



UNITED CAMPAIGNS FOR JUSTICE

Death in Police Custody

Report on the death of David Green

1997

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An avoidable death while in police custody

Summary of the case

David Green was found hanging in Hartlepool police station on 31 March 1997. He never regained consciousness and was declared dead in hospital on the 2 April 1997. The inquest into his death took place a year later in front of HM Coroner for Hartlepool and lasted from 20 to the 25 April 1998.

David was one of four children of David and Barbara Green and was 15 years old. On the evening of 30/3/97 he was found by householders to have broken into their home. Understandably they called the police. When police arrived David was sobbing and pleading. The householders told the inquest into his death that David threatened on more than one occasion, in the presence of the police that he would kill himself if he were taken to the police station. The two officers denied that this was said, claiming that the youngster bizarrely announced that he was going to 'hurt' himself and promptly headbutted the doorframe twice.

The arresting officer PC Johnston, did not relate the bizarre behaviour of David Green upon arrest because he did not see that it was relevant. As far as he was concerned the incident was over and was merely an attempt by David to persuade the occupants of the house not to press charges.

On arrival at the police station Custody Sergeant Harrison recorded 'Under the influence of something' in the custody record and placed David in an adult cell. This is contrary to the Police and Criminal Evidence Act 1984 Codes Of Practice on the detention of juveniles, which state that juveniles should be normally located in a detention room unless special recorded reasons apply. Sgt Harrison did not record any reason for this location but told the inquest he had placed David in an adult cell because it had a toilet. A juvenile detention room that was close to the custody officers' desk for safety reasons was vacant at the time but disregarded. The cell bells were not working at the time. (The faults had still not been rectified five months after his death) Shouting for help from the cell where David was located was unlikely to be heard or distinguished.

Neither Sgt Harrison nor PC Clarke his custody assistant asked David if he had taken drugs and if so what, despite him having in his possession a bottle containing 6 Temazepam tablets and him being unsteady on his feet. PC Clarke told the inquest that he thought that David appeared to be under the influence of either drink or drugs. Guidelines state that a police surgeon must see a prisoner of any age if there is a chance that drugs have been taken. Temazepam causes drowsiness and confusion when first taken and as it wears off there can be short-term memory loss, feelings of anxiety and guilt. Side effects can include paranoia, depression and suicidal tendencies.

Five weeks before his death David had been detained at Hartlepool Police station by a different Custody Officer Sergeant Chaffer in virtually identical circumstances. On that occasion he had in his possession a bottle of 12 Temazepam tablets. Close questioning by the Custody Sergeant elicited the information from David that he had taken 10 tablets and a police surgeon was immediately called and David placed in a juvenile detention room close by, with regular recorded checks by the Custody officer himself. The custody record was marked 'Intoxicated due to drugs'. Custody of David on that occasion was later taken over by Sgt Harrison and PC Clarke who were given a detailed handover and had full knowledge of the drugs background. Unbelievably both men denied at the inquest this involvement or that they had ever seen David before.

On 31/3/97 David was interviewed and expressed horror to find, that under the influence of drugs he had committed a burglary, something he had never done before, having previously committed shoplifting offences. During the interview David admitted having taken between 10 and 14 Temazepam (sleeping) tablets with alcohol that day before. The interviewing officers did not pass this information to the Custody Sgt. By now the effects of the drugs David had taken would be wearing off.

At this stage David could have waited in the custody area with his father while the charge sheet was prepared but was once again returned to an adult cell with no recorded reason for his location. No reassessment of his potential vulnerability took place. This was despite the fact that he now knew from Detective Constable Mason and his solicitor Mr Townsend that he would not be bailed back to his home address but would be spending the night at a local authority home prior to going to court the following morning. His solicitor had additionally told him that a custodial sentence was likely. His father who had never been told about his son's distress, threats to self-harm or his strange actions upon arrest told him off for his behaviour. On the way to the cell David asked for and was given his jacket, the waistband cord of which he was fatally, to use. No officer who gave evidence at the inquest could explain who had given him his jacket. (Evidence about the jacket came from the pathologist Dr Cooper who had been given this information from police officers shortly before carrying out his post-mortem, and from David's father. One of the paramedics noticed the jacket in the cell when trying to revive David.)

Approximately 50 minutes passed before David was found hanging during which time he had not been checked. Juveniles must be visited more than once an hour and at Hartlepool like most police forces checks are supposed to take place half hourly. David was

found hanging from the protruding and useless bell push by the drawstring from his jacket and was effectively dead. His father still in the station watched helplessly as officers tried unsuccessfully to revive David.

Treatment of the family

Following David's death on the 2 April his family received absolutely no communication whatsoever from the Cleveland Police, not even an expression of sympathy. The only contact that they had was when David lay dying in intensive care when David's father was asked to give a statement. After David's death they were then given absolutely no information or communication from anyone concerned – neither the Police nor the Police Complaints Authority. On receipt of a letter from INQUEST complaining about the lack of information given to the family the PCA did finally contact the family.

The family was put in contact with INQUEST by a sympathetic local media contact and we arranged for them to be legally represented at the inquest by solicitor Ruth Bunday. Unlike the police whose legal costs are paid for by the public purse legal aid does not extend to representation at inquests.

The police investigation

INQUEST is concerned that the Cleveland Police itself carried out the investigation into the death. Given the exceptionally serious nature of the death it would have been appropriate to have the death investigated by an outside force. Statements taken as part of the investigation can only be viewed as an attempt to exonerate the conduct of Hartlepool police officers. Officers most closely involved with David's care were not questioned about how David came about his coat or their knowledge of the broken cell bells. Two press releases released by the Police Complaints Authority after David's death gave conflicting information as to where in the police station he was located.

The inquest verdict

The Coroner refused to allow the inquest jury to consider whether neglect contributed to his death and they returned a verdict of 'Accidental Death'. Following the verdict the Cleveland Police issued a statement saying they were reassured that the Coroner was satisfied that nothing done by any of the officers who dealt with David contributed to the death. There was clear evidence at the inquest about failings in the care of David. The narrow remit of the inquest and the limitations of verdicts within existing inquest law meant the coroner did not allow the jury to consider 'neglect' as a possible verdict. It was therefore disingenuous of the Cleveland Police to imply that the verdict of Accidental death meant that they were beyond any criticism and further added to the indifference they had displayed about David's death from the outset.

Comment

An impulsive act, perhaps a cry for help and an attempt to avoid a remand in custody, resulted in a tragedy, unheard and unseen by those who had care and custody of the youngster. David was the youngest person ever to die in police custody. His death should send a clear warning to police forces around the country about the particular vulnerability of young people held in cells and the need for greater vigilance and monitoring. This death raises profound questions about the care afforded juveniles in police stations and about the adequacy of current guidelines within the Police and Criminal Evidence Codes of Practice and of their implementation. None of the police officers that had any involvement with David had received any specific training in suicide/self harm awareness or in drug awareness despite evidence at the inquest from the Chief Constable of Cleveland Police that all police officers received such training. There was a gross failure to care legally and properly for a vulnerable young boy and failures of communication between arresting, custodial and interviewing police officers, which proved fatal to his welfare.

INQUEST has raised its concerns about this case with Home Office Ministers, the Hartlepool MP and the Police Complaints Authority.