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89-93 Fonthill Road, London N4 3JH
Phone: 020 7263 1111 Fax: 020 7561 0799
inquest@inquest.org.uk www.inquest.org.uk

PRESS RELEASE
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JURY RETURN CRITICAL VERDICT AT INQUEST INTO THE DEATH OF 23 YEAR OLD GRAFFITI ARTIST IN HMP CAMP HILL

An inquest jury at the Isle of Wight Coroner's Court returned a critical verdict on Friday 26 November 2010 highlighting multiple failures in the care provided to Tom Collister in prison.

Tom Collister, aged 23, was found hanging in his cell in HMP Camp Hill on the morning of 7 February 2009. He was from Greater London, and was given a sentence of 30 months in October 2008 for criminal damage and graffiti. He was initially remanded to HMP Wandsworth, a local prison, along with his co-defendants, where he was visited regularly and supported by his family and girlfriend. In January 2009, without any explanation and while he was in the middle of a skills course and awaiting a medical appointment, Tom was transferred to HMP Camp Hill on the Isle of Wight, a distance that made visiting him difficult. His co-defendants remained in Wandsworth.

On 3 February 2009 Tom's sentencing appeal was heard in London and his sentence was reduced by 10 months. Tom believed that he would be kept in London for the remainder of his sentence and was extremely distressed when he was informed by prison escort staff that he would be sent back to Camp Hill. He was found dead in his cell four days later.

During the five day inquest the jury listened to phone calls made by Tom to his girlfriend and mother describing his time in Camp Hill as being unbearable, referring to the prison as "Concentration Camp Hill."

Although the jury found that the procedure for prisoners being checked for fitness to travel before leaving prison but not before leaving the Court of Appeal to return to prison was adequate, the night patrol system on the night of Tom's death did not provide adequate supervision to ensure prisoner safety on the wing. They also found that the response of the prison officer who discovered Tom's body was inadequate and that officers had not been given adequate training on how to react in an emergency to suspected suicide or self-harm and also inadequate first aid and resuscitation training. The inquest heard from the key officers involved on the night that Tom died that they had not read the relevant policies, much less been trained in how to respond to an emergency situation such as the one that arose on the morning that Tom died.

HM Assistant Deputy Coroner Hugh Calloway was sufficiently concerned by these officers' evidence that he has promised to report the shocking lack of training and inadequate supervision within HMP Camp Hill to the Ministry of Justice, National Offender

Management Service and the prison's governor under his rule 43 powers requiring that these inadequacies be addressed forthwith.

The family always believed that Tom did not intend to kill himself and that his death was a cry for help which went desperately wrong and are pleased the jury agreed with them and found that he did not intend to take his life.

Sara Lomri, solicitor for Tom's mother, Mrs. Collister, said:

> *The inquest heard a lot of complex evidence. It was important to the family that facts of the case were properly investigated so that they could be put before the jury. The jury's highly critical verdict of systematic and individual failings on the night Tom died is a testament to Tom's family's commitment to ensuring that justice was done.*

Tom's father, Martin Collister, said:

> *Tom hated it at HMP Camp Hill and we as his family believe that as a non-violent prisoner he should never have been sent there. Tom was convicted of criminal damage and given the longest sentence for graffiti in the country and was made an example of. Had his sentence been less severe he would not have been able to have been sent to HMP Camp Hill. We have been shocked by some of the evidence and errors that have come to light. The evidence shows that Tom was let down by a catalogue of errors which we believe contributed to the death of our beloved Tom.*

Deborah Coles, Co-Director of INQUEST, said:

> *The tragedy of this case was the decision to imprison Tom Collister in the first place. It is well recognised that prisoner's vulnerability is exacerbated by the lack of family contact and support in prison. The procedures for transferring prisoners must be reviewed in light of this tragic death as well as the clear failings in officer training.*

Tom Collister's mother was represented by barrister Kate Annand of Doughty Street Chambers, instructed by INQUEST Lawyers Group member Sara Lomri of Bindmans LLP.

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.

Please refer to INQUEST the organisation in all capital letters in order to distinguish it from the legal hearing.

Further Information	www.inquest.org.uk
INQUEST	office 020 7263 1111
Sara Lomri, Bindmans LLP	office 020 7833 4433