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PRESS RELEASE
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HIGHLY CRITICAL EVIDENCE ABOUT FAILINGS IN MEDICAL CARE HEARD AT INQUEST INTO DEATH OF RORY KINLOCH AT HMP BRIXTON

Rory Kinloch was found dead in his cell at HMP Brixton in the early hours of 15 June 2006, a week after arriving at the prison in relation to a minor matter. He died of an especially severe pneumonia.

Rory's family waited more than three years for the inquest into his death to conclude. At the inquest at Southwark Coroner's Court which finished yesterday they heard damning evidence of sub-standard medical care, a shambolic prison healthcare service and numerous failed opportunities to identify that Rory was seriously ill. The family were particularly distressed to hear expert evidence that Rory could have been saved right up until the night of his death.

The inquest heard that crucial information about Rory's medical history was said to have been mislaid at the prison and so was unavailable to those assessing him on arrival. This was the fourth death in six years at the prison where similar failures were identified.

The first GP who saw him admitted failing to provide basic medical care to Rory. This doctor cited scenes of hopeless chaos in the area he was supposed to examine patients as a contributory factor; he in fact resigned in protest some time later and told the inquest that he would "rather work in the Third World than for the Prison Service." The prison knowingly continued to operate this system even after medical staff had complained that it was unsafe.

The next GP to have contact with Rory also conceded that he had failed to provide basic medical care to Rory. He prescribed methadone without seeing Rory or his records, on the recommendation of an untrained nurse. There was a dispute between them as to whether the nurse had ever provided him with the history she had taken from Rory, in circumstances where the doctor explained that had if she had done he would have "actively intervened" in his care.

Rory was further failed by nursing staff at the prison; none of those who saw him had received training in their specialist role. At least two nurses who saw Rory failed to spot that he was seriously ill in the day(s) leading up to his death, although expert evidence suggested it was highly unlikely that he could have appeared well at that time, and indeed other witnesses reported that he seemed very unwell. The inquest also heard that these nurses routinely see up to 80 prisoners in two hours, and the family were aware from an

investigation by the Prisons and Probation Ombudsman that nurses had been observed spending just moments over their individual assessments of prisoners.

The Kinloch family hope that the coroner will make robust recommendations to the Prison Service about improving the quality of medical care at HMP Brixton, but remain concerned that the system there will only ever be as good as the quality and the will of the medical staff who work within it.

Rory Kinloch's family was represented at the inquest by INQUEST Lawyers group members barrister Paula Sparks of Doughty Street Chambers, instructed by Carolynn Gallwey of Bhatt Murphy Solicitors.

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

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