

PRESS RELEASE 28 JULY 2006

**DAMNING VERDICT AT INQUEST INTO DEATH OF VULNERABLE
MAN IN PRISON SEGREGATION UNIT**

The jury at the inquest into the death of 32 year old David Hull which began on 11 July 2006 returned a damning narrative verdict on 21 July at Portsmouth Magistrates Court.

David was found hanging in a cell in the segregation unit of HMP Kingston on 11 October 2004. He had a long history of depression and in the months leading up to his death had self harmed and attempted suicide on numerous occasions.

On 9 October David was moved to the segregation unit under restraint where he remained on suicide watch until his death. In the late evening of 11 October he was found hanging from his cell window bars and died the next day in hospital.

The jury concluded that **“David Charles Hull killed himself while the balance of his mind was disturbed and we the jury agree that David Hull’s death could have been avoided”**.

Issues of concern with the regime at HMP Kingston which were raised in their narrative verdict included:

- The decision to house David in the segregation unit, which the jury said was “inappropriate due to the increased risk that isolation has on the ... suicidal person”;
- The failure to use a specially designed “safer cell” and instead to place him in a cell with window bars;
- The self-harm prevention regime at HMP Kingston, saying that the “omission [of] or inadequate training in suicide and self harm was wholly insufficient”.
- The management of David’s suicide risk, noting that “the quality and timing of observations were inadequate and non-compliant with prison policies whilst David Hull was in the Segregation Unit and we found failed to comply with procedures within the FS2052SH [suicide and self-harm monitoring] system;
- The jury concluded that “support for David Hull whilst on Segregation on a personal level was sufficient but his suicidal tendencies were not sufficiently addressed” and in particular “that it was inappropriate to inform David Hull of the adjudication against him, because of his state of mind at that time and his threats of self harm.”

HM Coroner for Portsmouth and South East Hampshire David Horsley said at the close of the inquest that he would be considering making recommendations in accordance with his powers under S.43 of the Coroners Act to help avoid future deaths.

Deborah Coles, co-director of INQUEST, said

“This death raises serious concerns about the suitability of using segregation units to house vulnerable and at risk prisoners. It is vital that this death and the issues it raises are fully explored, failings identified and any recommendations implemented by the Prison Service.”

Tony Murphy, Mr Hull’s former partner’s solicitor said:

“The jury found that the Prison Service failed to protect the life of David Hull, a very vulnerable prisoner. It also heard evidence that the relevant Governor knowingly breached mandatory policies designed to protect life. The Prison Service must be asked to demonstrate how concrete lessons will be learned from this tragedy”.

Mr Hull’s former partner was represented by INQUEST Lawyers Group members barrister Richard Hermer of Doughty Street Chambers and solicitor Tony Murphy of Bindman and Partners.

Notes to Editors

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 and conducts policy and research work on the issues arising.

FS2052SH is the monitoring form used to record notes on the care of prisoners believed to be at risk of suicide and self-harm.

Segregation units are also sometimes referred to as ‘care and separation units’.

Further Information	
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