtfully designed spaces can positively impact a woman's childbirth experience (Goldkuhl et al., 2022).

8.1: Case Study- Danish Healing Architecture and Snoezelen-Inspired Birthing Rooms

	Alternative delivery room	Danish standard delivery room
Guiding focus of the physical birth environment	Promoting feelings of well-being, freedom, and control. A safe and normal birth with minimal intervention	Medical safety
Visual and auditory stimuli	Snoezelen-inspired audial and visual scenery on three walls providing positive distractions	The woman may bring own sound device
Interior, furniture, and equipment	Nordic contemporary style furniture resembling private home environment	Traditional hospital furniture and equipment, including lounge chair
	Traditional hospital labor bed and necessary equipment covered or placed less visibly	Traditional hospital labor bed as central feature of room
	Bathtub	Bathtub may be available
	Relaxation area with sofa bed, chairs, and coffee table	
Privacy	Single occupancy, private bathroom	Single occupancy, often private bathroom
Light	Overhead light off unless needed for assessment purposes	Overhead light controlled by staff, usually on unless the woman is sleeping
	Dimly lit scenario projections controlled by woman and her partner	
	Dimmed light in relaxation area	

Table. 1. Table showing Key characteristics of alternative and standard delivery rooms

Another example supporting the findings of Lisa Goldkuhl et al. is the work of Nielsen and Overgaard. In 2020, they conducted a qualitative study of women's birth experiences and the patient-centredness of care. Table 1 shows the differences between a standard Danish delivery room and an alternative delivery room. Similarly to the previous study, the research found that the environment supported women's needs by reducing stress and anxiety, enhancing physical comfort, and facilitating positive emotional and social interactions with partners.

The main difference between this study and the Swedish case study is the emphasis on how design affects the mother's ability to interact with the people around her, predominantly the partner/support system and midwife. The women expressed that the atmosphere created by the audio, visual, and spatial aspects of the room created opportunities for small talk and bonding with the midwife, likely due to the calming nature of the space encouraging people to slow down and interact more. Additionally, they valued the opportunities offered by the room to interact with their partner in a way that created equality. One woman stated,

"It makes a world of difference getting out of that bed. Because once you're in it, you are a patient. And I didn't feel like a patient when I walked around with him ... or sat in that cushion area with him. You're in it together" (Nielsen and Overgaard, 2020).

This highlights the importance of alternative seating areas for how a woman perceives her situation. Overall, the findings support the use of healing architecture in birthing environments, showing that thoughtful design can positively influence both psychological wellbeing and whether a birth experience is perceived positively.

9: Conclusion

This report has demonstrated that, even within the constraints of safety and medical necessity, the design of birthing environments can significantly influence women's experiences, both physiologically and psychologically. By prioritising control, privacy, safety, and comfort, and by adopting trauma-informed and human-centred approaches, healthcare design can reduce birth-related stress and trauma while supporting positive outcomes for both mother and baby. The case studies from Sweden and Denmark, along with research on lighting, acoustics, and home-like finishes, highlight practical strategies for achieving these goals. Moreover, by addressing gender bias and designing for female-specific needs, birthing environments can be empowering and equitable for women in spaces historically designed around men. The insights gained from this research will inform my interior design practice, particularly when creating spaces for pregnant, labouring, or postnatal women. Moving forward, these principles can be applied more widely, demonstrating that thoughtful, person-centred design is not only possible within healthcare constraints but essential for safer, more autonomous, and empowering birth experiences.

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Appendix A – Proof of ethics application acceptance

Type	Signatory Email	Signed Date	Validity
Supervisor	J.Wilson@mmu.ac.uk	10/11/2025 11:08	Valid
Second Signatory	L.Gannon@mmu.ac.uk	29/10/2025 11:07	Valid
Applicant	LUCIA.MORRIS@stu.mmu.ac.uk	28/10/2025 14:03	Valid

Appendix B – Verbatim Interview Transcript with Dr Sarah Dubberly

Interviewee: Dr Sarah Dubberly
Interviewer: Lucia Morris
Date: 09/11/2025
Location: At Sarah Dubberly's house

[00:00:00]
LM: Can you just talk about your professional background?
SD: Yeah. So I did—I'll start at the beginning—I did a degree in criminology and criminal justice, undergraduate. And then while I was doing that, I did lots of volunteering, so mental health advocate at the local hospital in the unit there. I also worked at the riding school where we had Women's Aid used to come, and young people from disadvantaged backgrounds in Liverpool. So that's where I really began to get an interest in social disadvantage, social equality, ensuring everybody gets a just start in life.
And then when I finished my degree, I didn't want to go into work yet and felt I had only just begun learning, so I went on and did a master's straightaway. While doing that, I then worked volunteering in the Duke of Edinburgh Award, helping deliver the award with probation and youth justice. And then I got a contract to undertake some research from Youth Lend Reward on how it was working with young offenders.
When I finished my master's and I finished that research contract, I then got a job in Cheshire, and we moved to Chester with the youth offending team. So I was the volunteer coordinator for the whole of Cheshire for the youth offending team. I only did that for a couple of years because it was like a part-time contract—because the Youth Justice Board had just been introduced—and then a job came up at Wrexham University delivering Youth Justice Board qualifications to all youth offending teams across the whole of Wales. And I got that contract for two years. And then it was going so well, we ended up with the contract delivering it through the southwest of England as well. So basically, it was nearly three years because my contract was extended, travelling around Wales to all the youth offending teams and the southwest of England, delivering these bespoke Youth Justice Board qualifications.
When that contract ended, I was made permanent, so I started a PhD. Okay. And then I worked at the university on the undergraduate teaching—undergraduate degree criminology. No, it was a criminal justice degree back then, working with offenders, and my PhD was looking at—started off looking at girls within the prison system. But we soon realised that there was successfully a move within Wales to divert girls from the prison system. Right, because, and especially Welsh girls, because they didn't have the facilities. So I changed my PhD because I wouldn't have had
the numbers in order to interview. So I changed my PhD and looked at how the Duke of Edinburgh Award—because we'd won a big contract from the Youth Justice Board—how the Duke of Edinburgh was working within the secure state, within prisons.
So I spent six months in prisons, going around six different establishments from local authority secured children's homes to Category A prisons, interviewing individuals who were sentenced—murder, manslaughter, sex offenders—and secure training centres, which is for younger children. So within the youth justice system, those are the three establishments. So I interviewed the young people—they're still young people, because within between the ages of 14 and 24—before they engaged with the Duke of Edinburgh Award on their perceptions of it. And then after they'd completed the Bronze Award and the impact they felt it had on their lives. So I was, yeah, within those secure establishments for that six-month period around the country.
And then not long after that, I became the programme leader for criminology at Wrexham University and improved us and got us up through the ranks. And we are currently second in the UK for student satisfaction—

first in the UK for student satisfaction, second in the UK for teaching quality. And then about six years ago, I got the manager role, principal lead for the criminal justice department. So policing, criminology, and law.
So in terms of females, I then—I was asked to become a trustee for the North Wales Women's Centre, maybe about four years ago now—three or four years ago. And so you also do that on a voluntary basis as well.
[00:05:35]
LM: So what does that involve?
SD: Basically, ensuring strategic inputs, outputs of North Wales Women's Centre. So ensuring that their direction is enhancing facilities for the most vulnerable women across North Wales. The Women's Centre has a place in Rhyl and they have a place in Bangor. Rhyl is the main one, Bangor's the second site, so females who have either offended for different reasons, females who are victims of abuse—that's some of the main work, really. Vulnerable women—a safe place for them to go. So the centre does all sorts in terms of offering skills, some basic skills, financial support, helping females get back into employment, helping females escape abuse, support them through that, support with probations as well. They work very closely with probation. They have a probation officer actually who is based in the centre a few days a week. Rhyl is extremely disadvantaged as a town, and then with that comes obviously a lot of difficulties and inequalities. So it's about supporting the females.
[00:07:14]
LM: Okay. What do you think are the sort of biggest issues that women are facing in the criminal justice systems in prison?
SD: Good question. Oh, there's so many. So, I think the criminal justice system has always been built and delivered for men, always. If you go back historically, females and children used to be imprisoned with men. And I'm talking back in the 18th, 19th century. And then it began to be recognised by some penal reformers—and there are really interesting people to look at, you should look at them—Elizabeth Fry, she was a penal reformer at the time, saying that when females were being sentenced, they were then being used inappropriately, becoming prostitutes within the prison environment, and that's when there was a need, back in—God, we are literally talking 19th century—for them to become a separate system. Now, with that, you would imagine a separate criminal justice system would mean an introduction of different facilities, an introduction of different offending behaviour programmes, but no. Over the years, there have been so many cases where the needs of females have been overlooked, really, because the system is built for males, and that still happens. It is a lot better than it's ever been, but it still happens. So, you need to look at reports around the Corston reports, okay, and then there's like the Corston review 10 years on. And basically, that looks at the at the facilities of female prisons. Female prisoners, when they are sentenced, are always sentenced for less serious offences than their male counterparts. And the impact of that is absolutely dramatic. So you'll have females who are sentenced for financial crimes, and that may be not paying the council tax bill, that may be diverting electricity from a neighbour because they don't have the financial—single parent, who don't work, don't have financial support from their ex-partners or fathers with their children. And males do not get sentenced to custody for the same offences, but females are sentenced more harshly for those offences. It's classed as doubly deviant. And that's what it's seen as—that females are often sentenced more harshly because they are being sentenced for standing out of their gendered expected roles within society. And the judiciary, whether it's a magistrate or a judge, will overly, harshly sentence a female, because they can't imagine their daughters or grandchildren or wives behaving in such a manner and will therefore then sentence more harshly. The contradiction of that is the chivalry thesis, which, the idea with that is that some sentences will see the females in front of them as their wives, daughters, grandchildren, and won't sentence as harshly. However, as a criminal justice system in England and Wales, our sentences tend to be more doubly deviant. Over the years, the female prison—so I've been around Styal, which is our closest female prison just outside Manchester. I got to watch a parole board within that prison, because I knew the judge who was chairing the parole board, so he asked if I wanted to go along. That was when I first started my original PhD idea, and that was quite an eye opener in the sense that it was—I was going to say, I don't use the word nice, but it feels wrong—nice to see that there was an attempt to make the prison less daunting and more family-friendly. However, there's a serious long way to go because the prison system isn't built for the complex needs which females bring to the prison environment. Their needs are far different from their male counterparts. So females within a prison environment will often struggle with eating disorders, mental health, self-harm, and suicide, because they're known as coping strategies within that prison environment. Now, male counterparts don't have those same level of coping strategies. What you'll see with the male counterparts is often, their coping will come out—they'll throw themselves into the gym, or increase violence, or they'll get stuck into employment within the prison because everybody can be employed within the prison environment—because obviously it's a community, so you still need cleaners and chefs and cooks and things. Whereas females, it really impacts their health and wellbeing. And that's why the prison environment is still not built for females.
LM: So you'd say the actual design of the prisons is still catered towards men.
SD: Yes, yeah. It is better than it used to be, but the actual design needs to be more holistic. It needs to be more

LM: So you'd say the actual design of the prisons is still catered towards men.
SD: Yes, yeah. It is better than it used to be, but the actual design needs to be more holistic. It needs to be more trauma-informed. And that's not to say that the overall aim of rehabilitation and punishment should be overlooked, but rehabilitation should be at the forefront of imprisonment, whereas, quite frankly, punishment is still at the forefront. It should be a mix between all areas of the theories of punishment.
[00:14:01]
LM: Okay. Interesting. One of the main areas that I was going to look into was sort of the gender bias in the data that is still being used to design the world, and I was wondering if you thought that about the actual design of prisons, because if you're saying that they're also getting sentenced for like less violent crimes, do you think the design of the prison could get away with being a little bit less—
SD: Punitive?
[00:14:40]
LM: Yeah, like, do you think if the women are having less violent crimes, that should be reflected in the design of the prison compared to male prisons?
SD: Yeah, 100%. So, in reading the Corston reports, you'll see within there that she is proposing and recommending that there is no need for female prisons. What you should have are more open prisons and community prisons, so that females aren't taken away from their families, because what you have often is, the females who are sentenced are often single parents, and then children end up in the care system, and therefore, when that happens, you've got a repetitive circle with the cycle of crime. Because once children lose their main parental support, they are more likely to follow in parents' footsteps. So they'll often lose their houses. So again, the impact it has on children, the impact it has on housing, and then employment. So when females then come out of the prison environment, they've lost their children, but they've also lost their house, so they can't get their children back because they don't have accommodation, and they can't have accommodation because they haven't got employment, and they can't have employment because they haven't got stable accommodation. And without employment and stable accommodation, they can't have their children back. And then you wonder why we have such high reoffending rates within this country. Our reoffending rates are the highest in Western Europe.
[00:16:19]
LM: Oh, wow.
SD: And these are the reasons why.
LM: Yeah—sort of built to fail.
SD: Yeah. Whereas Baroness Corston was arguing and argued that if we were to build community environments for females where they could carry out their rehabilitation, their punishments, to deter them from any future crimes, then we would be able to maintain that family environment and stability moving forward.
[00:16:50]
LM: See, what do you think about the mother and baby units then, do you think they're good?
SD: So, did you see the—did you watch the clip I sent?
LM: Yeah, it was really interesting.
SD: There's lots of clips like that. So the government's stance is that females within— I mean, female and baby units have improved over the years. That's the government stance. However, and they now, you know, they are not to be—within legislation and statutory requirements, is that females are not to give birth within shackles. However, it's still happening. And babies are dying because of it. And females aren't being listened to when they're saying I'm going into labour, or I've got twinges. Prison officers are still using their authority and power to say you don't look like you're in labour, you're not in labour, and you're not going to the hospital, and then babies have died.
[00:17:57]
LM: I found it in that clip and the woman was saying about how she was given medical advice and then because the guards didn't want to move, she wasn't allowed to go for a walk that she needed. I couldn't believe it.
SD: I know, and there were so many. You just need to Google a few things like that to get for you to be able to picture what they go through. It's barbaric—to think in the 21st century, females are still being treated like that. It's absolutely barbaric. You should look at the work of the Howard League for Penal Reform. Okay. They've done a lot around women and babies. They've done a considerable amount around women and babies and it is absolutely diabolical, their research. Their research is good, their findings are diabolical, sorry. There are now very few women and babies units because there are less women in the prison environment. I think they're currently at—I think it's 4%. It changes, obviously, week on week. I think it's currently, it's about 4%. So it'd be interesting—I don't know the current figures—to look at, at that 4%, how many are in with babies or how many are pregnant? That would be interesting. I don't look at current figures. So there's a few things—because there are so few women in prison these days in comparison to the male counterparts—that in itself is a disadvantage because there isn't the resources, they're overlooked because there isn't the resources, because they are a small minority of the prison population. So the resources go to the male counterparts. However, those women that are in prison are the most vulnerable women within the UK and therefore, you should argue and could argue that those females deserve better because they are more vulnerable—from mental health, suicidal tendencies, their background, what's led them there, are far more disadvantaged than their male counterparts. Now, to bring babies into that and pregnancy, the government guideline is that it is the—what's the—I can't think of the actual wording, but there is the wording there. There's a sentence. My brain is not

in work mode. How does it word? I used to know it off by heart. It's like the last available option. It's something like this, where females who are pregnant will be kept within the prison environment. Right. And that at all options, they should be released prior to giving birth. However, when you do some research, you soon realise that that's not the case, that you've still got nonviolent offenders within the prison environment giving birth. But the government guidelines are that only the most dangerous and serious offenders will remain in prison throughout that birth package.
[00:21:15]
LM: They're supposed to go to hospital?
SD: Yeah. Or be released into the community and be under the realms of probation rather than the prison system. They should be back in the community.
[00:21:27]
LM: There are some countries that will avoid sentencing women that are pregnant, right?
SD: Yep.
LM: Do you think that should be the case?
SD: Yes, yes, because we have a good enough probation system that a female should still be punished and can still be punished within probation, within a community sentence, because they can have high levels of supervision—and that's more successful—but it's supervision within the community, which can look at the offending behaviour, which can look at reoffending programmes, can look at the needs of the female, whereas those needs are often overlooked within that prison environment. They don't get the offending behaviour programmes as you do in the community. Offending behaviour programmes in custody are often not run, aren't often as run as successfully as they are in the community. All the research shows you that rehabilitation is more likely to occur, and desistance—which is to stop offending, to desist, to stop—desistance is more likely to occur if a female or a male is under a community sentence. All the research points in that direction. Which is why now we are also seeing a move away from sentencing children and young people, because we had such high reoffending rates through the 90s and early 2000s for children and young people, but there is now a diversion away from sentencing them, becoming more trauma-informed. So the criminal justice system is improving, but it's improving for children first, quite rightly, but it also needs to be improving for females too. So within mother and baby units, as I said, there aren't as many mother and baby units as there used to be, which is good because we're seeing less pregnant females sentenced. However, what that means then is those that are sentenced are often sent really far from home. You can be sent sort of 200 miles away, if not more, because there are so few women and babies units now. So, on a plus, that's really good, but on a negative then, you're further away from family.
LM: No support system.
SD: No support system at all. No communication, and all the research, again, shows that for rehabilitation to successfully take place, an offender should be sentenced within their local community because it means more in terms of reformation and reform in moving forward rather than an environment which means nothing to them and has that no meaning of self. Babies who are—there are different levels then of when babies are born in the prison system. And depending on the level of offence, at the moment they are saying that babies could only be kept with their parents—I think it's nine months. They used to stay until they were 18 months—again, you'll need to look at that, I can't think off the top of my head. But the evidence that was coming from research was that when babies had been staying with their parents up until 12 months or 18 months, they were coming out—they were claustrophobic, hadn't been out in the real world. And the long-term impact of that was absolutely dramatic on that child in terms of their social skills, language skills, agoraphobia, and that they were very disadvantaged in terms of their levels of—you know, when children, you get ill—12 months, you have some sort of assessment—they were always behind, in terms of their learning. So there was a move by the government for mothers to be able to allow their babies until they were nine months. Do you know, at the moment, I'm questioning what it is, I think it's still at nine months unless they were seeming to look at that in case they've changed it again recently, because they do tend to change it. So, absolutely fabulous that babies can stay with the females, and I do agree with that and I think that's what should happen. Some females will give birth and their babies will be taken straight away. So I think you need to look at that as well.
[00:26:03]
LM: Getting a place in these units is quite difficult, right?
SD: Really difficult because there's now hardly any of them. Again, which—you go back to Baroness Corston's report, which is her argument for why this should be community-based establishments. There's a few things. So you'll have females who give birth and they'll have their babies taken away from them by social services because they'll say it's for the protection of the child if that female's classed as violent. But then it's about looking at those individual—don't just take that for granted, because what is that violence? Has it been that they've killed a husband? Well, that husband could have been abusing them for 15 years. And it was their death next, or their husband's. So domestic abuse cases are really high within the prison environment—females who maybe have attempted murder or murdered their male partners, but that's down to abuse and long-term abuse, or whether they're still being abused and they're pregnant. And therefore the abuse hasn't—they've never retaliated with their abuse because it's always been towards them, but then they obviously become protective of their unborn child and fight back then when they're being abused while they're pregnant. That's really interesting. But then you've had cases where babies have been taken from that female because they're being classed as violent and dangerous. There were so many examples. It's quite unbelievable, really. So I think for you, in terms of designing an appropriate establishment, anything you design has to be trauma informed.
[00:27:55]

LM: Yeah. And what does that actually mean?
SD: Yeah, so there is a move within youth justice and slowly, and I say that very slowly, youth justice is far ahead of the game about being trauma-informed—that you must always have an understanding of what an individual has been through, because no one will ever know anybody's life. We are all equal. And because of that level of equality, we must not forget the disadvantaged lives that individuals have had. So your understanding of family life will be far different from anybody if you were to go into a prison environment and interview them about prison life. It's about everybody having an understanding of trauma and what that means, whether that's been from domestic abuse, violence—it might not be violence, it might be controlling coercive behaviour. Females who have lack of education, basic skills, females who have been financially controlled—that's a really big one and still is. Females who are not given any authority, are just slaves within their homes. And in becoming true—that's just an example from a female perspective—but in becoming trauma-informed, it's about recognising the backgrounds of individuals and understanding that in order to be able to work forward and considering rehabilitation, you have to be able to understand their backgrounds and you have to be able to not just understand, but be able to show common decency that not everybody is the same. Equality doesn't exist, even though we want it to exist and we hope that it does. A lot of the criminal justice system are the most vulnerable individuals you'll ever meet and that's where everybody deserves a fair chance. So it's about recognising and having an understanding that when you come to a prison environment, it isn't about punishment and deterrence. Actually, it's about ensuring that that individual can now write their name, knows how to pay a bill. What can you do to help them gain employment? Can they become self-sufficient? You know, what can you do to ensure that the years of abuse—and some females who have been abused from a young age, children, then end up, are more likely to then end up in abusive relationships as adults—so years of abuse, who could never have trusted anybody and will never trust and find trust very difficult because they've never had anybody to trust them, have always been victims, empowering them. So any establishment you build needs to be built around empowerment as well, empowerment to have self-confidence, to believe in themselves.
[00:31:10]
LM: And the skill sets to help themselves and go out of the situations they're in?
SD: Yeah, and those skill sets, you have to start at a basic level. Do you know how to pay bills? You know, do you even have a bank account? Because if they've been in coercive controlling relationships, they won't have the bank accounts, will have never opened a bank account, would not know how to pay bills. You know, females, sadly, within this day and age, are still basically used as slaves—and I'm talking a very minor, a few minority—those are the more disadvantaged women who end up in that prison environment. And often, you know, some females may be part of an organised crime group—OCG, organised crime group—but what are the reasons? They might be being used as prostitutes because, in doing so, they're given a roof over their heads. They've been blackmailed—drugs, drug use, prostitution, you know, strip clubs, houses, you know, it is so rife. It's disgusting that it's still so rife within this day and age. And it's having that understanding within the context. So, you know, if you think of a prison environment then, I would be wanting for females and mothers and babies, towards—you'd be wanting light, bright, colour, larger rooms, because that's—a lot of babies when they come out of prison environment are agoraphobic, they're only used to small spaces. There's been lots of research—the Howard League for Penal Reform have done around—can I remember the name of the case. There was a baby who'd come out, there was a toddler then was taken away from the mother. They'd only ever been with the mother in the prison environment—got to the age range where they can't stay in prison any longer, put into foster care, the foster carers kept losing the child, who kept putting himself in the cupboard and shutting the door, where they felt safe, because it never been used to being able to wander outside. So it's things like—you'd want gardens. HMP Birmingham are really good; they actually—at the prison this week—and they now do a lot; they have animals coming in the prison, they have birds of prey corner, they're doing gardens around the prison. So the prison environment is slowly learning.
[00:33:58]
LM: I read something that the children who are in the prisons with the mums get taken out on like walks in like the local neighbourhood. Does that happen?
SD: It should happen. I've heard of it happening too, and that's all because of the research, which I've spoken about, where it was found that there's been such length of trauma to which children, young people are.
LM: So, more of the recent things?
SD: Yes, yeah, definitely. Okay, yeah, there's been—it's called ROTL, Release on Temporary Licence. R-O-T-L. And I must find out what's happening with—so ROTL has always been used quite—I don't want to use the word "easily," because every individual has to go through a huge risk assessment process with ROTL. Also, I did a lot with ROTL when I was doing my PhD because some young people would get ROTL to go and do the expedition and then others wouldn't. So, and for adults as well, ROTL is used, and it should be used, because then they could maybe go into the local community, do some volunteering, etc., in preparation for release. But because of the number of prisoners who'd been wrongly released over the last few weeks and months, somebody told me that they've stopped all ROTL at the moment. But I don't know what's happening—it's obviously changing such things because there have been so many errors made recently. The system's on its knees. The system's on its knees. I mean, for the

system's on its knees. The system's on its knees. I mean, for the Prime Minister to say that himself—and bearing in mind, he's got a criminal justice background—for him to say the system is upbreaking is quite something, as Prime Minister, to say that, but it is—he's right.
[00:36:03]
LM: So even the fact that there's so little females in the prison system, that itself is now a disadvantage as well.
SD: Yeah, 100%.
LM: So what would you say if a woman is pregnant in prison—what's the actual process of that being like, so do they, you know, for example, extra meals or is there any sort of extra rights, that they then gain through being pregnant in prison?
SD: They are meant to have. I don't know about the extra meals. That's a really good question. And I actually don't know, but you'd be able to Google that and find that out. What you need to realise is, whatever you will read with regards to Ministry of Justice policies and statutory policies will be different to what's delivered in practice. So you can quote—and what you need to do is be quoting such things, that legislation states, "I'm going to make this up now, a pregnant female should be allowed to have more snacks within a prison environment," whatever, because you'd need it. The reality will be quite the opposite. I don't know that. I've not done any research in that area. I'd put my life on it.
[00:37:29]
LM: I've got a question as well because I saw something saying, people who are pregnant in prison are having less successful births, more stillbirths for example. So that's, I think, something I want to look into more is that, sort of why—what is different?
SD: That's why I sent you that clip, because within that clip, you know, you had a female being told—saying, "I need to go to hospital," and being told no—and then—stillbirths—crazy.
[00:38:03]
Break in interview due to SD not wanting this comment on record.
[00:40:50]
Break ends
LM: I think my essay needed this to sort of—that comparison, because I think one thing I'm going to try and look at is that sort of comparison. If you give birth in hospital, in prison, what effects is that environment having so that I can emphasise, like, the importance of the environment? Because when I've been looking into hospitals and stuff, like, there's so much research saying that, like, being able to personalise the environment and pick things—that's really beneficial, like medically, as well as, like, just psychologically, for the mums as well. So then I was thinking about, you know, you said in extreme sort of situations where people actually will give birth in prison. So are they giving birth—is there like a special room, like a labour and delivery room, or is it just sort of in the...
SD: They should be going to hospital. Yeah. Yeah. I think what I'd be looking at is, of those deaths, are they the—have those females had to give birth within the prison hospital? So lots of prisons have their own hospital wing, as you would expect, because it is a community. So have those births increased if they're giving birth in prisons? Whereas they should be going to a mother and baby unit, as we would have here in our local hospital. So those are the figures I'd be wanting to look at. Yeah. And are we having more survivals and more alive births if you've gone to your local community hospital rather than in the prison hospital?
[00:42:35]
LM: It still puts into question whether, like, going to hospital just for the birth is enough.
SD: Exactly.
LM: Because I think by that point, if you've done your whole pregnancy pretty much in prison, you're already going to be a disadvantaged medically and psychologically.
SD: And you—they won't have had the same level of support in preparation for that birth.
[00:42:57]
LM: Do you think there's enough, sort of, like, information support? You know, we're talking about giving people skills and things that they need. You know, if you were to be pregnant on the outside, you might go to classes or you might talk to a midwife or something. Do you think they'd get enough of that? No?
SD: No. No, not at all.
LM: So that's definitely something that you need more.
SD: And I would—you know, they do do parenting classes. I mean, there are parenting classes held at HMP Birmingham for men, they'll do parenting about what it's like to have a baby after, but I bet there's not enough through, you know, post-giving birth, prenatal classes. No.
LM: Do you think there's enough, like, emotional support after giving birth? I just think generally, and even for women who aren't in prison, there isn't enough. No. But I can then imagine if you—even if you got into the mother baby unit, you've had nine months, or however long it ends up being, and then your baby's taken away from you. That must be, like, psychologically really...
SD: Unbelievable. And people can have really difficult births. Yeah. I had a really difficult birth with Gabriella, and I was offered counselling and a lot of support after. I didn't take it. I was like, I don't need it, it'll be fine. On reflection, maybe I should have done, because when I went, when I was pregnant with Harriet then—it sounds extremely PTSD—but they decided that I wasn't capable mentally to give birth again to Harriet, which is why I had a C-section. And that was me being fully supported, with parents, family around, the NHS. So individuals within a prison environment will not, categorically, have that level of support at all.
LM: Because I was hoping to look into a little bit about the sort of percentage of women who do get PTSD following giving birth. I can imagine it'd be quite interesting to look into the sort percentage of women in

prison who would develop some sort of trauma from...
SD: Within the criminal justice system or within society as a whole, we're in a mental health crisis, and the prison system has been in a mental health crisis for a long time. The female prison system has been in a mental health crisis for years. This is not new, because you've got the most vulnerable females within that prison environment, and it's still not being addressed. You will have a couple of caseworkers within a prison and then that will be it. Counselling from a mental health perspective should be embedded in their daily lives within a prison environment, because unless those key emotional wellbeing skills are addressed before release from custody, then we end up back in that vicious circle again.
[00:45:55]
LM: It was a while ago, but I did watch something and I thought it might have been Styal where there was quite a young girl who was in there and she'd ended up dying because of her mental health in the prison, but it was all the guys talking about how, you know, it was really difficult because it was sort of becoming their job to look after them and that's not really what they're trained to do, is it? So therefore, how are they going to be given the right sort of stuff?
SD: There's such a huge staff turnover with prison officers now as well, which is why they're in a staffing crisis, because some people think the job is going to be something and it is not—it is so much more. It isn't about just being prison officers; you're also rehabilitation workers, you are counsellors, you are mental health workers, you're everything.
LM: How does someone get into becoming a prison officer? What's the—do you have to—do you start in the police or—sorry, I really have no idea how you—
SD: So, it's an interesting one. Really, it's just out of application. So a number of our students have gone on to become prison officers, but you don't need a degree to become a prison officer.
LM: Do you think you should need one?
[00:47:11]
Break in interview due to SD not wanting her comment on record.
[00:49:38]
Break ends
LM: Yeah. Let's see. Oh, yeah. Have you seen anything, even not in the UK or anywhere, that you think is—you mentioned briefly about the prison and mother baby unit, but that is having some really good practices and things.
SD: Yeah, you need to look at the, like, Swedish, Norwegian.
LM: They're meant to be good for—aren't they?
SD: So, yeah, you need to look at the Swedish and Norwegian systems and, as a comparison there, perspective—100%. We—oh gosh, pre-lockdown, I'm going to say, like, 2017-18. We set up—a pre-Brexit—we set up a relationship with Örebro University in Sweden, and I went over to build a relationship there. Fabulous, it was. And we used to get two students a year from Örebro University. And when the students came to us, and then the prison had just been opened, we'd get to take prison students around the prison, we get prison visits. Do you know I might be able to get you in in a couple of weeks, if you want to come with me? It'd be amazing. Anyway, I'll come back to that. Yeah. And they could not believe that the biggest prison in Western Europe was being built in Wrexham, because within Sweden, you have to literally commit murder in order to go to prison, and that is it. It's the most serious offences, offenders.
LM: And the alternative would be more like a rehabilitative—?
SD: Yeah, completely. Their whole system is really interesting. Yeah. So look at Sweden and Norway.
LM: Not that it's very academic, but have you seen the Netflix documentary of World's Toughest Prisons, or—?
SD: Yeah.
LM: It's quite good. Yeah, I think I could probably learn quite a lot from the design of the prisons not based in the UK. As well as, I think we've answered most of my questions. The ones giving birth in hospital, does she get your back to hospital for sort of checkups and stuff in the following period? Or would that be handled in hospital—the prison?
SD: No, she's meant—meant to go back to hospital. Right. So, but it will depend on every single individual case. Okay. But that would be interesting in terms of, because there are females who have died giving birth in prisons. Yeah. So that would be interesting to see, are those the ones—and again, it'd be really difficult to find that level of information. But you'd most probably have to go into coroner's reports to get that level of detail.
[00:53:10]
LM: Okay, and finally, if you could sort of change one key area in women's experiences—I mean, probably more focused on their pregnancy experiences and the mother and baby units—what do you think would be the main thing?
SD: I'd have them in the community. More in the community, yeah, yeah. 100%.
LM: So as in, like, never went into prison in the first place?
SD: Yeah, I'd go back to Baroness Corston's reports and I'd be implementing her recommendations for community establishments.
Interview ends: [00:53:45]

Appendix C – Verbatim Interview Transcript with Dr CJ O'Neil

Interviewee: CJ O'Neil
Interviewer: Lucia Morris
Date of interview: 12/11/2025
Location of interview: MMU Lowry Building Cafe

[Begin transcript: 00.00.00]
LM: Can you just tell me a bit about your professional background and the work you do with women?
CJ: In terms of artist kind of work.
LM: Yeah.
CJ: So I, well, I've been a lived experience rep with the maternal mental health in Manchester for, wait, three years. And that started because I have a traumatic birth experience after my son was born, and when I went, it didn't, it wasn't treated at the time. There was nothing offered at the time. It was only from something else happening that I was having treatment for that it came up as a primary trauma and I think it's so much more, like you said in your information so far, more common than people are aware. And there are different systems in place now. But what happened in that process of recovery was I had to be stuck in the room that I'd been in during my trauma, and my therapist said, you need to go and take yourself and walk through all these doorways. And so within my work, I've been kind of making work about those doors, and the doors from the hospital and a concession, which is of those, and, like, layering them on top of each other because, you know, different things that happen, like your memories get shattered and sometimes they layer up in funny ways, and you might remember exactly the same thing that happened in a completely different way than I do. And then, you're remembering it, that sort of goes out of order. And so the rooms that I was in sort of felt very dark, and I went back into the space, I went through all the doorways physically and met one of the midwives, and I went in through and was like, "Well, this is quite different from what I remembered," and what I could remember where the door was, because we had seen the light coming through and there were things like that really particular. Anyway, I made some work about that, worked out these two, like to do something positive, that would contribute to somebody else not necessarily having an experience of not having support. So I reached out to a friend, who was a midwife, and she put me in touch with someone and they said, oh, there's this lived experience role if you're interested on the NHS Manchester, they're doing therapeutic support for women who've had traumatic birth experiences, and so I would go to like a monthly meeting, but try and help you see it from a kind of lived experience perspective. And that ended up being like helping them design, like, promotional literature and stuff, and they wanted to design a poster that would speak to different types of women and I was like, those experiences are completely different and if you're going through, sort of, there's two pathways they talk about, which is loss and trauma. If you've lost a baby, you're in a completely different place than someone who's had a traumatic experience and still has a baby. And if you use design to try and speak to those two different groups of people, it's just not going to happen.
[00:03:12]
LM: So it needs to be tailored toward each group.
CJ: Yeah, and it was like, you've got to understand where that person is in their journey, and actually they're not aware that they're in trauma often, and that's, it's the GP that you need to target. And I think that happens often, that's our role as designers, to try and make really small but very significant changes to things that might help someone who's within that system.
[00:03:32]
LM: What do you think some of those small changes might look like?
CJ: I think a lot of it is around communication. And I think that it's very difficult, that room that I was in, I basically, I had gone back in, having had a massive bleed after my son was born, and they put me in the critical care room, left me on my own and my husband had taken the two kids home, and it was like this really, and they closed the door. Just that thing of being in a room with a closed door, it's quite kind of overwhelming, and they didn't because I was on the labour ward because they know how to. And so I could hear other people and acoustically, it's such a weird place to be, but I understand from a midwife perspective, there's, like, you've got to be able to see, and you've got to be able to hear, and they kind of knew I was okay until I went into surgery. But as a person experiencing it, that's very hard. So, I think for me, it might have just been, and maybe somebody did, come in and check on me regularly? You know, those sort of things that make people feel sort of safer. It's hard and I think that I find that going in as lived experiences, it's like, what do I do? This is massive.
[00:05:10]
LM: Do you think being in that environment at that period of time made it worse for you, and if you had been in a more supportive environment things could have been different?
CJ: Yeah, but then I don't know how that works medically.
[00:05:33]
LM: Yeah. I've done a lot of research into even small elements within health that will make a difference, even during the actual process of birth. And being able to personalise the environment to a higher extent actually has better effects physically as well as psychologically.
CJ: Yeah, yeah, yeah, absolutely. There's a really interesting group called Lion Arts, who do installations and things in hospitals, and we worked at, sounds really stupid, but it's an art. It's like changing the colour of the curtains. And it's actually bringing colour theory

and design into those sorts of places. There used to be a research group here called Arts of Health, by Clive Parkinson. It's slightly different, but Christina and Jade, I know she's your supervisor and she knows that kind of area, but I think in terms of the impact that creativity and design can have on those environments, it's massive, with the small changes, like colour and the associations with things. And you're talking about the personalisation, there's a theorist called Winnicott, but he talks about transitional objects that help us kind of navigate separation from a baby when it's born, and I think it's the same being as its mum, you have a toy that helps to comfort with that child as it learns that it's not the same being as its mum. And so that toy becomes this transitional object that helps that sort of psychological development stage. I think that we use transitional objects throughout our own lives, and I think we use them in a way to help us navigate change or, you know, you used sort of think, my mum was in these delirium and we'd given her a really beautiful blanket that I'd embroidered our names onto the corner of for her birthday of the previous year. She couldn't really, she was unclear. She knew who I was, but she wasn't clear where, who she was or why she was there and she was sort of delirious. But I walked in and she was rubbing the embroidery of our names, and it really made me realise the importance of the objects of that. You know, like I have rings that connect me to her and I have things and actually, if people have those objects in hospital environments, that can make a massive, two more, impact.
[00:08:03]
LM: Yeah, more personal things then, more things from home, stuff.
CJ: That sort of grounds them, yeah, and helps them feel safe. And also, the notion of just like somatic exercises, of, you know, breath work or sort of, yeah, predominantly breath work, and is that, you know, three, sort of, the health care professions, if they're trained in that or there's someone that is able to kind of build that into someone coming in in a panic state to actually how, the job, breath is still in, because you need to conserve it to have the energy as well.
[00:08:47]
LM: Because stress can make things a lot harder as well, can't it.
CJ: I used hypno birthing throughout, the delivery itself was amazing.
LM: Oh, really?
CJ: That was very different to my daughter's. It was my first and I was really scared. I was really scared. And the second time I wasn't, because I knew I'd been through and I knew it was possible and it worked, it really helped. I had headphones in the whole way through, and I said to my husband, "Shall I take these out?" and he's like, "Do not take the phones out."
LM: Hahaha
CJ: Yeah, yeah, hahah, because he knew how much it was having a positive impact on me. And that's the thing, it's things like that, that sort of, and it might not be necessarily design
[00:09:33]
LM: but I mean, yeah, but it's all about the sort of environment that you're creating for yourself.
CJ: Having headphones that work, headphones that allow you to just focus.
[00:09:54]
LM: Because hospitals can be quite scary for somebody. So I can imagine, that sort of, you, the comfort of being at home and having a home birth compared to, like, safety sort of side of being in hospital.
CJ: You know, smell I think we underestimate as well, so our kind of senses of smell and triggered responses, like, you know, it might not be the visual environment, it might be what it smells like, or sounds like, it has an impact on us too, so really thinking about the, like, the acoustics, because it's gotta be cleaned down, it's got to be clinical, it's really, you know, echoey sometimes, sometimes it's hard to take, to smells.
[00:10:38]
LM: Okay. So, what do you think about the experience after you give birth and your sort of lack of attention and support around post-partum, and do you think there should be any other major changes for women who have given birth, especially if it's been a traumatic birth?
CJ: Yeah. I think there are different changes now. I think there's more things in place. I was in and out in 12 hours. That's to do with NHS targets. But, like I say, the delivery was fine. It was the complications afterwards. And I kept saying, I feel like there's something wrong. I feel like there's a way. And I knew there was something seriously wrong with me and I didn't know what it was, but I just knew there was something wrong, that I didn't feel right. And it wasn't until I sort of was incredibly unwell. So it was sort of like I was getting scans and things, but it didn't seem very logical, in hindsight, how that process was dealt with, and so midwives coming, I think, after, there's a bit of "oh, you're alright," because they're pressured to get it done so quickly. I get it. I had this massive baby, everybody was just like, oh my God, he's so gorgeous. It was distracting me from how ill I was. And so I don't know. I've talked to the midwives about that, and that's why I did lived experience work and that talking to the nursing staff in Salford. About sharing that kind of lived experience with the students who are going through nursing now. Say we have a study that, this is what happens to be in my eyes and some of the nursing staff, and some of them had such a positive effect on me when I was born. I needed a blood transfusion. One of the midwives, the first one went in and I was like, it's so cold, because it comes out of the fridge and it was like I could feel it going through the whole body, and then the next pint I needed, she came up and went, "I got your blood in here," and she had it in her apron. So that it didn't make me feel so sick. She was like, this is just, this is amazing.
[00:13:04]

LM: Like that listening. And just seeing, like, what do they need.
CJ: Yeah. And sometimes it's that really small gesture, like, it didn't add to her workload. It just meant that it took longer for me to get blood, but I much preferred to have it warm and not freezing cold. But then in terms of that, then, so I witnessed that parent at the table that developed the session where we would work with women who have had the traumatic experience, but then had therapeutic support, psychological kind of treatment, and at the end of that, I said, there's a gap. If you have this treatment and you're with somebody and you work through this stuff, it's verbal. There's no tangible thing that kind of summarises that and so I said, I feel like if we could work together to make objects that summarise how far, not necessarily the trauma, but how far they'd come in recovering from the trauma. And it's sort of creating these doorways, so it's a doorway that they felt they'd stepped through, and all of the things that helped them kind of get to that point, that they were discharged and did automatically fit to kind of help the wall, you know, kind of keep going normally. So it was about making the same plates that I'd made, as sort of a tangible representation that they don't need to tell anyone else what it's about. It's there for them, and it's something that reminds them that actually, if they're having a bad day or they've forgotten, oh I should use my grounding objects, to remind them that they are safe, looking at that might trigger that memory. And so they said, it's great, yeah, yeah, yeah, but then we had issues funding and stuff, so we haven't actually done much.
But I'm now working with a group of women in the political mother line, and we're going to do a listening exercise with play with them to talk about what has gone on today. And then, so it's sort of, it just like shifts because it's a group of women who don't all have children, who haven't, you know, sort of given birth, and it's about their mothers, and their experience goes back, an ancestral mother line. And for some women that might come through into their own children, but for others have stopped with them, and what does that mean? And why can we do use, again, of the play as material to help us listen really well to somebody else's story. So rather than, sometimes, because I talked about it so much, in general I'm comfortable to talk about the trauma. If someone has never spoken about it, and it's very quiet, and if someone's looking at you to articulate that, so if you're both making something in the material and you're just talking and you're not really necessarily having to look at someone in the eye.
[00:15:53]
LM: Like, you know, like walking next to someone makes it easy to talk,
CJ: that sort of parenting tips, go for a dog walk and that's where she talks to me, or going on a drive. Well, I'm not looking at them, and so I'm not having an expectation. And they kind of, you know, it's the end of the day when they're supposed to sleep, that's when things come up. So I think it's maybe, it's a bit about this is about distracting the brain. So the brain is occupied and the hands are occupied with the material, and so then the brain is free to kind of talk about things that might be a bit more subconscious. So there's, it's all to do with trauma therapy as it's some kind of how it works, but yeah, I'm going to be doing that next week. Working with Irish women March next year, making and exploring their Irish heritage, different materials, different people, but again, that has the potential to bring up trauma of forced immigration or traumatic experiences that might have been in Ireland, under generations of things that have come up in stories that have been passed on, that they've never begun to fully understand, maybe.
[00:17:25]
LM: So I'm not set on an idea yet, but after we've done this essay, it will inform the final project. So I was thinking if the research did lead me there, which I think it will, I'd like to create space for anyone who has gone through a traumatic birth or something like that. What do you think, if I were to create a building or environment, would be helpful to have in that space to better support the women?
CJ: I think flexibility. And potentially, like part of the mother library, we meet in these spaces, but one of the sessions when I was home was a mass film, we were talking about your relationship with your mother and you were singing about it? Oh my God, I went out six times. I just couldn't stop crying. And so that feeling, to me, of having a sort of, was a separate space, an interlinked space, that's safe to go to as well, and it's not just about the direct environment for those conversations to happen. It's about a breakout space as well, and actually bringing creative practices has helped a lot of us access things we wouldn't have accessed necessarily. What happens, I guess, in those spaces could be quite different.
[00:18:54]
LM: It's flexibility around what actually goes on in the space and with being able to move freely around and have space to feel safe.
[00:19:10]
CJ: A lot of it's to do with safety and feeling safe, so colours that make it feel safe, being aware of what helps people feel safe. You know, I don't like having my back to the door. I don't, you know, sort of, someone else might be quite happy to do that. But after traumatic experiences it's good to just be conscious about that, for example, in conscious of everyone walking behind me, that's quite distracting. And I think it might be interesting, Emily Taylor, she's trained recovery specialist, so she's a ceramic artist, so she has these lovely, in the lecture, Ashley's on DC2 last year, it might be able to possess it. She talked for, like, the set of the space, and she has these photos of us sitting in circle as well. That's what I've been doing again for this project, sitting in a circle. This notion of no one's in control, we are equal participants, no one is the leading, so

so everyone is valid and valuable in the conversation, which is really important. But again, just having a space where the acoustics are good, and make you feel like it's a nice place to be from a sensory perspective.
[00:21:14]
LM: Is there anywhere, not necessarily in the UK, that you've seen, that has good practices or support for pregnant women?
CJ: Not in specific relation to traumatic birth. I know that in Denmark and Sweden the government allows for every single person to have a full year paid leave. It is your actual salary, not maternity leave, that you know you can have the full 12 months. And some universities have programs as well. Yeah, and paternal leave. I have a friend, he's got six weeks rather than two. It's systemic kind of changes like that that are helpful too.
[00:22:05]
LM: It's actually giving the woman's time and then the support from the partner as well.
CJ: This is, like, the different doors that I came through, but the colours are associated with different chakra points, so the kind of chakra of the solar plexus, just being in the heart chakra would have different colour alignments to them, so it's about how that works through your body. There's also a really interesting book by a guy, it's called The Body Keeps the Score. And it's quite high PTSD effects and the body and how it's the treatment of it. And I had something called EMDR, which is generally used with more experiences, published their memories, but that's, if it's a really visual process, and that's what helped me understand that I needed to kind of take myself, that's where I was in my head. I was still stuck in that room. And so it was quite, going back in and getting myself out of that space, and it's, I get a visualisation to make it make sense for me, because I'm visually driven. Whereas if someone else, it's, and it wasn't therapy in the same way. It was like a real somatic or connected to your body. So it really, really helped me. But these are, they're just layers of transfers. And then the other ones that I'm working on now, and then often you don't always have to say what... You don't always have to say. You can make these really nice pieces and choose to tell who. So these are all the women in the motherly project in their own doorways, kind of. And it's the same for them. They're all very different and the pieces are all second objects. But these are the two girls who only run the project, and really funny, coincidentally, they both have them and their back door, with their doors in opposite directions, and I was like, oh my God, that's such a beautiful, you know, they're holding this space. They're literally holding the door open for all of us to kind of be in this space. But it's, yeah, just giving them all value in them as individuals as well.
[00:26:59]
LM: I guess just to, like, sum it up. Is there, like, if you can put it in, would be the one thing you change about willing to experience of trauma? If there is one that you'd change.
CJ: I think it's listening to the individual. Like, you have to watch how someone reacts to something. You might be saying, what do you need? They might not know what they need. So actually, offering some suggestions and being generous.
[interview ends at 27.58.50]