

For immediate release 7 September 2007

INQUEST INTO DEATH OF VULNERABLE TEENAGER DANIEL NELSON

**11am Tuesday 11 September 2007
before HM Coroner for Doncaster Mr S Hooper
sitting at Doncaster Law Courts
College Road, Doncaster DN1 3HT**

The inquest begins on Tuesday 11 September 2007 into the death of Daniel Nelson, who died in Doncaster Young Offender Institution on 20 September 2005 when a remand prisoner there. It was his first time in custody. He was 18 years of age.

When Daniel was first remanded to Doncaster YOI on 25 August 2005 his behaviour was perfectly normal, but on 11 September he told a Health Care Nurse that there were hanging ropes under his bed in the house block, that staff were going to hang him, and before they did he would do it himself. The Nurse opened a FS2052SH self harm form and admitted Daniel to Health Care, where he was to stay until his death.

Between 11 and 20 September 2005 when he was found dead in his cell, he made no less than four attempts at self harm, three involving ligatures and one a plastic knife. He was placed initially on a 30 minute watch, changed after the first self harm attempt to a 15 minute watch, but was never made subject to constant observation despite more and more extraordinary and unpredictable behaviour. He was moved to a ligature free cell, but twice before his ultimate death was found to have managed to wedge a ligature in the door of his cell proving to others and to himself that it was not either safe or ligature free.

During his time in Health Care he hardly slept. An entry in his records for Sunday 18 September spoke of 'six days and nights unrelenting outbursts'. He was interviewed by a visiting psychiatrist on 15 September, but through a cloudy perspex door so Daniel could hardly be seen.

Daniel had been in care since 1999 and was still subject to a Pathway Plan through Social Services for children leaving care. However, his personal adviser, discovering that Daniel was in custody, made an appointment to see him on 25 September, by which time he was dead, and meanwhile passed on no details of Daniel's vulnerability to prison staff.

Daniel's sister Lisa was his next of kin and her full name and full address were always available to the prison. Whilst she had no home telephone number, no effort was made to contact her in any other way despite the fact that Daniel was heard again and again to cry out for Lisa and for his mum and his dad.

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His family were thus never told that he was in Health Care, or that there were anxieties as to his mental health, or that he had attempted self harm, and remain devastated that they were not so informed. They believe that contact from them would have helped to reassure Daniel, and certainly they would have been able to press for a transfer at a much earlier stage for Daniel to be committed to hospital under the Mental Health Act, and/or constantly observed rather than at 15 minute intervals in a cell which he clearly knew was capable of offering a ligature point.

Deborah Coles, Co-director of INQUEST said:

“This is a tragic case which highlights our concerns about the use of imprisonment for vulnerable young people. We hope that the coroner will examine the serious issues raised by Daniel’s time in the Health Care Centre at Doncaster YOI in detail.”

Lisa Clarke is represented at the inquest by INQUEST Lawyers Group member Ruth Bunday, of Harrison Bunday Solicitors.

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 on inquest procedures and their rights in the coroner’s courts.

There have been 186 deaths of young people aged 21 and under in prisons and YOIs from January 1995 to date. Two children aged 14 and 15 also died in the custody of the Youth Justice Board in 2004.

Deaths of young people in prison in England & Wales 1995-2007														
Classification	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Self-Inflicted	11	14	16	15	19	18	15	16	13	6	13	3	5	164
Non-Self-Inflicted	0	3	1	3	1	0	0	2	2	1	1	0	2	16
Homicide	1	0	2	1		2	0	0	0	0	0	0	0	6

Source: INQUEST Casework and monitoring

Further Information	www.inquest.org.uk
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