

INQUEST PRESS RELEASE WEDNESDAY 12 OCTOBER 2005

JURY RETURN VERDICT IN MARCUS DOWNIE INQUEST – 20 YEAR OLD BLACK MAN WHO DIED IN HMP CHELMSFORD

The jury in the inquest into the death of Marcus Downie today found that 'he took his life while suffering from schizophrenia'. They found that 'the system for ensuring that Mr Downie actually received and took his medication was unsatisfactory'. Marcus, who died at HMP Chelmsford on 11th May 2002 aged 20, was a diagnosed schizophrenic and had been prescribed anti psychotic medication. He had only been on remand for one month (pending sentencing for road traffic offences) before he was found hanging in his cell in the segregation unit.

The inquest examined key issues including:

- The monitoring of the mentally ill and how and when they take their medication;
- How the cell bell system is implemented;
- The appropriateness of the segregation block for young offenders;
- Risk assessment of the vulnerable in HMP Chelmsford.

At the conclusion of the evidence the Coroner left the jury the option of a narrative verdict. She indicated at the conclusion of the inquest that she would consider raising her concerns about Mr Downie's death with the prison.

Helen Shaw, Co-Director of INQUEST said:

"Marcus Downie was clearly a vulnerable young man with serious mental health problems who was owed a particular duty of care and it is profoundly shocking that a prisoner with a major mental illness died in the segregation unit. It has taken nearly three and a half years for Marcus's inquest to be heard and in that time the opportunity to learn lessons and to prevent similar deaths occurring has been seriously undermined. Delays of this length are not uncommon for inquests following a death in prison and additional resources are needed now and cannot wait for the government's proposed reform of the inquest system."

Notes to Editors

INQUEST has had longstanding concerns about the number of deaths in segregation units and has repeatedly drawn attention to the disturbing number of self-inflicted deaths in prison of people who had a known previous psychiatric history; the link between prison deaths and inadequate or inappropriate health care; the stereotyping of black people with mental health problems and the need for a reduction in the use of imprisonment rather than treatment of vulnerable people, for whom prison is the worst place to be. Prisoners with mental health problems are often at risk more to themselves than to others as the increasing catalogue of self-inflicted deaths in prison reveals.

The family was represented by INQUEST Lawyers Group members James Bell of Christian Khan Solicitors and Leslie Thomas of Garden Court Chambers.

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INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts.