Joint Committee On Human Rights Written Evidence

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13. Memorandum from Inquest

1. INTRODUCTION

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families and friends of those who die in custody to provide an independent free legal and advice service to bereaved people on inquest procedures and their rights in the Coroner's Court. We provide specialist advice to lawyers, the bereaved, advice agencies, policy makers, the media and the general public on contentious deaths and their investigation. We also monitor deaths in custody where such information is publicly available and identify trends and patterns arising.

INQUEST is unique in working directly with the families of those who die in all forms of state custody—in which we include deaths in prison, young offender institutions, immigration detention centres, police custody or while being detained by police or following pursuit, and those detained under the Mental Health Act as they involve people whose liberty has been taken away.

We have accrued a unique and expert body of knowledge on issues relating to deaths in custody and seek to utilise this towards the goal of proper post-death investigation and the prevention of custodial deaths. INQUEST has been at the forefront of working alongside bereaved people to bring the circumstances of the deaths into the public domain and under public scrutiny and to hold the relevant authorities to account. We have reported our concerns about custodial deaths and their investigation at a national and international level.[141] We were also consultants to the Liberty project on deaths in police custody and many of our recommendations were endorsed in their final report.

There have been a significant number of high profile deaths in custody that have raised public and parliamentary disquiet. This legacy needs to be fully understood if we are to move forward and ensure that the custodians are truly accountable to the community they serve.

INQUEST has supported families' calls for a full public inquiry into the issues raised by deaths in custody for many years but these have received a negative response from government. INQUEST has been frustrated by the failure to learn the lessons from deaths occurring in different custodial settings and the lack of joined up learning between agencies. In our view this has resulted in more deaths occurring because of the failure to approach this serious human rights issue in a holistic way. Many of issues arising from deaths in custody need to be fed into the wider agenda for social inclusion of government, local authorities and voluntary sector. Many of the deaths which occur are part of a pattern which impact on policies on combating racism, drug and alcohol use, homelessness, mental health, crime prevention and policing.

To this end we recommend the setting up of a Standing Commission on Custodial Deaths which would bring together the experiences from the separate investigation bodies set up to deal with the police, prisons, hospital deaths and the others. Such an over-arching body could identify key issues and problems arising out of the investigation and inquest process following deaths and it would monitor the outcomes and progress of any recommendations. It could also look at serious incidents of self-harm or near deaths in custody where there is a need to review and identify any lessons. Arising from this it would develop policy and research, disseminate findings where appropriate and encourage collaborative working. Lessons learnt in one institution could be promoted in the other institutions, best practice could be promoted and new policies designed to prevent deaths could be drafted and implemented across all the institutions. It would play a key role in the promotion of a culture of human rights in regard to the protection of people in custody.

It should also have powers to hold a wider inquiry where it sees a consistent pattern of deaths. Such an inquiry could give voice to and a platform for examination of those broader thematic issues and those issues of democratic accountability, democratic control and redress over systemic management failings that fall outside the scope of the inquest. One of its functions would also be to lay the past to rest and assisting the process of effecting real and meaningful change.

This submission details current concerns arising from our casework and monitoring of the investigation and inquest process following deaths in custody. In the last ten years 1824 men, women and children have died in police and prison custody.[142] Many of these deaths raise concerns about inhuman and degrading treatment, systemic failings and the unlawful use and abuse of force. Since 1990 there have been nine unlawful killing verdicts returned at inquests into these deaths and no successful prosecution of any police or prison officer.[143]

We draw the committee's attention to:

— The increasing number of deaths in police and prison custody—a disturbing number raising concerns about inhuman and degrading treatment;

— deaths due to alleged drunkenness or drug intoxication;

— deaths involving poor medical care;

— fatal shootings;

— police pursuits—an increasing percentage of police related deaths are following pursuits or otherwise involving police vehicles;

— the lack of accountability and transparency in the investigation process;

— the disproportionate number of deaths of black people following the use of force;

— the poor treatment of the mentally ill in custody and inadequate medical care;

— the lack of central collection and collation of information on deaths of detained patients and monitoring of the issues arising from inquests;

— the poor treatment of bereaved families following a death in custody/psychiatric care;

— the inadequacy of the current investigation and inquest process;

— the inequality of arms of the family compared to the state ;

— the failure of the state to learn from previous deaths and to ensure inter-agency communication and learning; and

— the lack of accountability of state agencies.

And

— An independent public inquiry should be set up to look at all the issues relating to deaths in custody in an open, systematic and inclusive way. We have been frustrated at the government's piecemeal approach to the complex issues of deaths in custody and their investigation and the lack of "joined up government" on this issue.

And

— The need to establish a Standing Commission on Custodial Deaths.

2. DEATHS IN PRISON

2.a Issues arising from prison deaths:

— institutionalised attitudes towards prisoners that cause an indifference to pain and distress and help to prevent learning;

— young people in deep distress described as manipulative trouble makers;

— a disturbing number of self-inflicted deaths in prison of people who had a known previous psychiatric history;

— the rise in the number of youth deaths and in particular of remand prisoners, the need for an understanding of the needs of young people;

— a significant rise in the number of deaths of women in custody;

— the link between prison deaths and inadequate or inappropriate health care;

— the increasing number of drug related self-inflicted deaths in prison of prisoners who are not given treatment and support for drug withdrawal;

— the stereotyping of black people with mental health problems;

— the use of prison as a "place of safety" for those with serious mental health problems;

— the number of self-inflicted deaths which occur within Health Care Centres;

— the need for a reduction in the use of imprisonment rather than treatment of vulnerable people, for whom prison is the worst place to be. Prisoners with mental health problems are often a risk more to themselves than to others as the increasing catalogue of self-inflicted deaths in prison reveals;

— inadequate policies to deal with bullying;

— there has been a pattern of failure to acknowledge self harming behaviour as an expression of distress which has often led to such behaviour being treated as a discipline problem and for clearly distressed people to be placed in segregation rather than receiving appropriate care;

— continuing problems with cell design, access to ligature points; and

— the need for diversion schemes for those suffering from mental health problems, drugs and alcohol problems.

2.b Women's deaths

There is a crisis in women's prisons highlighted by the increasing number of deaths and incidents of self-harm and the numbers of women prisoners with mental health and or drug and alcohol problems being sent to prison. This year 14 women have died in prison custody, the highest number ever recorded. 12 out of the 14 have died as a result of hanging themselves, two having taken an overdose of medication.

In response to public concern about the situation at Styal prison where six women died during an eight month period the Prison Minister announced an investigation by the Prison Ombudsman into the death of Julie Walsh. We were concerned at the narrow remit of the review and that it was not reinvestigating the other deaths. There was also concern that families of the other women who died were being asked for their views without having had disclosure of the investigation reports into their relative's death. INQUEST feels that this investigation was a missed opportunity to set up a wide-ranging independent public inquiry that examined all of the recent deaths, any institutional and systemic failings and most importantly involved bereaved families and women prisoners themselves.

INQUEST put in a submission to the investigation about our concerns the treatment of bereaved families following deaths in prison. Our contact with some of the families affected reveal concerns about communication with the Ombudsman's office about the timing and publication of the report. Our concern is also with his use of Prison Service investigators to conduct his investigation.

2.c Deaths of children and young people

INQUEST has prioritised work on the deaths of young people and children in custody since 1990, when we advised and supported the family of Philip Knight, a 15 year old boy who took his own life in Swansea prison. We have been frustrated by the large number of cases that have raised similar issues and the apparent failure of the Prison Service to learn the lessons.

We believe that for many young people prison is inappropriate and that their experience of imprisonment has *directly* contributed to their death.

Between January 1990 and December 2003 there have been 177 self-inflicted deaths of young people in prison (21 and under). There have been a total of 947 self-inflicted deaths in prison. These figures are situated in the context of 21,760 reported incidents of self-harm in prison between 1998 and April 2002. Although these are not broken down in detail it is recognised widely that self-harm amongst young prisoners, particularly women, is an urgent problem.

We would like to draw the committee's attention to the case of Joseph Scholes which is illustrative of the concerns these deaths raise about the way in which the criminal justice deals with children. It also reveals the inadequacy of the current inquest system to deal with the complexity of issues by these cases that engage Article 2 of the Human Rights Act.

Joseph was a deeply disturbed boy who had disclosed a history of alleged sexual abuse from an early age. On 24 March 2002 he hanged himself in his cell at Stoke Heath Young Offender Institution in Shropshire. His death occurred just nine days into his two-year sentence for street robbery.

Joseph's death and other tragedies like it, raise serious issues about the ability of the present system to cope with society's most vulnerable young people and to provide them with a safe as well as a secure environment. The question arises as to how best to identify any systemic failings that do exist and how future tragedies can be avoided.

The case for a public inquiry rather than an inquest

INQUEST, Nacro and Yvonne Scholes, Joseph's mother recently launched[144] a call for a public inquiry into his death.

The narrative of Joseph's life is grim reading and reveals a catalogue of failures by state agencies to provide appropriate care and help to an exceedingly vulnerable child.[145]

Joseph's death raises a number of wider questions about the treatment and care of children in the criminal justice system and the accountability of those agencies responsible, in particular the Youth Justice Board, the Prison Service and Social Services Departments. It asks questions of society and how it should respond when children show clear signs of being disturbed and in need of professional intervention. It raises questions about how agencies and individuals could have intervened in Joseph's case and how we can ensure that we have better systems and better practice in the future.

These are issues of policy, which no inquest—however well conducted—can cover in the way a public inquiry could. A public inquiry into a case like Joseph's would be able to examine the fundamental flaws in our system for dealing with children who break the law—flaws which have led to 25 children aged 15 to 17 taking their own lives in custody since 1990.

The current inquest system is incapable of dealing with the systemic issues highlighted in cases such as Joseph's and consequently fails victims, their families and the wider public interest in seeking to ensure that lessons are learnt to avoid future fatalities. Given the pattern of deaths of children in prison, the number of different state agencies involved in Joseph's care, the systemic and wide-ranging issues involved, and the narrow confines of the coronial system, any inquest into Joseph's death will not be able to fulfil the state's obligations under Article 2 incorporated by the Human Rights Act 1998 to identify faults in the system that might have led or contributed to the death and to enable steps to be taken to prevent the recurrence of such deaths in the future.

Six months before Joseph died 16 year old Kevin Jacobs hung himself from the bars of his cell. He too had been identified by prison staff, social workers and doctors exceptionally vulnerable disturbed and "at risk" young boy. The inquest jury returned a verdict of "system neglect" fining "gross deficiencies within the system and a failure to provide consistent and safe accommodation."[146]

DEATHS INVOLVING THE USE OF FORCE

3.a The General Issues

INQUEST has worked with many of the families of those who have died on the most significant and controversial deaths in all forms of custody over the past two decades in particular those involving the use of force.[147] The majority of these involve the police.

INQUEST's work in this area reveals serious shortcomings in the existing mechanisms of legal and democratic accountability, and the consequent impact in particular on community relations has been profound, resulting in a lack of public confidence in the current system. Until recently complacency and inaction have characterised the response from government agencies during the last two decades to these deaths. This indicates a failure and/or unwillingness to ensure that systems are in place to learn the lessons to prevent further deaths and ensure accountability of agencies of the state.

For two decades we have documented our concerns about deaths where the use of restraint by state agents has either caused or played a significant contributory factor in the death of the deceased. Casework[148] in police prison and psychiatric custody has revealed concerns about the excessive use of force generally including the use of CS spray, US style batons, firearms, strip cells and medication as well as the use of dangerous "control and restraint" methods such as body belts, "neck holds, and other restraint techniques resulting in the inhibition of the respiratory system, asphyxia and death."[149]

The recent inquest[150] into the death of Roger Sylvester highlighted the issue of the police using dangerous methods of restraint despite a pattern of previous deaths.

A recurrent theme in these deaths is a quick resort to the use of force in general and restraint in particular among our detaining authorities—even where there are available and practical alternatives, which are not considered. In theory restraint is supposed to be deployed as a means of last resort but is not translated into practice. Regulations governing the use of restraint as a means of last resort appear to remain enshrined only on paper.

While the number of deaths involving the use of force are a small minority of all deaths in custody they have been the most controversial because of what they have revealed about the excessive use of force by functionaries of the state.

There is no central collation of statistical or other information on restraint related deaths—we are dependent on the individual agencies for that information where it is made available, and our own monitoring.

In 2002 and 2003 our casework on police custody related deaths has seen a disturbing increase in the number of restraint related deaths particularly on those with mental health problems.[151]

3.b Particular problems with the criminal justice and inquest system in these deaths

It is extremely rare for there to be a prosecution after a death in custody even where there has been an inquest verdict of unlawful killing.[152]

Despite a pattern of cases where inquest juries have rejected the official version of events and found overwhelming evidence of unlawful use of force and neglect, no police or prison officer or nurse has been held responsible either at an individual level or at a senior management level for the institutional and systemic failures to improve training and other policies.

Our monitoring of the cases has revealed an institutionalised unwillingness and reluctance to approach these deaths as potential homicides. This infects the whole process from the investigation carried out by the police through to the considerations by the Crown Prosecution Service. This serves only to encourage a culture of impunity and sends out a clear message to police and prison officers and other detaining agents that these deaths can occur as a result of their acts or omissions and they will not be called to account. The perception is created that state agents are above the law. This is one of the most contentious issues in relation to the approach of the criminal justice system in relation to all deaths in custody.

Our casework suggests that when the use of certain kinds of violence is embedded in the working culture of any organisation (whether a hospital or the police) it isn't easily eradicated by directives from above. Where there exist no real sanctions for those who abuse restraint and force, it is easy to see how those individuals working in detaining authorities are allowed to feel that they can act with impunity. The bottom line therefore relates essentially to the means by which the use of restraint is regulated and the extent to which such regulation and its implementation is open to public scrutiny as a basic safeguard against the abuse of force.

There are limited opportunities for the public scrutiny of the abuse of restraint and force in our custodial institutions. Within the agencies involved there exist internal investigative and disciplinary processes, which by their very definition are not open to public scrutiny. Guidelines/manuals on the use of restraint have been shrouded in secrecy and not made available. In the absence of criminal proceedings against those responsible for such abuse, we are left with the inquest with all its limitations as the only forum at which the ensuing deaths can be subjected to any semblance of public scrutiny.

We address some of the problems of the inquest system below and these are all the more apparent in dealing with these particularly disturbing deaths.

3.c Racism and stereotyping

Since 1990 INQUEST's monitoring has revealed how a disproportionate number of black people and those from minority ethnic groups have died as a result of restraint or serious medical neglect. It is the emergence of statistical information backed by factual accounts about the circumstances of the death that has been crucial to understanding the influence of institutional racism on the treatment of black people in custody. Another group over represented are the mentally ill where "negative imagery" once again informs their treatment—the stereotype of the mentally ill as "mad", "bad" and "dangerous".

These issues have been raised consistently by INQUEST with the United Nations Committee on the Elimination of Racial Discrimination who have commented on their dissatisfaction with the current methods for investigating the deaths. It was also touched upon in the Lawrence Inquiry report. This pattern of deaths in custody feeds the perception and reality of racism within the police and prison service and within the NHS.

Cases have revealed a use of violence on some occasions that is greatly disproportionate to the risks posed involving black and Irish people and the mentally ill, raising questions about the attitudes and assumptions of some state officials and pre-conceived ideas about the propensity to violence of particular groups of people.

There has been considerable public anger particularly amongst the black and Irish communities about what some of these cases have revealed about the unlawful and excessive use of force used against black and minority groups. Frequently at inquests there is an attempt to demonise the person who has died and reference made to their "superhuman" strength, and their "animalistic" behaviour.

The disproportionate number of black deaths in custody following the use of force was an issue that the government was slow to acknowledge despite the fact that INQUEST were documenting this issue at a national and international level.

The Home Office Bulletin "Deaths during or following police contact 2002-03 published on 20 November 2003 highlighted the rise in the number of deaths of people from minority ethnic communities. In response to this the Government has announced that it has commissioned research from the PCA in an attempt to discover any common factors underlying these deaths. It is a matter of concern that their response to this situation is to seek research from a discredited organisation in who the public have little or no confidence in given their history of involvement in a number of high profile black deaths in custody. INQUEST has not been contacted as part of this research.

3.d The failures to learn the lessons

These deaths show a systemic failure to learn lessons: to review, revise and implement policies, instigate new training, to share and disseminate information and guidance across different state agencies.

Evidence of dangerous practice and culture has emerged but the lessons to be learned have not been applied to the range of organisations that are increasingly involved in restraining people:

— police and prison officers and those working in psychiatric custody;

— immigration officers;

— private security firms detaining asylum seekers;

— security guards; and

— and those working in care homes for children, people with learning disabilities and older people.

In the majority of restraint-related deaths coroners have reiterated their concerns about restraint training and made recommendations but there is no mechanism for monitoring such recommendations and their communication and subsequent implementation across relevant Government departments.

In our view this failure to act and ensure inter-agency communication and collaboration in terms of policy and practice around restraint has resulted in more deaths and serious injury.

3.e Deaths of detained patients

The deaths of detained patients remain shrouded in secrecy and are not in the public domain to the extent as those that occur in police and prison custody.

Of particular concern is the failure of government or any of its arms length bodies to collate and publish annual statistical information about deaths of detained patients. The existing internal systems for examining and reporting these deaths are so poor that we believe some contentious deaths could escape any public scrutiny.[153] And in relation to the inquest system there is no requirement for the coroner to sit with a jury—a matter that must be addressed in any forthcoming reform of the inquest system.

INQUEST has been unable to take up the issue of the deaths of detained patients in the same way that is has worked consistently on the deaths of people in other forms of custody. We believe that it has been due to the relentless pressure we have applied in those cases that some change has happened in these settings. This is impossible when even access to information about who has died and in what circumstances is not available.

3.f What does INQUEST's work reveal about deaths involving use of force?

— The need for independent investigations into deaths following the use of force. All deaths should be treated as potential homicides until proven otherwise.

— Police related deaths are not being treated with the seriousness they deserve in terms of the investigation process—the Police Complaints Authority are continuing to sanction the same police force investigating itself even in cases where there are clear questions about the possible abuse of force. Very few members pass on our details to families. Families frequently complain about their conduct and that they appear to be a mouthpiece for the police. Families have also complained that Family Liaison Officers have been actively discouraged families from contacting INQUEST or from seeking legal advice and representation.

— Questions about inappropriate restraint, racist treatment, and lack of training and awareness and the failure to review and revise practices in light of deaths.

— Poor implementation, understanding and co-ordination of restraint training, and a lack of joined up thinking across government departments, made worse by the constant introduction of new theories that dilute the importance of training of the dangers of methods of restraint.

— There should be national training standards across different agencies and the establishment of an inter-agency group to share best practice and working with the Health and Safety Executive, to set

up and monitor standards for the validation of training modules and courses;

— The persisting ignorance about restraint related health risks—failure to keep watch on the physical well being of a restrained person has played a major part in many deaths.

— The lack of centrally collected and publicly reported information on the deaths of detained patients—following pressure on the police and prison service by INQUEST details are now provided on all deaths in police and prison custody including racial/ethnic group. This should happen as a matter of course.

— Cases have revealed a use of violence disproportionate to the risks posed to officer/nurse, especially involving black people and the mentally ill raising questions about the attitudes and assumptions held by some state officials and systemic and persistent deficiencies in police and prison officer practices. Training must include an understanding of why violence occurs and how to deflect it and use of alternative, non-aggressive techniques rather than the ready resort to the use of force.

— The majority of inquests have seen coroners recommendations but there is no mechanism to monitor recommendations made by inquests and inquiries and their communication and subsequent implementation across relevant government departments.

— Custodians have a difficult and sometimes dangerous job to do, to do their job however they must have the confidence of those they serve, to earn and maintain that confidence there must be a system of accountability that is open and transparent.

— There needs to be an urgent inquiry into the use of restraint across different state agencies.

4. THE INQUEST SYSTEM

INQUEST has always argued that the right to an inquest is fundamental but that the current inquest system is failing particularly in relation to deaths that involve questions of state and corporate accountability.

There are severe shortcomings in the current systems for investigating and providing remedies after deaths in custody. These shortcomings violate Article 2 of the European Convention on Human Rights which enshrines the right to and which places a positive duty on the state to secure life. Investigations of deaths in custody are secretive, slow and not independent. The relatives of the deceased are too often excluded and marginalised. To them, the investigation can often appear less a search for truth than an attempt to avoid blame, frustrate disclosure, restrict the remit of the investigation and demonise the deceased.

We gave a detailed submission to the Home Office Fundamental Review of Coroner Services[154] detailing our concerns about the investigation and inquest system based on 21 years of advising bereaved families, monitoring post death investigations and attending inquests around the country.

"Any new system [of investigation] needs to operate within a framework that ensures openness, accountability, compatibility with the Human Rights Act and sensitivity to bereaved people and the public. To establish such a framework there needs to be clear national protocols for all aspects of post-death investigation. Those protocols need to enshrine clearly defined mechanisms of accountability, minimum levels of service delivery and a system of sanctions where practice falls below acceptable standards. The protocols need to set out clearly the rationale for each step that is taken, in a manner that is understood by professionals, bereaved people and the public. Above all it needs to be a system that balances the needs of the State with those of bereaved people and ensures that all participants have an equality of resources and information. Whilst the process will be painful for bereaved people it will be more bearable if it is seen to have legitimacy and meaningful outcomes."[155]

Public campaigns pursued by bereaved families following controversial deaths in custody and following major disasters have focused attention on the investigation process following contentious deaths in custody and the inadequacy of the coroners court as a forum for the examination of deaths where the state is suspected of having some responsibility. INQUEST monitoring has shown how the state uses the inquest and not the criminal prosecution and trial for the public examination of these deaths. These factors have serious consequences for families faced with an unexpected or violent death.

"The narrow focus of the inquiry puts artificial and invidious limits on the scope and style of conduct of the Coroner's inquiry, which often exclude from the inquest the issues of greatest concern to the family. The inquest is usually the only investigation of death to which a family has access. Importantly, for the public interest and democratic accountability it is the only public forum in which contentious deaths will be subject to scrutiny. Inquests are too often at risk, particularly in the absence of legal representation for the family, of being opportunities for official and sanitised versions of deaths to be given judicial approval—rather than being an opportunity for the family to contest the evidence presented, to discover the truth and full circumstances surrounding the death of their loved one."[156]

5. INVESTIGATIONS

Accessibility

Too often families are left isolated from the investigation process. They are unable to access the investigators let alone the actual investigation. Frequently families are contacted immediately after the death and asked to co-operate or participate in the investigation of their loved one. At this very early stage they will be going through a whole myriad of emotions. Grieving for their loved one, angry frustrated at the level of information forthcoming. There may also be feelings of guilt and of course shock.

When an investigator who is viewed as part of the Prison or Police Service then asks at this stage of the bereavement process for the family to be involved in the investigation it is not surprising that families are unwilling or more likely, are unable to get involved. This is before they have had chance to clarify in their mind what the issues they feel are relevant and when they are in no mental state to answer fully or accurately. In our view for a family to properly participate in any investigation they need time and space and often support from a third party such as someone from INQUEST or a solicitor/advisor. Their role can be very important in determining the terms of reference and scope of the investigation. Again if they were informed from the outset that they could participate in the investigation with the assistance of a third party and have a say in the terms of reference it might go someway to reassuring them that the death is being taken seriously. Clear issues of sensitivity arise from such interviews. Irrespective of whether or not a family decides to have full participation in the process they should still be kept informed of the progress of the investigation. INQUEST believes that more work needs to be done in this area and that we have an important role to play in this.

The investigators

All the investigators into deaths in prison are currently employees of the Prison Service. These investigators have often been unable to establish a relationship with families who are very often not confident in the way a death is being investigated because it is not seen as independent of the prison service. This of course is multi-factorial but issues of impartiality are paramount. A clear need for independent investigators is required and well documented in previous submissions made by INQUEST. In the recent death at HMP Styal the Prison Ombudsman was asked to investigate. However from the contact we have had with some of the families affected, it has not been clear to them that the PPO is independent from the Prison Service. This needs to be made more explicit. There may well be a need to have prison employees involved in the investigation but the need to demonstrate independence is paramount.

Length of an investigation

It is our experience that investigations into police and prison deaths are not generally released to the family until there is a date for an inquest. The inquest may not be held for 6—12 months, sometimes longer.

In a recent case involving a restraint related death in police custody the family was informed that although the inquest was unlikely to be heard for at least a year, possibly longer it was unlikely that they would receive disclosure until 28 days before the inquest. This is in line with the pre-inquest disclosure guidance but in view is completely unreasonable. We do not see why the investigation reports are not disclosed immediately on completion. This would also allow the family/family lawyer to raise matters that they do not feel have been addressed in the investigation (see paragraph below on disclosure of information).

Disclosure is not provided as of right, not provided early enough and is too obstructive and allows material to be kept secret. In our experience disclosure is something the family/family lawyer has to fight for. The introduction of the voluntary protocol in April 1999 has brought some clarity to the process of disclosure and was welcomed but many problems still remain, particularly in the most contentious cases. Early disclosure of custody-generated documents is vital if the family and their representatives are to have *effective and constructive participation* in the investigation.

Findings and recommendations arising from investigations and inquests

Funding

It has often been lawyers instructed by families in pushing the boundaries of the inquest system who have helped to expose through their legal representation systemic and practice problems that have contributed to deaths. Indeed many of the changes to police/prison training and guidance or public awareness of health and safety issues have been as a direct result of families representation at inquests and our lobbying work thereafter for change and for lessons to be learnt.

There is unlimited public funding for experienced and quality lawyers to represent the Police while union or association funding is available for the police officers, or medical officers. INQUEST believes that where such a death occurs there should be an automatic right to public funding for legal representation without means testing. Although there has been some progress and all deaths in custody (though not involving deaths following police pursuits) are now recognised as coming within the scope of the funding code. Relatives of the deceased whom the law recognises have a legitimate interest cannot afford to take up that representation unless they are eligible for legal aid which effectively excludes a lot of low and middle income families. The Legal Services Commission has taken a very restrictive interpretation of eligibility.

The recent decision of Khan will improve the situation as it has resulted in a new statutory instrument[157] that gives the power to the Legal Services Commission to ask the Secretary of State at the Department of Constitutional Affairs to waive financial eligibility criteria in requests for funding for representation in inquest cases that engage Article 2.

The narrow remit of the inquest and its dependence on the police/prison investigation prohibits exploration of the wider policy issues or indeed any mention whatsoever of any other death than the one currently being investigated. Indeed the High Court in the Sacker case and the House of Lords in Amin[158] have recently questioned whether the present coronial system is an appropriate means for looking into cases that raise wider issues of concern.

Coroners have very wide discretionary powers to determine the scope of each inquest and although there is case law specific to deaths in custody that requires a "full and fearless investigation", that is open to wide interpretation. There is great variation in their practice and similar deaths in different parts of the country may be treated in very different ways.

The majority of information that has entered the public domain about deaths in custody has arisen only because of the deceased's family and friends full participation in the inquest proceedings facilitated by their legal representation. It is very rare for a coroner in the absence of legal representation on behalf of the deceased to conduct the kind of searching questions that occur when a family is represented. Many coroners are ill-equipped and are unaware of what is happening nationally to clean an understanding of broader policy issues surrounding custody type deaths or have not been provided with all the relevant disclosure by the police because they have not known what to request. The issue of resources is also a serious problem for coroners. This is very relevant when considering the inquest is the only public forum in which these deaths are subjected to any scrutiny and where systemic failings can be exposed. We are aware that there are custody deaths that have not been properly scrutinised because families did not have information and the resources or where the deceased had no interested family.

Our experience of such inquests is that lawyers representing custodial institutions are consistently instructed to take a defensive approach to the proceedings, trying to shroud what has happened or to attack the character of the deceased rather than assisting the court in the exercise of an impartial scrutiny of the death. In addition the approach to the inquest from the authorities as a damage limitation exercise means that there has been a reluctance to learn from these investigations.

The recent inquest into the death of Roger Sylvester gives a good example. The lawyer acting on behalf of the Metropolitan Commissioner paid for out of the taxpayers purse via the Metropolitan Police Authority did not take a neutral role but launched an attack on the deceased and the lawyers and family campaign accusing us of having a political agenda.

We also see this post death where misleading, inaccurate information is placed into the public domain by police about the death in an attempt to demonise the deceased, blame them for their own death and deflect attention away from the conduct of the police.

6. IMPLICATIONS OF THE HUMAN RIGHTS ACT

The limited ambit of investigations, ineffective inquiries and the failure to prosecute those responsible has all been issues for bereaved families. They have also increasingly become an issuein law both in the ECHR and in the domestic courts.

Where a citizen dies or suffers ill treatment in custody, the reaction of the State raises very serious questions about the protection of human rights. As a public authority the Police/prison service/has to comply with the Human Rights Act and all courts and tribunals including the coroner's court are also under a duty to ensure that convention rights are protected.

There is already in existence case law about the importance of a full inquiry into deaths in custody and indeed under the Coroners Act there is a requirement for an inquest with a jury to sit on such deaths. The problem is that under the Coroners Act 1988 the inquest has a very narrow remit and is manifestly not a public inquiry; it is concerned primarily with establishing the medical cause of death, how the person died, by what means and not in what broader circumstances.

The most significant recent development in coronial law has to be the implementation of the Human Rights Act and the direct incorporation of Article 2 (the right to protect and safeguard life) into domestic law. The obligation on the state to protect the right to life requires the state taking appropriate measures to protect life, to investigate deaths and ill treatment in custody thoroughly and to prosecute where there is sufficient evidence to justify proceedings.

The obligation to take positive steps to protect life also requires some sort of investigation where death has occurred in a way, which engages Article 2 and 3 of the Convention because any fault in the system for protecting the right to life may well lead to further deaths (McCann v UK) and the lack of an effective investigation will in itself constitute a violation of Article 2.

The decision of the House of Lords on 16 October this year in the case of the SSHD ex-parte Amin, establishes once and for all consistent minimum standards for the state's duty to investigate deaths in custody.[159]

The case arises out of the murder in a cell at Feltham YOI of Zahid Mubarek by his cellmate Robert Stewart. Despite a wealth of evidence warning of the dangers posed by Stewart, from his previous violent conduct in custody, his volatile mental state and racism they had been allocated to share a cell for 6 weeks before his murder. There was a complex history of investigations by the police, the Prison Service and the CRE, However no public hearings had been held and no opportunity arouse for the significant involvement of the next of kin.

The House of Lords ruled that whichever form the investigation takes there are minimum standards, which must be met as, set out in Jordan v UK[160] and Edwards v UK. The Court concluded in Jordan that there were five essential requirements of the investigatory obligation: independence, effectiveness, promptness and reasonable expedition, public scrutiny and accessibility to the family of the deceased. The lack of an investigation which embodies the requisite qualities will and of itself constitute a violation of Article 2.

It ruled that such requirements apply with at least equal force to a "state neglect" or omission case (relevant to deaths in police custody) as to a state `lethal hands' case.

The approach to the House of Lords to the inquest issue is instructive. The coroner's affidavit explained her exercise of her discretion not to hold an inquest into this case (a discretion coroners have where a criminal trial has taken place) She gave detailed reasons why the resource and procedural restraints to which coroners and inquests are subject make an inquest an unsuitable vehicle for investigating publicly the issues raised by this case.

It was conceded for the family that in principle an independent police investigation and an inquest are capable of fulfilling the "Jordan" requirements and the state's investigative obligations as established by McCann as to the adequacy of the Gibraltar/SAS shootings inquest.

Many of INQUEST's concerns about the inquest process were put forward for the family at the Amin hearing including: inconsistency of disclosure of evidence to the family despite the Home Office circular, inconsistency of funding, the narrow boundaries to the jury's findings, coroners current restrictions upon system neglect. The Amin judgement recognises these concerns as legitimate and these comments are a vindication of our concerns about the inadequacy of the current inquest system in relation to contentious deaths in custody.

The Lords accepted the coroners reasoning both as to the problem of resources and legal restriction and agreed that many of the issues needing investigation `would be beyond the scope of inquest. Lord Bingham refers to the Home Office review of coroners recommendations indicating that if implemented they would avoid such problems and adding that *"no doubt they are receiving urgent official attention."* (our emphasis).

There is now strong recognition of the need for more effective investigation than can be currently provided by inquests. The issues raised about individual and system neglect in the Amin although rare are sadly not unique. Until substantially reformed there is strong judicial recognition for the need for more effective investigations than can currently be provided by inquests and provides an important incentive to accelerate the programme for inquest reform.

This legally significant case has been brought about because of the courageous struggle by the family of the deceased whose campaigning will contribute to the future protection of vulnerable prisoners. Lord Bingham recognised this as one of main purposes of the investigation and thereby humanely connected the needs of the bereaved with the duties of the state. [161]

7. THE TREATMENT OF FAMILIES

Finally we would draw the Committee's attention to the poor treatment of bereaved families following deaths in custody. Despite a wider acknowledgement of the issues faced by bereaved people discussed below this thinking has bypassed families affected by deaths in custody.

In our submission to the Fundamental Review of Coroner Services[162] we wrote:

"In our experience the nature of the circumstances of many of the deaths on which we work inherently attracts prejudice and strong feelings and the majority of families we work with do not experience the system as compassionate. Families feel overwhelmingly excluded, dissatisfied and let down by it as a process for establishing the facts. The coroner's inquest has become an arena for some of the most unsatisfactory rituals that follow a death—accusations, deceit, cover-up, legal chicanery, mystification; everything but a simple and uncontroversial procedure to establish the facts.

There have been some important procedural changes but little substantial systemic change. Some of the more recently appointed coroners do have a different approach to their work but like many institutions what is needed is a culture shift. There are important developments taking place in the wake of the Alder Hey scandal and the beginnings of a greater understanding of the support needs of families following sudden and unnatural death. However, we remain concerned that the mainstream provision of bereavement support is delivered in the absence of evidence-based research on the particular impact of bereavement and the inquest process. It is also clear that those families who suffer the death of a loved one in custody are not considered in any of the initiatives taking place. There seems to be an institutional inability for the authorities to acknowledge that the need of a family whose loved one has died in custody are just as acute as those of someone who has lost a loved one following a death in hospital or a murder. However most new bereavement initiatives do not appear to have considered these families at all."[163]

With custody related deaths the lack of support and appropriate assistance is more acute with families feeling doubly victimised—they have suffered a death and because of its nature they are treated as though they are criminals.

All deaths in custody involve an inquest so the potential role of the Coroner's Service in guaranteeing informed and effective access to appropriate bereavement intervention options for bereaved families must therefore be a central concern in developing a new system.

Finding out how someone has died is a fundamental human right and an essential part of the bereavement process and in coming to terms with the death. All of the families who have sought our assistance have been motivated by a need to establish the truth for their own peace of mind, and to prevent others going through the same experience. Above all, they want an acknowledgement of fault or responsibility where appropriate, an apology where an apology is due, for justice to be seen to be done and for lessons to be learnt.

Maximising the possibility for families and friends to discover the truth is the guiding principle of INQUEST's casework service. The family can have a real information deficit after a death in custody. They have a very steep learning curve to understand the various investigations that are initiated by such a death. Some argue that the family should not be overloaded with information. Access to proper information and advice is crucial in ensuring that people are aware of their rights and it is the responsibility of the State to ensure that this happens at the earliest possible opportunity.

This should include information about access to the body, post-mortems, organ retention, rights regarding disclosure, the inquest process, and legal rights.

"The way families are informed of a death and the treatment they receive from officialdom at this stage can crucially set the tone for the way they are able to interact with the process."[164]

In our submission to the Prison Ombudsman on the treatment of families we documented our concerns about the poor treatment of families by many state agencies and the need for families to receive clear, accessible and accurate information about the circumstances of the death and where they can seek advice and support. It is a matter of real concern that there is still no mandatory requirement on the part of the police/prison service/NHS to give out INQUEST's details and information leaflet. This happens on an ad hoc basis only and is entirely dependent on the individual with contact with the bereaved. Provision of our information would at least give families *the choice* as to whether or not they contact us. We have too many families contacting us at a later stage in the process having been referred by friends/press etc and who would have benefited from specialist advice and emotional support much earlier.

A recent example of this is the mother of a young woman who took her own life in Styal prison in November 2002. She was given no information about INQUEST from the Prison Service or the Prisons Ombudsman when in contact with her as part of their investigation into Styal.

The mother of the deceased found about us via a small advice service in North Wales and contacted us for help. We have been able to find her a solicitor to assist her with preparing for the inquest which is yet to be heard and to refer her to a family who have been through a similar experience

for emotional support. The result of the failure to refer the mother to us a year ago is that she has been alone and unsupported.

December 2003

Name	*Ethnicity*	*Date/type*	*Location/force*	*Prosecution*	*Inquest*	*Verdict*
Oliver Pryce	Black	1990 Police	Cleveland Police	No	Yes	Unlawful killing
Omasase Lumumba	Black	1991 Prison	HMP Pentonville—London	No	Yes	Unlawful killing
Leon Patterson	Black	1992 Police	Manchester Police	No	Yes	Unlawful killing quashed; new inquest 1996 misadventure contributed to by neglect
Joy Gardner	Black	1993 Police/ Immigration officers	Metropolitan Police	Yes—acquitted	No	No inquest
Richard O'Brien	Irish	1994 Police	Metropolitan Police	Yes—acquitted	Yes	Unlawful killing
Shiji Lapite	Black	1994 Police	Metropolitan Police	No	Yes	Unlawful killing
Alton Manning	Black	1995 Prison	HMP Blakenhurst Kidderminster	No	Yes	Unlawful killing
David Ewin	UK White	1995 Police shooting	Metropolitan Police	Yes—hung jury	No	No inquest
Ibrahima Sey	Black	1996 Police	Metropolitan Police	No	Yes	Unlawful killing
Christopher Alder	Black	1998 Police	Humberside Police	Officers charged with and acquitted of manslaughter in 2002	Yes	Unlawful killing
James Ashley	UK White	1997 Police	Sussex Police	Yes—acquitted	No	No inquest
Roger Sylvester	Black	1999 Police	Metropolitan Police	No	Yes	Unlawful killing

Appendix 1

DEATHS IN PRISON CUSTODY 1993-2003

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Self-Inflicted	48	59	59	64	69	83	91	81	72	95	90	811
Non-Self-Inflicted	2	5	7	53	47	45	55	57	50	55	65	441
Homicide (NSI)	1	2	3	2	2	6	0	3	1	0	1	21
Control & Restraint	0	1	3	0	0	0	0	0	0	0	0	4

Awaiting Classification	0	0	0	0	0	0	0	1	1	3	2	7
Total												1284

BLACK DEATHS IN PRISON 1993-2003

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Self-Inflicted	3	3	8	3	6	9	7	8	5	8	6	66
(Percentage)	6%	5%	14%	5%	9%	11%	8%	10%	7%	8%	7%	8%
Non-Self-Inflicted	1	1	0	5	6	5	10	1	2	1	6	38
(Percentage)	50%	20%	0%	9%	13%	11%	18%	2%	4%	2%	9%	9%
Homicide (NSI)	0	1	0	1	0	0	0	1	0	0	0	3
(Percentage)	0%	50%	0%	50%	0%	0%	0%	33%	0%	0%	0%	14%
Control & Restraint	0	0	3	0	0	0	0	0	0	0	0	3
(Percentage)	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	75%

YOUTH DEATHS (21 AND UNDER) IN PRISON 1993-2003

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Self-Inflicted	3	12	11	14	16	15	19	18	15	16	13	152
(Percentage)	6%	20%	19%	22%	23%	18%	21%	22%	21%	17%	14%	19%
Non-Self-Inflicted	0	2	0	3	1	3	1	0	0	2	2	14
(Percentage)	0%	40%	0%	6%	2%	7%	2%	0%	0%	4%	3%	3%
Homicide (NSI)	0	0	1	0	2	1	0	2	0	0	0	6
(Percentage)	0%	0%	33%	0%	100%	17%	0%	67%	0%	0%	0%	29%

JUVENILE DEATHS IN PRISON 1993-2003 (AGED 17 AND UNDER)

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Homicide (NSI)	0	0	1	0	0	0	0	0	0	0	0	1
	0%	0%	33%	0%	0%	0%	0%	0%	0%	0%	0%	5%
Self-Inflicted	1	2	1	1	1	3	2	3	3	2	0	19
	2%	3%	2%	2%	1%	4%	2%	4%	4%	2%	0%	2%

NB these figures are also included in the table of Youth deaths above

DEATHS OF WOMEN IN PRISON 1993-2003

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Self-Inflicted	1	1	2	2	3	4	5	8	6	9	14	55
(Percentage)	2%	2%	3%	3%	4%	5%	5%	10%	8%	9%	16%	7%
Non-Self-Inflicted	1	0	0	2	1	1	4	1	1	2	1	14
(Percentage)	50%	0%	0%	4%	2%	2%	7%	2%	2%	4%	2%	3%

DEATHS IN POLICE CUSTODY—ALL FORCES 1993-2003

Type	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Custody deaths	36	52	48	57	58	65	46	36	34	47	38	517
Pursuit	2	1	2	9	17	10	8	24	26	34	22	155
RTA	0	0	2	4	6	8	6	5	9	7	9	56
Shooting	3	1	2	2	0	2	3	2	4	2	2	23

BLACK DEATHS IN POLICE CUSTODY—ALL FORCES 1993-2003

Type	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Custody	3	8	3	9	11	6	8	4	6	8	6	72
(Percentage)	6%	22%	6%	19%	19%	10%	12%	9%	17%	24%	13%	14%
Shooting	0	0	0	0	0	0	0	0	1	1	0	2
(Percentage)	0%	0%	0%	0%	0%	0%	0%	0%	25%	50%	0%	9%

POLICE CUSTODY DEATHS—RESTRAINT ISSUES RAISED 1993-2003

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
All Forces	2	5	7	5	5	9	6	5	5	5	7	75
(Percentage)	6%	10%	15%	9%	9%	14%	13%	14%	15%	11%	18%	15%

Source for all statistical information: INQUEST monitoring.

* Figures for Black deaths, Youth deaths, restraint-related deaths and deaths of Women are all included in the relevant tables for deaths in Prison and Police custody.

* All percentages refer to the proportion of the total number of that classification of death in that year or total.

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141 The Ashworth Inquiry 1992; United Nations Committee on the Elimination of Racial Discrimination 1996 and 2000; Council of Europe Committee on the Prevention of Torture 1997; Home Affairs Select Committee on Police Complaints and Discipline 1997; United Nations Committee Against Torture 1998; Inquiry into the death of Steven Lawrence 1998; Health Select Committee into Adverse Clinical Incidents and Outcomes in Medical Care 1999; Health Select Committee Inquiry into the Provision of Mental Health Services 2000; Attorney General's review of the role of the Crown Prosecution Service in deaths in custody 2002; Fundamental Review of Coroners' Services 2002; Joint Committee on Human Rights-deaths in prison 2002; Independent Inquiry into the death in psychiatric care of David Bennett 2003. Back

142 For statistical analysis see appendix 1. Back

143 *See* appendix 2. Back

144 Prison suicide of Joseph, 16, a phone thief who fell victim to sentencing policy-Independent 12/11/03. Back

145 A child's death in custody-Call for a public inquiry-INQUEST and NACRO Campaign Briefing-November 2003. Back

146 INQUEST press release 26 September 2002. Back

147 Forthcoming publication-Deaths in Custody following the use of force-INQUEST 2004. Back

148 This means working closely with family members, very soon after the death, referring them to appropriate lawyers, working with the legal team, attending the inquest, raising the issues with relevant agencies and government departments and with MPs and other interested organisations. This gives us a unique body of knowledge from which to comment on the deaths and the issues they raise. Back

149 *See* INQUEST reports on the deaths of Denis Stevens, Alton Manning, Kenneth Severin, Harry Stanley, Brian Douglas, Wayne Douglas, Shiji Lapite, Glenn Howard, Roger Sylvester and Giles Freeman. Back

150 September 2003. Back

151 *See* cases of Giles Freeman, Mikey Powell, Andrew Jordan. Back

152 INQUEST/Liberty/Bhatt Murphy submission to Attorney General review of CPS decision making following deaths in custody-2002. Back

153 INQUEST written evidence to the Inquiry into the death of David Bennett 2003. Back

154 How the inquest system fails bereaved people-INQUEST's submission to the Fundamental Review of Coroner Services-Deborah Coles and Helen Shaw-INQUEST 2002. Back

155 Coles and Shaw *op cit.* *Back*

156 Coles and Shaw *op cit*. Back

157 The Community Legal Service (Financial) (Amendment No. 2) Regulations 2003. Statutory Instrument 2003 No. 2838. Back

158 SSHD *v* Amin 16 October 2003. Back

159 *See* INQUEST Law Winter 2003 Article by Paddy O'Connor QC. Back

160 Jordan and ors v. UK (4 May 2001) ECHR. Back

161 O'Connor *op cit.* Back

162 Coles and Shaw *op cit.* Back

163 Coles and Shaw *op cit.* Back

164 Coles and Shaw *op. cit.* Back

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