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INQUEST JURY FIND STAFF FAILINGS CONTRIBUTE TO 18 YEAR OLD'S DEATH IN YOUNG OFFENDER INSTITUTION

The jury in the inquest into the death of 18 year old Karl Lewis today returned a lengthy narrative verdict highlighting institutional failings and lack of staff training as contributing factors to his death.

Karl was found hanged in his cell at HM Young Offenders' Institution Stoke Heath on 22 January 2005 after only three months at the institution. During his short time there he was placed on no less than four separate self harm monitoring forms due to the risk of suicide he posed and yet still did not receive adequate care or attention that he required. His case highlights the inability of the current custodial systems to treat vulnerable young prisoners.

SYSTEMIC FAILURES

During the inquest, 47 witnesses gave evidence revealing serious failures and errors in the care provided to him by the Youth Offending Service, Social Services, Probation Service and Prison Service. This included paperwork such as crucial pre-sentence reports which accompanied Karl to Stoke Heath being incorrect and wrongly stating that there was no record of Karl self-harming in the past. The inquest heard that Karl did not receive the care he should have done whilst in Stoke Heath and that even after he had been placed on the "self harm at risk" procedure for the third time in as many months he was still not referred for a mental health assessment. The jury found that these failures by the various state agencies were contributory factors in Karl's death.

Two days after a visit from his family with his newborn daughter on 19 January 2005, Karl was placed on the "self-harm at risk" procedure for the fourth time after an officer discovered cuts he had made to his wrist with a razor blade. He was seen by a nurse who was not qualified to assess mental health issues and who decided – wrongly – that Karl should remain in his cell and on the minimum level of observation instead of transferring him to the health care centre. Expert evidence to the inquest was given that Karl should have been referred immediately for assessment and not left unobserved. The jury found that he should have been admitted to the health care centre instead of being left alone in his cell which meant that 'by nature he was not in a safe area'.

LEFT HANGING

Karl was discovered by the night orderly who was untrained in either suicide prevention or first aid. Instead of entering the cell to help him in accordance with policy the orderly left him hanging while he went to summon assistance from another part of the prison. It is impossible to know if vital seconds that could have saved Karl's life were lost as a result of

this. The coroner ruled that the jury could not make findings of fact contrary to the families wishes.

The family were disappointed by this ruling and hope that the Prison Service will nonetheless act quickly to ensure that staff charged with the care of vulnerable young people – especially at night – are properly equipped and trained to deal with that responsibility.

Following the jury’s verdict, Deborah Coles, co-director of INQUEST, said:

“Once more the use of prison for those with mental health problems is shown to be unacceptable. This death again raises serious questions about the treatment and care of vulnerable prisoners in Stoke Heath. Having worked closely with the family of another vulnerable boy, Joseph Scholes, who died alone in his cell aged 16 in the same Institution, the critical findings in the case of Karl Lewis bring into question whether recommendations for change were acted on in the light of previous deaths at Stoke Heath. The Prison Service must be brought to account for their failure to act to prevent other deaths.”

Karl’s family commend the coroner on having conducted a thorough and wide-reaching inquiry, and are satisfied that the jury’s verdict broadly reflects many concerns that they themselves have had since the tragic loss of Karl.

Karl’s family were represented at the inquest by INQUEST Lawyers Group members solicitorCarolynn Gallwey of Bhatt Murphy Solicitors and barrister Paul Bowen of Doughty Street Chambers.

ENDS

Notes to Editors

1. Since the early 1990s INQUEST has worked with the families of many of the children and young people who have taken their own lives in state custody. The inquests into their deaths have raised serious questions about the care and management of vulnerable young prisoners.

2. Judgment will be handed down this Tuesday 17 October at the High Court in the case of Joseph Scholes, whose mother Yvonne has challenged the refusal of the government to hold a public inquiry into his death in Stoke Heath YOI in 2002.

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