JURY RETURNS CRITICAL VERDICT ON PRISON SERVICE AND PRIMARY CARE TRUST

A jury at Suffolk Coroners Court has returned a highly critical verdict at the inquest into the death of 36-year old Iqbal Khan at HMP Highpoint.

The deceased was a married father of two with no previous history of depression or self harm. He was taken into custody in May 2006 where he developed depression in December 2006. In January 2007 Mr Khan absconded from HMP Kirkham leaving behind two suicide notes. He attended the Royal London Hospital where he was diagnosed with possible psychotic depression and returned to custody at HMP Pentonville with a letter from a doctor recommending “continuous observation due to risk of self harm”. No action was taken in response to this letter and no member of prison or healthcare staff recalls even seeing it.

HMP Kirkham did not inform HMP Pentonville of the suicide notes, nor send Mr Khan’s medical notes. HMP Pentonville did not request Mr Khan’s medical notes. At HMP Pentonville Mr Khan was placed on suicide watch on three occasions between 1 February 2007 and 23 April 2007, the third after having set fire to himself and/or his cell and suffering severe burns.

On 23 April 2007 Mr Khan was transferred to HMP Highpoint without a mental health assessment to confirm that he was fit for transfer. HMP Highpoint had one psychiatric nurse for 900 prisoners, who only saw Mr Khan after concerns raised by his family about his mental health and then only on two occasions. Mr Khan was never referred to a GP or psychiatrist or given a mental health assessment at HMP Highpoint. Neither the psychiatric nurse at HMP Highpoint nor anyone else with comparable mental health experience saw Mr Khan during the last two weeks of his life.

Mr Khan was found hanging in his cell at 9.30am on 30 May 2007. He was pronounced dead at 9.50am.

The inquest hearing took place from 6 to 30 April 2010 and 16 to 24 June 2010. The jury returned its verdict on 24 June 2010 after three days’ deliberation. The jury found that the following issues caused or contributed to Mr Khan’s death:

1. The failures between prisons to pass on or chase up Mr Khan’s missing medical notes;

2. The failure to respond appropriately to concerns raised by Mr Khan’s cellmate about Mr Khan’s mental health;

3. The decision to transfer Mr Khan to HMP Highpoint without a mental health assessment; and

4. The fact that no formal mental health assessment of Mr Khan was carried out during his time at HMP Highpoint.

The jury also found that:

1. HMP Pentonville (where Mr Khan was held prior to HMP Highpoint) did not respond appropriately to a letter from a doctor at the Royal London Hospital recommending that Mr Khan be continuously observed due to risk of self harm; and

2. Mr Khan took his own life in part because the risk of his doing so was not recognised and therefore appropriate precautions were not taken to prevent him doing so.

The level of the Coroner's concern was such that he has decided to make a number of recommendations to the relevant authorities aimed at preventing future deaths in similar circumstances. These recommendations relate to the better transfer of information between and within prisons and related agencies.

The deceased's family was represented by Alice Hardy of Bhatt Murphy and Henrietta Hill of Doughty Street.