

For immediate release 20 February 2008

DAMNING CRITICAL VERDICT AT INQUEST INTO THE DEATH OF 16 YEAR OLD GARETH PRICE

A jury today delivered a highly critical verdict at the inquest into the death of 16 year old Gareth Price. In an unusually detailed narrative, the jury highlighted failures by all the agencies involved in Gareth's care including Youth Offending Teams and the Prison Service. The jury concluded that the collective failings of the agencies ultimately contributed to Gareth's death.

Gareth Price was found hanging in his cell at Lancaster Farms Young Offender Institution on 19 January 2005. The jury's verdict highlights concern over the inappropriateness of prison for troubled teenagers and the ability of the youth justice system to ensure the safety of children in its care.

In his conclusion, the coroner Dr James Adeley stated:

"What appals me about this death is the number of organisations and individuals who missed opportunities to intervene in Gareth Price's life... This wasn't a single missed opportunity but covered prison and community youth offending teams who failed both on a managerial and individual basis, to psychiatrists, psychologists, solicitor and the prison."

The coroner has indicated he will be making a significant number of rule 43 recommendations to the relevant authorities with the hope of preventing similar deaths in the future.

The jury found that the following contributed to Gareth's death:

- failure of YOT services to arrange meetings for Gareth, incomplete documentation and assessments, and haphazard communication between services;
- grave error of Gareth's family solicitor in doing nothing with a psychiatrist's report warning of the risk Gareth Price posed to himself around the time of sentencing;
- the psychiatrist who concluded Gareth was at risk assumed incorrectly her report would be shared with relevant agencies;
- serious omission by the prison not to have informed Gareth's parents that he had self-harmed;
- loss of prison psychologist's report highlighting Gareth's risk of self-harm in the internal mail;
- training of prison officers with regard to suicide prevention was inadequate;
- failure of health staff to monitor Gareth's mental health following self-harm episodes

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The family made the following statement:

“We will never understand why every agency involved in Gareth’s care knew he was self-harming and suicidal, yet nobody told us. What hurts the most is that warnings by experts that Gareth was at high risk of killing himself were not brought to the attention of prison officers and medical staff dealing with him either. If everyone involved with Gareth had done their job properly he might not have died”.

Deborah Coles, Co-Director of INQUEST said:

“It is shameful that despite all the information available about how vulnerable Gareth was every agency that he came into contact with failed him. This verdict calls into serious question the competence of the Youth Justice Board and its fitness for purpose. Since Gareth’s death two more children have died in custody, including a 15 year old who was also found hanging at Lancaster Farms YOI.

How many more have to die before the government hold the Youth Justice Board to account for its failings and review the use of prison for vulnerable and troubled children? The government must set up a full and holistic public enquiry into the youth justice system before more children die”.

Gareth’s family was represented by INQUEST Lawyers Group members Joanne Kearsley of Farleys Solicitors and barrister Colin Hutchinson of Garden Court Chambers.

Notes to editors:

1. Gareth Price first received counselling for symptoms of Post Traumatic Stress Disorder when he was 14 following a series of traumatic bereavements in his early teens. Concerns about Gareth’s mental health in prison prompted the commission of two expert reports which both identified a high risk that Gareth would attempt suicide around his sentencing date. Tragically, these warnings were either ignored or lost and Gareth hanged himself the day before he was due to be sentenced. During his five months in prison Suicide/Self Harm Warning forms were opened for Gareth on four occasions, yet his parents were never informed of his attempts to self-harm.
2. Gareth was the 28th child to die in state custody since 1990. 30 have now died including Liam McManus who was found hanging at Lancaster Farms YOI on 29 November 2007 aged 15. A table of child custody deaths can be found on the INQUEST website at: http://inquest.org.uk/pdf/Deaths_of_Children_in_Penal_Custody_1990-date.pdf
3. The Youth Justice Board mission statement says, “The YJB oversees the youth justice system in England and Wales. We work to prevent offending and reoffending by children and young people under the age of 18, and to ensure that custody for them is safe, secure, and addresses the causes of their offending behaviour.”
4. 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.

Further Information	www.inquest.org.uk
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