

PRESS RELEASE

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JURY FIND RESTRAINT AND NEGLIGENCE CAUSED DEATH OF BELMARSH PRISONER GODFREY MOYO

Sitting before HM Deputy Coroner for London (Inner South), Andrew Walker
HM Coroner's Court, Tennis Street, London SE1 1YD

The inquest into the death of 25 year old Godfrey Moyo whilst on remand at HMP Belmarsh concluded today with the jury deciding that the medical cause of his death was (a) positional asphyxia with left ventricular failure following restraint and (b) epilepsy.

In their damning narrative verdict the jury found that:

"On 3 January 2005 at approximately 2.50am at Belmarsh prison Mr Godfrey Moyo suffered an epileptic fit in his cell. Prison officers were alerted and together with a nurse were dispatched to the cell. Upon regaining consciousness, Mr Moyo experienced post-ictal behavioural disturbance and attacked a cellmate.

Prison officers entered the cell to bring Mr Moyo under control. A vigorous struggle ensued between Mr Moyo and five prison officers in which three officers sustained injuries.

Prison officers brought Mr Moyo to the floor on the landing outside the cell. Full control was achieved immediately. Mr Moyo was then restrained in the face down prone position for approximately 30 minutes.

During this time Mr Moyo suffered at least two further fits, followed by periods of unconsciousness in which his breathing was restricted as a result of his position.

Mr Moyo began to suffer from the effects of positional asphyxia. The first nurse on the scene failed to adequately monitor Mr Moyo's condition during the restraint, which contributed to his death by neglect.

The prison officers also failed to recognise the signs of distress being shown by Mr Moyo during the restraint, as highlighted by their control and restraint training. At no time during the restraint by any persons present was an attempt made to move Mr Moyo off his front as per the control and restraint guidelines or place him in the recovery position during periods of unconsciousness.

Upon arrival of the second nurse, Mr Moyo was lifted from the prone position and carried to the health care centre. Throughout the move Mr Moyo was unconscious.

Inquest

Upon arrival to the health care centre at approximately 3.30am Mr Moyo was placed in the Intensive Care Cell in a kneeling position against the cell bed with his upper chest and head resting on the mattress. His head was resting on the mattress while in a kneeling position Mr Moyo remained under restraint.

A doctor prescribed a 2ml intra muscular dosage of Lorazepam by telephone. The second nurse administered the drug to Mr Moyo and exited the cell followed by the prison officers.

Mr Moyo died in the intensive care cell between 3.30 to 3.50am. The second nurse failed to adequately monitor Mr Moyo's condition while he was in the intensive care cell, which directly contributed to Mr Moyo's death by neglect. The first nurse raised concerns on her ability to monitor Mr Moyo's condition while he was in the ICS to the second nurse. However these concerns were not acted on.

In addition insufficient communication between the two nurses prevented the seriousness of Mr Moyo's condition being properly recognised, which meant that an ambulance was not called until too late, approximately an hour after Mr Moyo was placed in the intensive care cell.

The second nurse and prison officers re-entered the cell and discovered that Mr Moyo was not breathing.

CPR was commenced and an ambulance was called at 4.45 am. However resuscitation by staff at the prison, paramedics and hospital staff failed to revive Mr Moyo."

Lomaculo Moyo, Godfrey's sister, commented:

I have waited four and half years to hear what happened on 3 January 2005 in HMP Belmarsh. I have been brave enough to sit here to hear painful evidence of the appalling and inhumane way that my brother was treated by prison staff including nursing staff at HM Belmarsh.

The jury's verdict reflects the shocking evidence of what happened on 3 January 2005.

Godfrey was failed by a system that was meant to protect him – if staff had been doing their job properly his death could have been avoided.

Deborah Coles, Co-director of INQUEST said:

Dangerous restraint methods and neglect caused Mr Moyo's death. He was treated as a discipline and control problem rather than a human being in urgent need of medical treatment and care. The responsibility for his death rests with the Prison Service and we await their response to this damning verdict. INQUEST will be raising the serious issues in this case at a policy and parliamentary level.

Inquest

When explaining why he would make a detailed report (under rule 43 of the Coroners Rules 1984) in due course to ministers about how similar deaths can be avoided in future, HM Deputy Coroner said "where do I start?" and said he was concerned by the "complete lack of understanding of epilepsy among the staff including medical staff"– and "this seems to be a system that was fundamentally flawed."

The evidence that the jury heard included the following:

- Despite the fact that Godfrey Moyo suffered seizures twice in HMP Belmarsh (July and October 2004), there was no adequate care plan in place and no risk assessment, particularly as regards post-ictal violence.
- On the evidence of one nurse, the two nurses did not speak to each other at all; from the time that the nurses were together on the landing outside Godfrey Moyo's cell to when he was found dead in the cell in the Health Care Centre (i.e. a period of approximately 1.5 hours).
- One officer's evidence was that Godfrey Moyo was restrained until unconscious.
- All the officers gave clear evidence that they left Godfrey Moyo in the prone position for longer than absolutely necessary.
- Godfrey Moyo had unexplained injuries to his neck which one pathologist gave evidence were caused beyond reasonable doubt by compression of his neck.
- The recovery position is the only safe position in which to place an unconscious person.
- That staff failed to use a trolley although it was available.
- Some of the officers who gave evidence said that they were unable to recognise trigger signs of positional asphyxia notwithstanding their training.
- That Godfrey Moyo was not given the most appropriate medicine for his condition (rectal diazepam), despite the pharmacist finding it the following day.

Godfrey Moyo's family is represented by INQUEST Lawyers Group members, barrister Leslie Thomas of Garden Court Chambers instructed by Daniel Machover of Hickman and Rose Solicitors.

Notes to editors:

INQUEST has monitored a disproportionate number of deaths following restraint involving people from Black and Minority Ethnic communities This is the first restraint related death in prison since the deaths of three black men in prison in 1995, Dennis Stevens in Dartmoor prison on 11th October 1995, Kenneth Severin in HMP Belmarsh on 16 November 1995 and Alton Manning on 8 December 1995. See www.inquest.org.uk

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.

Further Information	www.inquest.org.uk
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