

## PRESS RELEASE

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### FAMILY VINDICATED BY NEGLIGENCE VERDICT AT SECOND INQUEST INTO DEATH OF PAUL CALVERT IN HMP PENTONVILLE

The jury at the inquest into the death of 40 year old Paul Calvert in HMP Pentonville in 2004 today returned a verdict of accidental death contributed to by neglect. The inquest was held before HM Assistant Deputy Coroner for Inner North London, Gail Elliman, at St Pancras Coroner's Court, London.

This was the second inquest in this case. Following the first inquest into Paul's death in March 2007, his family brought a successful legal challenge in the High Court. The original verdict was quashed in April 2009 as the coroner had unlawfully failed to allow the jury to find neglect, and directed them that they could not leave judgmental narrative conclusions.

Paul Calvert was found hanging in his cell in Pentonville on 24 October 2004, less than two days after being remanded into the prison. Paul was known to have problems with drugs and alcohol and had a history of self-harm and suicide attempts.

There was evidence at the inquest to show:

- Prison officers failed to pay proper attention to the emergency cell alarms, taking part in games of backgammon instead of answering those alarms.
- The audible alarm for the emergency cell bells had been disabled so that it made no noise for a period of up to 18 months.
- There were no systems for maintenance of the alarm panels.
- There was widespread practice of officers expecting prisoners to answer the emergency cell alarms.
- Officers failed to take adequate steps to prevent misuse of the emergency alarm system.
- The assessment of Paul's risk of suicide was inadequate.

A number of other issues were raised, such as the system for the retrieval of past records, staffing and training.

The coroner directed the jury that they could leave a verdict of neglect if they thought one or a combination of several failings had a clear causative link to the death.

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# Inquest

Deborah Coles, Co-Director of INQUEST, said:

*This is a vindication of Paul's family's determination to obtain a just verdict despite the legal setbacks they encountered. The evidence heard about the neglect of basic health and safety at HMP Pentonville must result in all prisons examining how they discharge their duty of care, especially to vulnerable prisoners.*

Paul Calvert's family was represented at the inquest by INQUEST Lawyers Group members Valentina Santambrogio of Coninghams Solicitors and barrister Adam Straw of Took's Chambers.

## 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.

Further Information	<a href="http://www.inquest.org.uk">http://www.inquest.org.uk</a>
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