

PRESS RELEASE

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CATALOGUE OF FAILINGS BY POLICE AND MEDICAL STAFF CONTRIBUTED TO THE DEATH OF DANGEROUSLY ILL MAN

The jury at the inquest relating to Mark Camm, who died in June 2004 having been held at Wood Street police station in Wakefield, today catalogued a shocking series of failings on behalf of all those who dealt with him - failings which contributed to his death.

Mark Camm was arrested on suspicion of being drunk and disorderly and subsequently spent more than 24 hours in a police cell. He was unable to speak, spent most of his time in custody motionless, showed difficulty in walking and ultimately collapsed on his cell floor. Police actions were influenced throughout by incorrect assumptions about Mark. When he was finally taken to Pinderfields Hospital A&E, it was a further 13 hours before he was diagnosed as having a life-threatening brain condition. Mark died on 29 June 2004 in Leeds General Infirmary.

Disturbing CCTV and audio footage of Mark's time in police custody revealed what the jury described as "wholly inappropriate banter", which itself shifted attention away from his deteriorating condition. One expert medical witness commented that Mark's dog, who had been with him on arrest, appeared to have received better care than Mark.

The jury's conclusions detailed in a damning seven page narrative verdict included:

- Mark was wrongly identified as being drunk and disorderly and as refusing to speak.
- Police policy requiring detailed checks on vulnerable prisoners were not "adhered to at any time" resulting in many lost opportunities to check on Mark's condition
- Dishonest entries were made in the custody record.
- "The medical treatment Mark received by the Forensic Medical Examiners service deprived him of a realistic opportunity of a meaningful recovery."
- A wholly inadequate assessment was made at A&E which could have otherwise allowed Mark an opportunity for suitable treatment.

HM Coroner for West Yorkshire (Eastern District), David Hinchliff, made a rule 43 report recommending that the Chief Constable of West Yorkshire Police hold a full review of all the relevant CCTV and audio evidence and undertake a wide-ranging inspection of custody arrangements to determine if they are fit for purpose.

continues...

Inquest

Mark's family spoke after the inquest:

"Everybody failed Mark: whether police officers, doctors called to Wood Street police station, Wakefield, or doctors and nurses at the Accident and Emergency Department of Pinderfields Hospital.

Mark lost a chance of survival. But even if he had ultimately died in any event, his sisters lost the chance to be with him while he was still conscious, to reassure him, to remind him of how much his family loved him.

We thank Humberside Police for a tireless and painstaking investigation into the conduct of those who were responsible for Mark's care, and who let him down. We hope that lessons have been learned. But we fear that there will always be a lack of transparency and a culture of acceptance where corners are cut. Mandatory provisions for the care of prisoners were ignored when Mark was in custody, and records deliberately falsified. As 25 hours ticked by, and Mark remained speechless in a cell, his chances of survival ebbed away.

We will always be indebted to our solicitor, Ruth Bunday, for the tenacity with which she has represented Mark's interests."

Deborah Coles, Co-Director of INQUEST, said:

"The treatment that Mark Camm received was frankly shameful. The jury have detailed a litany of incompetence, prejudice and appalling practice by professional after professional. This case highlights INQUEST's ongoing concerns about the treatment of vulnerable detainees in police custody and we will be working with the family to ensure those responsible are held to account."

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 and conducts policy work on the issues arising.

INQUEST is campaigning to ensure that a Coroners Bill is included in the Queen's Speech in December. Without fundamental reform the inquest system will continue to be hampered by delay, inconsistency of approach and lack of resources and be 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.

Further Information	www.inquest.org.uk
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