INQUEST
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PRESS RELEASE

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OVERWHELMING FAILINGS BY PRISON AND HEALTHCARE STAFF CONTRIBUTED TO DEATH OF VULNERABLE BLACK PRISONER AT HMP RYE HILL

An inquest jury sitting before HM Assistant Deputy Coroner for Northamptonshire, Tom Osbourne, today concluded that a catalogue of serious failings at the privately-run HMP Rye Hill caused or contributed to the death of 23 year old Michael Bailey who was found hanged in the segregation unit of the prison on 24 March 2005.

The jury concluded that the prison had failed in relation to every single aspect of Michael's care that they had been asked to consider and that there was a "*failure on the part of all staff to take responsibility for ensuring Michael Bailey's safety*".

During the five week inquest, distressing evidence was heard about the severe deterioration in Michael's mental health in the six days prior to his death. Michael, who had previously been described by all as a confident outgoing person, began to exhibit severe symptoms of psychosis, often crying uncontrollably, stating the walls and demons were speaking to him and telling staff at the prison he was ready to die. Michael had written a detailed farewell note to his family and on one occasion walked around the exercise yard naked for two hours reciting the Lord's Prayer.

The jury found that both prison and medical staff:

- failed to undertake an adequate mental health assessment;
- failed in their communication about his condition and care needs;
- failed to recognise the serious nature of his condition;
- failed to move Michael out of the segregation unit into healthcare when it became clear that he was at risk;
- failed to place him in a safe cell;
- failed to do all that could be reasonably be expected to prevent Michael hanging himself.

During the inquest the jury had heard that, despite a suicide and self harm monitoring form (F2052SH) being opened for Michael, key events were not recorded in it and the document was rarely read by staff. Observations required to keep Michael safe, which were supposed to be carried out six times an hour, did not take place and staff admitted to routinely falsifying these records. Indeed, when Michael was discovered motionless behind his cell door on the 24 March, an officer was instructed to falsify the watch records before going to provide assistance.

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The jury also criticised the lack of trained and experienced staff, the lack of effective management and fundamental systems failure in dealing with suicide and self harm.

Deborah Coles, co-director of INQUEST, said:

> *"The shocking circumstances of Michael Bailey's death, the first of three controversial deaths at the privately-run HMP Rye Hill, highlight both an appalling breakdown in procedures designed to protect life and uncaring and inhumane treatment of a vulnerable man. However, what is more concerning is that this represents not just a series of shameful individual failures, but a fundamental failure by the Prison Service to ensure that privately-run prisons are safe and meet acceptable standards for those in their care."*

Michael's mother Caroline Bailey commented:

> *"Over the past few weeks, I along with Michael's family and friends have endured hearing the details of the painful and dreadful last days of my dear son's life.*
>
> *We have listened as staff blamed each other as to why nothing was done to alleviate Michael's suffering as he cried out for help. If just one of those involved had done their job properly, Michael could still be with us. They, each and every one owed Michael a duty of care and they failed him time and time again. I do not know how they can live with themselves."*

Michael Bailey's family were represented by INQUEST Lawyers Group members barrister Leslie Thomas of Garden Court Chambers, instructed by Nogah Ofer of Hickman and Rose Solicitors.

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Notes to Editors:

1. 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.

2. Following the death of Michael Bailey a police investigation was conducted which resulted in charges being brought against four officers. Paul Smith, Daniel Daymond and Samantha Prime were charged with gross negligence manslaughter. Ben King was charged with intending to pervert the course of justice and Daniel Daymond charged that he counselled or procured Ben King to do so. All charges were dismissed by the judge half way through proceedings in response to a submission that there was no case to answer.

3. In her inspection report dated June 2005, the Chief Inspector of Prisons, Anne Owers, found that "the prison had deteriorated to the extent that we considered that it was at that time an

unsafe and unstable environment, both for prisoners and staff." She was so concerned by the state of Rye Hill prison that she "immediately informed ministers and urged the chief executive of the National Offender Management Service to take immediate and decisive action". The report contains accounts of assaults, deaths, hostage-taking, indiscipline and high availability of drugs, drink and mobile telephones for prisoners. Inspectors also found inexperienced, inadequately supported staff in charge of large numbers of prisoners.

4. HMP Rye Hill is a privately-run prison near Rugby which opened in early 2001.

5.

Homicides and self-inflicted deaths in HMP Rye Hill 2001-date				
Name	Ethnicity	Age	Date of Death	Classification
Aleskey Baronovsky	Ukrainian White	34	10/06/2006	Self-Inflicted
Wayne Reid	UK Black	44	13/04/2005	Homicide
Michael Bailey	UK Black	23	24/03/2005	Self-Inflicted