

## PRESS RELEASE

For immediate release 30 November 2009

### JURY RETURNS VERDICT OF MISADVENTURE CONTRIBUTED TO BY NEGLECT AT INQUEST INTO DEATH IN MIDDLESBROUGH POLICE STATION OF MOYRA STOCKILL

Today the jury returned a verdict of misadventure contributed to by neglect at the inquest into the death of 61 year old Moyra Stockill in Middlesbrough police station on 10 December 2003. The inquest has heard damning evidence about the circumstances of Mrs Stockill's death. She was found dead in a cell just hours after being conveyed from St Luke's Psychiatric Hospital where she had been detained under section 3 of the Mental Health Act.

The jury heard that on 10 December 2003, Moyra Stockill was failed by everyone with whom she came into contact. The nurse in charge of the High Dependency Ward at St. Luke's Psychiatric Hospital allowed her to be removed, unlawfully, to a police station. Senior medical staff and managers had ample opportunity to alert the police, by a simple telephone call of a few seconds duration, of the risks she posed to herself. Mrs Stockill had a habit of placing things in her mouth, including tissues, which could lead to a risk of choking. She always alerted staff by pointing after this had occurred.

The Custody Sergeant who accepted Mrs Stockill into detention failed to carry out a proper risk assessment or to cause proper enquiries to be made of the hospital. She failed to pass on what information was available to a colleague who saw Mrs Stockill pointing at her throat.

Mrs Stockill's daughter, Clare Barker, said:

*This inquest has clarified the catalogue of gross failings by NHS and police staff. The devastation they have caused me and my family cannot be put into words. I am appalled by the standard of care which my mother received. I hope no other family ever has to endure the same pain and suffering, which is ongoing.*

Ruth Bunday, of Harrison Bunday, solicitor for the family said:

*We are really grateful to the jury for their careful consideration, over such a long period, of these tragic events.*

Deborah Coles, Co-Director, of INQUEST said:

*This entirely preventable death of an extremely vulnerable woman must result in decisive action to address these gross failings so we can be assured that the same kind of tragedy will not be repeated.*



Moyra Stockill's family was represented at the inquest by INQUEST Lawyers Group member Ruth Bunday of Harrison Bunday Solicitors, Leeds.

**Notes to editors:**

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.

INQUEST is represented on the Ministerial Council on Deaths in Custody and the Ministry of Justice Coroner Service Stakeholder Forum.

Further Information	<a href="http://www.inquest.org.uk">www.inquest.org.uk</a>
Ruth Bunday, Harrison Bunday Solicitors	office 0113 237 4047
Deborah Coles, Co-Director of INQUEST	office 020 7263 1111