

PRESS RELEASE

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INQUEST JURY HIGHLY CRITICAL OF CARE OF NEWLY-SENTENCED PRISONER AT HMP WAKEFIELD

Brendan Flynn was found hanging in the segregation unit of HMP Wakefield just after midnight on 11 August 2004, a few days after receiving a 20 year sentence. He was 28 at the time of his death.

An inquest jury sitting before HM Assistant Deputy Coroner for West Yorkshire, Melanie Jane Williamson, today found that:

1. Brendan hanged himself while the balance of his mind was disturbed.
2. An absence of a radio and reading materials in Brendan's cell had contributed to his state of mind.
3. Two officers (the number on duty that night) would have been sufficient to open Brendan's door in an emergency. The rule requiring three officers plus a manager plus a dog to open a cell was too cautious.
4. Brendan should have been placed automatically on suicide watch (F2052SH) as a newly-sentenced prisoner on a long determinate sentence.
5. Brendan should have been placed on a suicide watch in any event after reporting his head was a mess on 9 August 2004.
6. The medical assessments completed on Brendan were inadequate.
7. Staff had received inadequate, insufficient and inconsistent suicide awareness training.

The jury's verdict confirms the findings of HM Chief Inspector of Prisons, Ann Owers, whose report of an unannounced inspection in December 2008 of HMP Wakefield is published today. She found that "it was not clear that suicide and self-harm, or violence reduction, procedures were properly targeted at the specific risks presented or faced by Wakefield's particular population".

Evidence received by jury

At the inquest, the jury heard that HMP Wakefield has a policy of automatically placing prisoners newly sentenced to life imprisonment on suicide watch. However, this policy was not applied to Brendan, despite the fact that he had just received a 20 year sentence, and had told staff that his "head was a mess".

Instead, the jury heard that Brendan was placed in solitary confinement on the segregation unit, without a radio, reading material, or any other means of distracting him from his

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sentence. The prison doctor confirmed that he was suitable for segregation after a consultation that lasted for only 34 seconds.

The jury heard evidence that it can take as little as four minutes to die from asphyxiation. However, prison officers did not enter Brendan's cell or carry out emergency first aid procedures until over seven minutes after Brendan was first seen to be hanging. The jury heard that the delay was due to a prison policy which prevents officers from unlocking category A prisoners during the night unless there are three prison officers, a manager and dog present at the cell door, yet only two prison officers were actually on duty in that part of the prison at night time.

The jury also heard evidence of a climate of bullying and intimidation in Wakefield's segregation unit. One prisoner described it as a "bully block".

A number of the prison officers who gave evidence at the inquest admitted that they could not remember when they had last received any training on suicide awareness or suicide prevention.

Falsified and missing evidence

At the inquest a prison officer admitted falsifying a local form, which some witnesses agreed was a risk assessment form, known as a BARAR form, following Brendan's death. The officer accepted that she had completed the form on the day after Brendan's death and backdated it to make it appear that it was completed the day before his death.

Brendan's family are also concerned that the jury was unable to view vital CCTV footage from the segregation unit on the night of his death. During the inquest the prison said that it had failed to retain the footage for the 30 minutes before Brendan was discovered hanging in his cell due to basic error in downloading the half an hour before midnight because they did not realise that entering 24.00 (as opposed to 23.59) would select the 30mins from a whole 24 hours too early.

Daniel Machover, solicitor for the family, said:

Brendan Flynn's family thank the coroner and the jury for the attention they have given this case over the past three weeks.

They believe that the prison did not give Brendan the care and attention he needed and in particular that they were wrong to segregate him, leaving him on his own and with nothing to occupy him, so soon after he had been given such a long prison sentence and when it should have been obvious that he was vulnerable.

Of most concern to the family, however, are the very serious problems with the evidence that have emerged in this case. It is unfortunately clear that: evidence was falsified; some officers did not tell the truth; and critical material – including documents but also critical CCTV footage – has gone missing.

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An inquest is supposed to help a grieving family obtain answers. Tampering with evidence is not only unlawful but also prevents a family from getting satisfaction and prevents full findings in the public interest. It leaves only suspicion and more questions. The family hopes that this will be the most important lesson to be learned from Brendan's death.

Brendan's mother, Audrey Milward, said:

Brendan was my youngest child and very close to me. He did cause problems – he could be as wild as the wind – but he was also outgoing and popular. I will remember him as always laughing. Words cannot express how I, his children, his nieces and nephews and all his family feel about having him taken from us so suddenly and in this way.

Brendan Flynn's family was represented by Nick Armstrong of Matrix Chambers and INQUEST Lawyers Group member Daniel Machover of Hickman & Rose solicitors.

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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.