Bhatt Murphy Solicitors

PRESS RELEASE

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COURT OF APPEAL: INQUESTS MUST IDENTIFY SYSTEM FAILINGS THAT MIGHT HAVE PREVENTED A YOUNG MAN'S DEATH IN PRISON

THE COURT OF APPEAL HAS CONCLUDED THAT THE INQUEST INTO 18 YEAR OLD KARL LEWIS' DEATH SHOULD HAVE IDENTIFIED THE LACK OF TRAINING, EQUIPMENT AND PROCEDURE WHICH DELAYED ASSISTANCE BEING OFFERED AFTER HE WAS FOUND HANGING EVEN THOUGH IT WILL NEVER BE KNOWN WHETHER SWIFTER INTERVENTION WOULD HAVE PREVENTED HIS DEATH

1. The Inquest touching upon Karl Lewis' death at Stoke Heath Young Offenders Institution on 8 October 2004 concluded that failures of communication between social services, the Youth Offending Team and the prison concerning Karl's sad history of self-harm together with the lack of supervision and care within the prison, caused this young man's death.

2. The Court of Appeal has remarked that the duty of care owed to vulnerable young prisoners is, "Too often neglected. What happened to Karl Lewis exemplifies this."

3. Karl's father brought judicial review of the Coroner's conclusion that the failure to respond promptly to Karl after he was found hanging could not form any part of the Inquest's jury's verdict or the Coroner's report because there was no way of knowing whether a more appropriate and swifter response would have saved Karl's life.

4. The support grade worker who looked through the observation window and saw Karl hanging had not had any training on suicide prevention or first aid and there was no procedure to guide his actions. He was also not equipped with a "cut down" tool. He elected not to enter the cell. He used his radio to summon assistance but the signal relied upon did not reflect the urgency. The assistance took longer than it should have done and when Karl was cut down, he was dead.

   Sedley LJ said, "What can without the slightest doubt be said is that the failures of training, equipment and procedure" that were identified in the course of the inquest "ought not to have occurred."

5. The Court of Appeal concluded that the Coroner was under an obligation to make a report setting out "the want of equipment, training and effective procedure which the undisputed evidence revealed" because action was needed to remedy those deficiencies to prevent similar future fatalities.

6. The Court stopped short of concluding that the jury in this case should have been asked to reach a verdict on this aspect because the facts were not in dispute but concluded that, "it may be in cases [where the facts are disputed or uncertain] that a finding by verdict is desirable or even necessary" to found the Coroner's report.

Keith Lewis, Karl's father welcomed the Court's conclusions, "I brought these proceedings in the hope that Karl's death might not be in vain. I hope the fact that Coroners are now required to include within their reports matters that might have prevented the death, will ensure that lessons are learned and other deaths prevented."

Deb Coles, co-director of INQUEST, the charity that supports bereaved families and who provided evidence that was relied upon by the Court of Appeal commented, "Sadly, it is often impossible to establish whether earlier intervention would have prevented a death by hanging. The identification of failings that might have prevented the death is of critical importance to bereaved families and plays an important role in reducing future similar fatalities. We welcome this clarification of Inquest law."

Keith Lewis was represented by Tim Owen QC of Matrix Chambers and Paul Bowen of Doughty Street Chambers.

For further information, please contact:

Fiona Murphy
Partner
f.murphy@bhattmurphy.co.uk
020 7729 1115

Note to Editor:
The Coroners and Justice Act 2009 has received the Royal Assent but will not become law until at April 2012 at the earliest. The Act places a mandatory responsibility upon Coroners to make reports were action should be taken to prevent similar deaths. This case establishes that Article 2 (the right to life) requires Coroners' to exercise this power under the existing legislation.