

PRESS RELEASE

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INQUEST VERDICT INTO THE DEATH OF ALEKSEY BARANOVSKY AT HMP RYE HILL

The jury at the inquest into the death of 33 year-old Aleksey Baranovsky today reached its verdict by slamming the appalling care and conditions that led to his death at Rye Hill prison. They concluded that his death was caused by anaemia due to chronic blood loss and also by under nutrition. However, they listed seven additional failings by the prison that caused or contributed to the death.

Jocelyn Cockburn, partner at law firm Hodge Jones & Allen who is acting for Mr Baranovsky's family, expressed relief at the verdict. She commented:

In light of the evidence that emerged throughout this long inquest, Mr Baranovsky's family is relieved that the jury reached the correct verdict in highlighting the dreadful conditions that led to his untimely death. Let us not forget that only a year before Aleksey's death, HMP Rye Hill was heavily criticised by HM Chief Inspector of Prisons who stated that the prison was an unsafe and an unstable environment, both for prisoners and staff; and that Mr Baranovsky's death was one of three controversial deaths at the privately-run prison in a fifteen month time period.

We hope that lessons have been learnt from this long and painful inquest to ensure that the appalling level of care that Mr Baranovsky received is not inflicted upon other prisoners at Rye Hill or any other prison.

The coroner added his own swingeing criticism after the jury had handed down the verdict and said that in his view Aleksey's treatment was "*appalling and unacceptable in any modern society and shameful.*"

Deborah Coles, Co-Director of INQUEST, which arranged the family's legal representation, comments:

The importance of family legal representation at inquests and robust public scrutiny of prison deaths is demonstrated by the strong jury narrative and coroner's comments in this case. Government ministers must be held accountable for their failures to ensure action was taken on the clear warnings about Rye Hill prison and the fact that prisoner's lives were at risk. They need to inform the public about how those responsible for this death have been held to account. The three deaths that have occurred in this prison raise serious questions about the appropriateness of the privatisation of prisons and prison health care.

Inquest

Jocelyn Cockburn says: "In light of these findings we invite the prison to make a formal apology to the family, something which has not been forthcoming over the last three years."

The inquest verdict recorded the following failures at Rye Hill:

"Aleksey Baranovsky died in his cell in the healthcare unit of Rye Hill prison after a prolonged period of deliberate self harm by way of cutting himself and regularly refusing food. This was during the period from 22 April 2006 until 10 June 2006. During this time Mr Baranovsky repeatedly refused medical attention.

We find that the following factors caused or contributed to his death:

- *A failure to carry out an adequate mental health assessment*
- *A failure to carry out a full and adequate health assessment on admission or at any time that he was at Rye Hill prison*
- *A failure to assess healthcare needs and draw up a detailed care plan regarding Mr Baranovsky's long term care*
- *Inadequate systems and processes regarding those verbal and written communications between healthcare prison security and prison management leading to insufficient management of Mr Baranovsky's well being*
- *Insufficient training and knowledge of some prison policies resulting in poor implementation of key safeguards*
- *Failure to carry out and follow agreed actions regarding care*
- *Inadequate interventions at time of greatest healthcare need."*

-ENDS-

Notes to editors:

INQUEST is the only organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. Its casework priorities are deaths in prison and in police custody, in immigration detention and in secure training centres. INQUEST develops policy proposals and undertakes research to campaign for changes to the inquest and investigation process, reduce the number of custodial deaths, and improve the treatment and care of those within the institutions where the deaths occur.

INQUEST is campaigning to ensure that the Coroners and Justice Bill 2009 results in fundamental reform of an inquest system currently hampered by delay, inconsistency of approach and lack of resources and unable to fulfil its vital function of preventing unnecessary deaths.

The government must also make changes to ensure that bereaved families can participate effectively in inquest hearings by having equal access, alongside the police and Prison Service, to non means-tested public funding for their legal representation. [INQUEST's briefing on the Coroners & Justice Bill](#)

Further Information	www.inquest.org.uk
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