7 April 2022

MEDIA RELEASE

Kelly Hartigan-Burns: Inquest finds litany of failures in Lancashire police custody death

Before HM Senior Coroner Dr James Adeley
Preston Coroner's Court
28 February – 7 April 2022

Kelly Hartigan-Burns, 35, died in 2016 after being arrested and put in a Blackburn police cell whilst in a mental health crisis. An inquest has now confirmed what Kelly's family have been made to agonise over since she died – that the police officers who took responsibility for Kelly that night failed her at every turn.

They jury concluded that "if officers had shown more compassion, acted diligently, practiced common sense, followed guidance and procedure from the moment they found Kelly and throughout her detention there may have been a different outcome."

The jury gave an open conclusion with a narrative detailing a litany of failures which contributed to Kelly's death, including the failure to record previous incidents on the system, to obtain and relay the relevant information, and in the management of Kelly in the custody suite.

Kelly was failed by Lancashire Constabulary at every level, from the control room, to the response on the street, in her home and at the police station. The jury identified significant individual and corporate failings. The family feel the jury's conclusion vindicates their long battle over the past six years for this wrongdoing to be recognised.

In October 2021, a finding of gross misconduct at a professional standards hearing was made against Jason Marsden, the custody sergeant involved in Kelly's death, barring him from returning to work for the police.

BACKGROUND
Kelly was found unresponsive in a cell at Greenbank Police Station in Blackburn at around 1.30am on 4 December 2016, having self-ligatured. She was taken to hospital and put on life support where on 5 December 2016 she was pronounced dead.

Originally from Bolton, Kelly lived in Darwen with her civil partner Cal Hartigan-Burns. Cal sadly died in 2019 before learning the full details of what happened to Kelly.

Kelly's family describe her as a bright and positive person. Although her mental health was impacted by the sudden and traumatic death of her father when she was a teenager, she went on to get her degree and to work as a substance misuse practitioner.

Kelly's history of mental ill health, self-harm and alcohol misuse brought her under the care of community mental health professionals at East Lancashire NHS Trust. By the end of November 2016, her family had become increasingly concerned about her.

It took more than five years for Kelly's death to become the subject of an inquest, following protracted decision making by the then Independent Office for Police Conduct and the Crown Prosecution Service, and following the disciplinary hearing for Jason Marsden.

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KEY EVIDENCE

Late on 3 December 2016, a member of the public called 999 and reported seeing Kelly walking in and out of traffic in her pyjamas saying she wanted to die. Lancashire police officers attended and took her home to her partner, Cal, who was a mental health nurse.

Until her death in 2019, Cal maintained that she had told the officers that Kelly was a suicide risk and that she was worried that Kelly would try to tie something around her neck. She recalled discussing previous incidents with officers who agreed that Kelly was at risk of suicide.

The incident logs shown during the inquest recorded five separate incidents in the preceding 12 months, including numerous references to mental ill health, attempts to ligature, and detention under section 136 of the Mental Health Act 1983.

Instead of using their mental health powers to take Kelly to a place of safety, police arrested her for common assault arising from an argument she had had with Cal earlier that evening. Officers took her to Greenbank Police Station, still in her pyjamas. None of the information about Kelly's history or risk of self-harm featured in the decision to put her in a cell.

While she was being booked in, a custody detention officer sought to forcibly remove Kelly's wedding rings and later attempted a leg swipe on Kelly – a use of force she was not trained in – resulting in the detention officer kicking Kelly.

The custody sergeant who booked her in did not even ask Kelly's name. Even once it became known to custody staff that Kelly was on psychiatric medication and had a warning marker for suicide on her record, no steps were taken to keep her safe.

No one went to speak to her and she was not placed in a CCTV cell, even though there was a vacant one beside the cell where she died. The custody sergeant then left two hours early without checking on her. His colleagues didn't either, until Kelly was found unresponsive in the cell and was taken to hospital where she later died.

Evidence emerged during the inquest that there had a been a near-miss incident earlier in 2016, due to arresting officers' failure to relay to custody that the detained person had suffered a head injury whilst being transported there. That person was then admitted to A&E where a brain bleed was discovered.

There had also been an inspection in May-June 2016 by HM Inspectorate of Constabulary into Lancashire Constabulary's custody suites. The resulting report highlighted confusion about safeguarding procedures, failures to treat detained persons with respect and dignity, as well as the overuse and under-recording of physical force against detainees.

It appears that lessons from the near-miss and critical inspection were not addressed by Lancashire Constabulary with any effective change, and Kelly died just months later in their custody.

CONCLUSIONS

After hearing four weeks of evidence, the jury concluded Kelly died "of a self-applied ligature of unknown intention". Alongside this open conclusion, the jury gave a critical narrative conclusion.

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They found the following issues contributed to Kelly's death:

- The absence of information relating to multiple episodes of attempted self-harm and suicide, as evidenced in police intelligence logs, which could have been recorded or accessed in Police National Computer warning markers and 'Protecting Vulnerable People' reports.
- The lack of training by Lancashire Constabulary Frontline officers concerning in which circumstances Police National Computer markers should be created, which contributed to a lack of markers on the system and thus her death.

The jury also found that the senior attending officer, who was first on the scene, should have requested more information from the control room regarding the suicide marker that was recorded. The incident was initially graded as a 'threat to life', but the jury found no evidence to suggest that the senior officer attending informed other key officers involved about why that was, or of any potential risk of self-harm or suicide by Kelly. This was among other serious failures in communication between officers highlighted by the jury.

The jury also found the manner in which Kelly was treated and overall management of her within the Greenbank custody suite increased the risk of suicide or self-harm in custody. This included the failure to build rapport, explain the process, and the use of force against her, which all contributed to her increased agitation.

The coroner will now consider the issues Lancashire needs to address to prevent future deaths. At present, the systems with respect to warning markers remain the same as when Kelly died.

June Hartigan, Kelly's mother, responded on behalf of the family: "*Today we thank the jury for their careful consideration of the evidence and their extremely serious criticisms of every layer of Lancashire Police. It's now a matter of public record – and enduring shame – how Lancashire police officers treated Kelly that night.*

For the last 5 years we have been tortured by what we knew must have happened, by all the things the police did wrong, and all the ways in which Kelly might have been saved. While it helps to hear that the jury could see the same level of wrongdoing, the fact it has taken five years to reach this stage means this is something of a hollow victory.

The last 5 years have been agonising. We spent years challenging IOPC and CPS decision making. It seems now that the IOPC failed to gather the evidence which would have allowed the jury to consider corporate manslaughter as a conclusion."

Kelly was beautiful, clever, and funny and she should still be here with us today. She was a loving daughter, granddaughter niece, sister, aunt."

Bhatt Murphy who represented June Hartigan, Kelly's mother, and Stuart Hartigan, Kelly's brother said: "*After considering 17 days of live evidence the jury concluded that a myriad of failings led to Kelly's death. Kelly's family were entitled to place their trust in police officers to keep Kelly safe. In failing to consider glaringly relevant information or perform an adequate risk assessment on the highly vulnerable person they had taken into their custody, Lancashire Constabulary violated that trust. Troublingly, there is little evidence to show that Lancashire Constabulary have learned from the failures which led to Kelly's death or implemented changes to prevent future tragedies."*

Deborah Coles, Director of INQUEST, said: "*Kelly was a woman in mental health crisis, in need of care and specialist support – not custody. Police officers treated her distress, vulnerability, and suicide risk with reckless indifference.*

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The inaction and abject failure to follow police guidance and derogatory attitudes towards Kelly resulted in her preventable death.

This is reflective of a misogynistic culture within policing affecting the treatment that women receive. Lancaster Police at a senior management level were put on notice about the safety risks to detainees. That they failed to act shows institutional resistance to learning and meaningful change for which they should be held to account."

ENDS

NOTES TO EDITORS
For further information and photos contact Amy Ooi on a.ooi@bhattmurphy.co.uk.

The family are represented by INQUEST Lawyers Group members Carolynn Gallwey and Amy Ooi of Bhatt Murphy solicitors and Fiona Murphy of Doughty Street Chambers.

Journalists should refer to the Samaritans Media Guidelines for reporting suicide and self-harm and guidance for reporting on inquests.

Gross misconduct charges against police involved:
A Lancashire police hearing concluded last October with a finding of gross misconduct against the custody sergeant who booked her in. The misconduct hearing found that Police Sergeant Jason Marsden did breach professional standards and this was gross misconduct.

Marsden, 51, retired just under a month before the hearing. The sanction for gross misconduct in this case would have been dismissal without notice, had he still been in post. He has been barred from working in the police in future. See media release.

INQUEST is the only charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes death in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question, such as the deaths and wider issues around Hillsborough and Grenfell Tower. Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people.

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

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