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CRITICAL VERDICT RETURNED AT THE INQUEST INTO THE DEATH OF VULNERABLE TEENAGER STEVEN HART

The inquest into the death of mentally ill teenager Steven Hart concluded today, having opened on 4 October 2007 before HM Deputy Coroner John Sleightholme sitting at Harrogate Magistrates Court.

The jury raised important concerns in a narrative verdict about Steven's discharge from hospital : the lack of clinical or evaluation notes from nursing staff, the police handling of Steven and his condition; the failure both to question Steven more persistently and the witnesses who reported his disturbed behaviour and the point police chose to set him down – an unlit road with no path and Steven being depleted through lack of food and drink.

John Brook, Steven's brother said,

"I wouldn't leave a dog where Steven was dropped off at the A1 junction or I'd get locked up".

Ruth Bunday of Harrison Bunday Solicitors, said on behalf of Steven's family:

"The family are very appreciative of the extensive investigation carried out by HM Coroner Mr Sleightholme and the painstaking attention given and questions asked by the jury. However an inquest held five years after the death has resulted in many totally unsatisfactory responses by witnesses to the effect that they 'would' have done such and such or 'must' have done this or that, rather than providing a real recollection of what happened.

The family remain convinced that Steven should never have been allowed to leave hospital on 26 September 2002 without seeing a doctor, without transport arrangements in place, to set out without money, food or drink on a ten hour walk which would end in his death. Steven's own consultant told the inquest that even when Steven was well he was still vulnerable and unpredictable."

Deborah Coles, Co-Director of INQUEST, said

"This case raises all too familiar systemic failings during the treatment and care of a vulnerable mentally ill teenager. Such tragic deaths must be rigorously and promptly scrutinised to ensure lessons are learned. A five year delay frustrates the learning process and the opportunity for safeguards to be put in place to protect the lives of vulnerable people in the future."

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Background

Steven Hart was 18 years old when he died, naked, on the A1 on 26 September 2002 just after 10pm. Having discharged himself from a psychiatric ward at the Friarage Hospital, Northallerton at approximately 12.30pm, he had wandered around the countryside for nine and a half hours, penniless, trying to find his way to his home in Harrogate.

Steven had been taken to Harrogate Hospital during the evening of 24 September 2002 by his mother and sister in law in a disorientated state. He had a history of paranoid schizophrenia and agreed to his admission to a psychiatric ward he knew well and where he was well known to staff. However, after his family had left it was discovered that there was no bed available and he was transferred to a hospital strange to him and many miles away in Northallerton. His family was not informed.

Steven's condition remained deeply disturbed for the whole of 25 September, but by the following day he appeared to have stabilised, and sought to discharge himself. No transport could be arranged immediately and Steven chose to leave, though he asked a nurse to show him the way out as he could not read the signs to the hospital exit and could not remember his admission.

Thereafter a total of four 999 calls were made by members of the public who observed Steven's strange behaviour, lost and vulnerable, wandering apparently in circles trying to find a road home. The first alarm call was not connected to later calls to Force Control due to a shift change, but calls around 8pm, by which time it was dark, led to a police officer giving Steven a lift to the A61 road to Ripon and Harrogate at its intersection with the A1. Steven set off again on foot but was observed some twelve minutes later retracing his steps over the A1 once more, and within a further four minutes observed on the A1 itself by a concerned motorist who rang 999, walking southbound down the fast lane of the northbound carriageway. Less than an hour later, having removed his clothes, he was run over in a similar position and killed. No blame attaches to the motorist concerned.

Steven's mother was represented at the inquest by INQUEST Lawyers Group member Ruth Bunday of Harrison Bunday solicitors in Leeds.

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.

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