

## INQUEST's further evidence to the Joint Committee on Human Rights<sup>1</sup> September 2004 - Deaths in Custody – The Current Issues

Since we made our written submission to the Committee in December 2003 there have been a number of significant developments that we wish to bring to the Committee's attention.

- **Prison/secure training centres** - deaths of young people and children
- **Prison** - rising number of self-inflicted **deaths of women** and the failure to publish the Prisons Ombudsman report into Styal prison
- **Police Custody – deaths of people from black and minority ethnic groups** - television programme on Christopher Alder and subsequent developments; the death of Kebba Jobe
- **Psychiatric detention – deaths following the use of 'control and restraint'** Launch of, government response to and subsequent handling of the Independent Inquiry into death of David 'Rocky' Bennett; another restraint related death in Prestwich Hospital, Manchester
- **Treatment of Bereaved Families** - the harmful effects on bereaved families of failing to provide them with information and support about where to go for help and advice following a custody death; the failure of the Prisons Ombudsman to give out INQUEST specialist literature to bereaved families
- **Policy and legal developments** affecting the inquest system; delay in inquests into deaths in custody being heard; problems with funding; inconsistency in decision making regarding public funding for inquests

### Statistics

This submission details additional issues arising from our casework and monitoring of the investigation and inquest process following deaths in custody in 2004. Since January there have been 18 deaths in police custody, two police shootings and 72 self-inflicted deaths in prison 11 of which were of women. There have been two deaths of children in secure

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<sup>1</sup> This document should be read in addition to the evidence submitted in December 2003.

training centres, including that of a 14 year old, the youngest death in custody ever recorded. There have been two deaths in immigration detention centres. Although the information on deaths of detained patients in psychiatric hospitals are not circulated we are aware through our casework of a number of deaths.

### **Deaths in Prison**

We remain concerned about the lack of action to address the questions raised by the number of deaths of children and young people in custody.

### **Joseph Scholes – update**

In our previous evidence we reported specifically on the case of Joseph Scholes. The inquest into his death took place in April 2004. At the conclusion of the inquest the Jury returned a verdict of *“accidental death in part contributed to because the risk was not properly recognised and appropriate precautions were not taken to prevent it.”* In an unprecedented move, the coroner announced that he would be writing to the Home Secretary to say that a public inquiry should be set up in light of the issues that had arisen at the inquest. This is especially important in light of the recent House of Lords verdict, which signified a major breakthrough for inquest law.<sup>2</sup>

It is time to review the policy and practice that places vulnerable children in the kinds of conditions that can ultimately cost them their lives. Currently we are waiting for a response from the Home Secretary to the call for a public inquiry which is widely supported by key penal and children’s rights organisations, by members of the House of Commons and House of Lords, by leading lawyers, and a range of individuals.

Chris Ruane, Yvonne Scholes’ MP tabled the following Early Day Motion on 30<sup>th</sup> June 2004 (as of 13<sup>th</sup> September 75 MPs had added their signatures):

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<sup>2</sup> The essence of these decisions is that they require an inquest to return verdicts which properly reflect (a) whether a person takes their own life in part because the dangers of their doing so were not recognised by the prison authorities and (b) whether appropriate precautions could have been taken to prevent the death. These two judgements have the power to open up the inquest system.

*That this House notes that Joseph Scholes was a 16 year old boy who hanged himself in Stoke Heath Young Offenders Institution on 24th March 2002 just nine days into a two year sentence; further notes despite being recognised by all concerned as a deeply disturbed child he was allocated to Prison Service accommodation without the standards of care needed for such a vulnerable child; further notes that the number of children sent to prison has doubled in the last 10 years, with increasingly younger children being given custody, and that concern has been expressed by the UN Committee on the Rights of the Child and the Joint Committee on Human Rights on the practice of sentencing children to custody; further notes that, since 1990, 25 children have taken their own lives in prisons and that Yvonne Scholes, Joseph's mother has, together with INQUEST and Nacro and supported by key penal and children's rights organisations and charities as well as honourable Members and Members of the House of Lords, called for a public inquiry; further notes that the Coroner, as part of his public duty to prevent the recurrence of fatalities, reported to the Home Secretary following the inquest into Joseph's death that there should be a public inquiry; and therefore calls upon the Government to set up a comprehensive public inquiry to deal with the many issues concerning Joseph's death so that lessons can be learnt about the treatment of children in the criminal justice system.*

As of 30<sup>th</sup> June the Government response was as follows:

**Lord Dholakia** asked Her Majesty's Government:

*Whether they will establish a public inquiry into the circumstances surrounding the death of Joseph **Scholes** in Stoke Heath Young Offender Institution in March 2002, as recommended by the coroner.[HL3214]*

**The Minister of State, Home Office (Baroness Scotland of Asthal):**

*The coroner has written to my right honorable friend the Home Secretary, commenting on a number of issues arising from the inquest. We are considering his comments and will reply in due course. We will make known our response by means of a Ministerial Statement.*

As of 14th September 2004 there had not yet been any response.

**We also have continuing concerns about the treatment of Yvonne Scholes by the Prison Service. (See below – Treatment of Families)**

### **Death of Gareth Myatt**

On April 19<sup>th</sup>, the day the Joseph Scholes inquest commenced, 15-year old Gareth Myatt died in a Ravensbrook secure training centre, near Northampton, run by Rebound, a subsidiary of Group Four. He died after being restrained by three adult members of staff.

Imprisonment, restraint and solitary confinement are all detrimental to the health of children. Those responsible for restraining Gareth are still working and were not formally interviewed by police until several months after the incident. If this had happened in a domestic home or indeed in a youth club, the staff involved would have been instantly arrested and separately interviewed.

We remain concerned at the apparent failure of the police to treat this death as a potential homicide.

On the 18<sup>th</sup> June the Youth Justice Board announced that it had suspended the use of the restraint technique used against Gareth Myatt and were conducting a review of the seated double embrace restraint technique. Police investigating Gareth's death at Rainsbrook in April called for the technique to be withdrawn after hearing from independent experts.

A statement from the Youth Justice Board said: *“The technique, part of a range of options for dealing with juveniles in some secure establishments, has been suspended pending a full review of the potential medical implications of the hold.”*

We have consistently raised concerns about the dangers of restraint techniques and their contribution to a number of deaths – most recently in our written and oral evidence to the public inquiry into the death of David ‘Rocky’ Bennett.

We have warned of the ever-present risk of more deaths because of the slow progress in ensuring evidence based joined up thinking approach concerning restraint techniques, training and the dangers of positional asphyxia across **all** custodial settings. The expert group set up by the Department of Health following the death of David Bennett (see below) is a welcome step in that direction but its focus is on managing violence and aggression in mental health settings. As the Committee know, many of the deaths involving restraint have involved people without mental health problems and in other custodial settings or during the course of arrest.

The death of Gareth Myatt begs questions about how it was that potentially lethal methods of restraint were being used against children and what medical input and advice was taken before such methods were introduced. Our understanding is that the restraint methods used are designed specifically for use on children and that training is provided by the Prison Service. It is well documented that there are high levels of restraint used against children in secure training centres and young offender institutions. Parliamentary Questions have revealed that children were physically restrained 11,500 times in the three secure training centres in five years.

We have major concerns about the poor treatment of Gareth Myatt’s mother, Pam Myatt (see below – Treatment of Families).

### **The death of Adam Rickwood - youngest child to die in custody of the State**

Since Gareth’s death another child has died – 14 year old Adam Rickwood, the youngest death in custody ever recorded. He was found hanging in his room in Hassockfield secure training centre. His family have raised their concerns over his vulnerability and the suicide risk he posed. He had allegedly been restrained shortly before his subsequent death by

hanging. The family had raised their concerns about his mental state with staff at the centre. His death raises serious concerns about what suicide prevention policies and procedures were in place in Hassockfield given the known vulnerability of the children accommodated there.

Following Adam's death there has been no comment from either the Prisons Minister or the Home Secretary. Instead the Home Office issued a statement to BBC Radio 4 stating that they will await the coroner's recommendations. This is a matter of real concern as there is likely to be considerable delay (as we set out below) between Adam's death and any inquest. (Again there are concerns about the way in which his family were treated following his death. Until INQUEST contacted the family via the Youth Justice Board they had received no information about where to go for advice and support from any of the state agencies involved.)

### **Call for public inquiry into the treatment of children in the criminal justice system**

These two deaths make the call for a public inquiry into the treatment of children within the criminal justice system even more pressing and we would urge the committee to support such a recommendation as supported by the families of Joseph Scholes, Gareth Myatt and Adam Rickwood.

### **Delay in custody inquests**

One of INQUEST's key concerns about the way in which deaths in custody are investigated is the serious delay from the death through to the investigation and subsequent inquests. Delays of over a year are not uncommon – in part due to the length of time such investigations take, the lack of resources available to coroners and the fact that these are jury inquests and can last up to two weeks. This is often made worse by the shortage of suitably qualified forensic pathologists and other experts. The delay clearly causes all concerned great difficulty but this is particularly so for bereaved people who have described how their lives have been put on hold until they have been through the inquest process. INQUEST's evidence-based research on families' experience of the

inquest system has highlighted the detrimental effects that delays in finding out how a relative has died has placed on the physical and mental health of family members.<sup>3</sup>

As there is no public scrutiny of the death for such a long period, the opportunity for identifying what went wrong and to seek to prevent recurrences in the future, learning the lessons and preventing other deaths is seriously delayed.

### **Delays in holding inquests into Article 2 cases**

Delays of one to two years are not uncommon – indeed of the families that gave oral evidence to the Committee all have had serious delays in the inquests being heard:

Joseph Scholes died March 2002, inquest held April 2004

Sarah Campbell, died January 2003, inquest set for January 2005

Paul Day, died October 2002, inquest set January 2005

Roger Sylvester, died January 1999, inquest held September 2003

Andrew Jordan, died October 2003, inquest date not set.

Giles Freeman died October 2002, inquest set December 2004

Andrew Barclay, died April 2003, inquest date not yet set.

There are also problems with particular coroners' jurisdictions that have a number of custody inquests outstanding.

### **Women's deaths in prison**

The female prison population has grown 173% in the last ten years. On July 2<sup>nd</sup> this year there were 4,475 women locked up in prison compared with the average of 1,811 ten years ago. Last year 14 women took their own lives in prison, a 64% increase on the previous year and a number that has by far exceeded any year since INQUEST's

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<sup>3</sup> Chapter 5 – How the inquest system fails bereaved people – INQUEST's submission to the Fundamental Review of Coroner Services - 2002

monitoring began in the early 1980s. Women account for only 6% of the average daily population and yet were 15% of the total number of the 94 self-inflicted deaths in prison last year. Women are three times more likely to kill themselves than men and account for over half of incidents of self harm - there were 21,000 incidents in women's prisons in 2003.

So far this year 11 women have killed themselves, 15% of the total number of self-inflicted deaths, which so far total 72 (as of 14<sup>th</sup> September). Seven of these occurred in a two month period and two within 24 hours of each other on 28 and 29 July 2004. We remain appalled at the lack of action from the Government concerning the escalating number of deaths.

#### Self Inflicted Deaths of Women in Prison 2004

Self Inflicted Deaths of Women in Prison 2004						
Name	Date Of Death	Ethnicity	Age	Status	Cause	Establishment
Marie Walsh	29/07/2004	UK White	29	Convicted	Hanging	HMP New Hall
Rebecca Turner	28/07/2004	UK White	22	Convicted	Hanging	HMP Low Newton
Rebecca Smith	01/06/2004	UK White	40	Convicted	Suffocation/Hanging	HMP Buckley Hall
Heather Wait	08/05/2004	UK White	28	Convicted	Hanging	HMP Holloway
Sharon Miller	08/05/2004	UK White	45	Convicted	Hanging	HMP Durham
Paige Tapp	18/04/2004	UK White	23	Convicted	Hanging	HMP Send
Louise Davis	18/04/2004	White	32	Convicted	Hanging	HMP New Hall
Julie Hope	17/04/2004	White	35	Remanded	Hanging	HMP Holloway
Sheena Kotecha	03/04/2004	UK Asian	22	Convicted	Hanging	HMP Brockhill
April Sherman	13/01/2004	UK White	27	Remanded	Hanging	HMP Edmunds Hill
Tina Bromley	04/01/2004	UK White	37	Convicted	Hanging	HMP Edmunds Hill

INQUEST is working with the families of many of the women who have died and has been monitoring the deaths and subsequent investigation and inquest process. Our anger and frustration is with the lack of accountability following such deaths and the failure of the State to learn the lessons. The six deaths of women at Styal prison in Manchester provide the most harrowing examples of institutional neglect and systemic failings and demonstrate the failure of the State to fulfil its obligations under Article 2 of the Human Rights Act to protect life. Six women died in Styal between August 10<sup>th</sup> 2002 and 12<sup>th</sup> August 2003.

### **Chief Inspector of Prisons Reports into Styal prison – failure to act on recommendations**

The Prisons Inspectorate conducted a full inspection of Styal prison and its highly critical report published in February 2002 identified systemic failings particularly in the treatment and care of women withdrawing from drugs and the detoxification facilities available.

On 13 June 2004 another critical report was published by the Chief Inspector of Prisons Anne Owers CBE, following the Inspectorate's unannounced inspection of Styal in January this year.

In the June 2004 report the Chief Inspector says that despite her previous recommendation in February 2002 "*that, as a matter of urgency, a proper detoxification regime should be put in place*", little had been done:

*"Waite wing holds many of the most vulnerable women: remanded or recently-sentenced and in the great majority of cases withdrawing from drugs" said the Chief Inspector: "Yet, as our last report pointed out, there was no effective or safe detoxification: indeed, some women were fitting and vomiting in their cells."*

Funding for improved drug services was not made available until a year ago said the Chief Inspector and even then it was ill thought-through:

*"Only after the sixth death in mid 2003 was a methadone prescribing regime put in place to manage heroin withdrawal properly, and that regime was set up in great haste, within a matter of days".*

Safety in the initial stages of custody had undoubtedly been improved by the availability of methadone said Ms Owers:

*"However, what was available, and had been put in place at speed, was far from being a satisfactory regime for women in the first days of custody.*

*A combination of inadequate dispensing facilities and insufficient staff meant that the whole regime was focused around methadone dispensing, there was no regime to support and occupy prisoners during or after detoxification, and no care plans or monitoring; and very little that met the needs of non-drug-dependent women. "*

Women spent long periods of inactivity in their cells said Ms Owers - many for over 19 hours a day. Residential staff were often dispirited and distant, feeling that their role had been reduced to little more than medical orderlies - with the regime dominated by the dispensing of methadone.

*"There was an urgent need to improve the activities available to all those on Waite wing, and for a regime that supported detoxification, rather than one that was entirely dominated by prescribing"* said the Chief Inspector.

The use of force by prison staff at Styal - as in other female prisons - was high said Ms Owers, and she was particularly concerned about the frequency and length of use of the special cell for prisoners under restraint.

*"Women were held there for lengthy periods - an average of seven and-a-half hours - sometimes long after records showed that they had calmed down, managers were not monitoring the reasons, or the extent, of use of special cells... and, for the second time in recent inspections of women's establishments, we were disturbed to find that a woman who had been cut down from a ligature had been [disciplined] for refusing to move to a safer cell. "*

Home Office Ministers and Prison Service management must be held responsible for their failure to take action following the findings and recommendations of the Prisons Inspectorate.

The failure to make public the report of the Prisons Ombudsman which was concluded in December 2003 has meant that the key findings and conclusions of the Ombudsman investigation have not been disseminated across the prison estate, especially the women's prisons. Only one of the inquests into the six deaths into the deaths at Styal has yet taken place.

When the Prisons Minister announced the Ombudsman investigation into the death of Julie Walsh in August 2003 we issued the following comment:

*“While INQUEST welcomes the investigation into Julie’s death, we are extremely concerned that the Ombudsman will not be examining all the deaths at Styal. To select one death from the six that have occurred cannot capture a comprehensive overview of the systemic failings. This belated response to the serious disquiet about the series of deaths of women in HMP Styal is a missed opportunity. What is needed is a wide-ranging independent public inquiry that examines all of the recent deaths, any institutional and systemic failings and most importantly involves bereaved families and women prisoners themselves. We are concerned that the proposed inquiry with its limited time frame and narrow remit cannot possibly establish what is going wrong and ensure that lessons are learnt. 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. A full inquiry could examine all the deaths in this context and make a significant contribution to preventing any further loss of life.”*

A wide ranging inquiry held in public may well have prevented the shamefully rising death toll.

## Deaths in Police Custody

### **Update on Christopher Alder case**

There was a wide degree of public disquiet following the showing of the BBC documentary<sup>4</sup> about 37 year old Christopher Alder's death that included the video evidence of his death on the floor of the custody suite in Queens Gardens Police Station in Hull on 1<sup>st</sup> April 1998. The Home Secretary rejected calls for a public inquiry into this death, the police investigation and subsequent failed prosecution. Instead he referred the case to the IPCC asking them to conduct a review. The family have recently launched judicial review proceedings into the Home Secretary's decision not to hold a public inquiry. The IPCC are currently beginning their review.

### **Death of Kebba Jobe**

42 year old Gambian Kebba Jobe was arrested by police in the early afternoon of Saturday 15th May 2004. Undercover Metropolitan Police officers who had been involved in an ongoing operation to target the sale of soft drugs in the Camden Lock area of London had approached Kebba and a friend. Two officers identified themselves as police and Kebba's friend ran from the scene pursued by one of the officers. The remaining officer attempted to arrest Kebba and a struggle ensued. At some point during the struggle it is believed Kebba had severe breathing difficulties. Kebba is believed to have had a large packet of herbal cannabis in his mouth which it is alleged was placed in there by Kebba. Although many of the facts are unclear it is believed the officer had realised Kebba had swallowed or placed the package in his mouth. Passers by are believed to have told the officer that Kebba was clearly having difficulties breathing and had told the officer to get off him as he lay on the floor. Further officers arrived and London Ambulance Service were in attendance. It is believed that the officer failed to inform any of the other police officers or

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<sup>4</sup> Death on Camera BBC1 14<sup>th</sup> April 2004

the Ambulance staff that Kebba had something blocking his airway. Kebba died at the scene.

This was the first black death in police custody since the IPCC was set up and was an opportunity for them to demonstrate their independence and determination to disassociate themselves from the mistakes of the past where the police were investigating themselves in very contentious circumstances. The IPCC firstly agreed to the Metropolitan Police investigating before passing it to Essex Police who themselves had been discredited over their investigation of the Roger Sylvester case. Following representation to the IPCC by INQUEST and the UFFC it was announced on 13 August that the IPCC had taken full control of the investigation. While this was to be welcomed it was a belated response to a serious problem – clearly the beginning of an investigation is critical in securing the crime scene and key evidence, interviewing witnesses etc. and very much influences the ongoing investigation.

### **Deaths in psychiatric detention**

In February, the independent inquiry report into the death of David ‘Rocky’ Bennett was released.<sup>5</sup> The Inquiry’s findings were welcomed by INQUEST, particularly the recommendation that prone restraint should be used for no longer than 3 minutes, as well as its recognition of the role racism played in David Bennett’s death and of many of the issues INQUEST has been concerned about for many years.<sup>6</sup> The report was hard hitting in its condemnation of the racism within NHS mental health services and the contribution the panel believed it made to Rocky Bennett’s death. The Secretary of State for Health made a commitment in February, which he confirmed to parliament on June 8<sup>th</sup>, to set out an action plan and response to the recommendations by July. But a decision was made to reject key findings in relation to institutional racism and the suggested time limit on restraint.

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<sup>5</sup> Rocky was a 38-year old black man who had been a detained patient in the Norvic clinic for three years. His death followed an incident involving the use of restraint. The jury at the inquest returned a verdict of accidental death aggravated by neglect on 17<sup>th</sup> May 2001 and said that the cause of death was due to prolonged restraint and long-term anti-psychotic drug therapy.

<sup>6</sup> INQUEST gave extensive written and oral evidence to the Inquiry.

Following a meeting with the family, their lawyer and INQUEST the day before on 22<sup>nd</sup> July, the day parliament went into recess, there was a Ministerial Statement from the Minister of State, Rosie Winterton MP announcing the delay in publishing the response to the report to an unspecified date in the Autumn. The family and INQUEST have co-operated with the process from the outset and are deeply disappointed by the lack of progress made to date. One of the overriding concerns of both INQUEST and the family is that action needed to be taken urgently to prevent further deaths and improve the way families are treated following such cases. Our concerns echoed that of Sir John Blofeld, the chair of the Inquiry Panel who said at the launch:

*Some of our report makes gloomy reading. But it is more than time that the nettle of race relations in the mental health side of the NHS was firmly grasped.*

*Many of the matters in part two of the report had previously been identified in earlier reports and by different committees and seminars. It was important to gather them together in one document and to make comprehensive recommendations. Our report attempts to do this.*

*But now the time for identification of these topics is past. It is time to take action. Limited action has been taken in the past but it is a sorry tale of too little too late. There can in future be no excuses for delay.*

*Black and ethnic minority citizens should not have to claim their rights, they should be given them as a matter of course. They are not demanding more than they are entitled to, nor are they claiming preferential treatment. They are simply asking for justice, which has been denied them for too long.*

Nothing has happened to change practice since February, and on May 28, 24-year-old Azrar Ayub, a patient at the secure Edenfield Unit at Prestwich Hospital near Manchester was found dead following an incident involving alleged sedation and restraint by staff at the hospital.

## Treatment of Bereaved Families

### **The Independent Police Complaints Commission**

We are pleased to report that following our recent presentation to the Chair and Deputy Chair and the Commissioners, the IPCC have agreed to disseminate our information to bereaved families and we welcome this. We hope that Prisons and Probation Ombudsman takes note of this decision.

### **The Prisons and Probation Ombudsman**

INQUEST remains concerned that as we write the Prisons and Probation Ombudsman has still not agreed to distribute our specialist leaflets to families bereaved after deaths in prison custody. We still have families contacting us in some distress after a very difficult search to find our organisation some weeks or months after the death. The Prisons and Probation Ombudsman has only agreed to include us in a more general leaflet detailing support groups saying that they do not want “to act as a direct conduit for others”. As the only organisation working specifically with bereaved families following custody deaths we find this unacceptable and feel that is denying families their right to choose whether or not to take up such support. In our experience, families often have a mistrust of information given to them by state agencies and are more likely to respond to a leaflet that sets out the organisation’s work and its independence from any of the state agencies involved. In a recent presentation to the Ministerial group on suicide we raised the importance of families having the opportunity of accessing *independent* advice and support at the earliest possible stage and, whatever official systems are in place, there is still a vital role for independent advice, support and advocacy to assist families in effectively participating in the investigation and inquest and to make it a more meaningful process.

### **Equality of arms**

We are also concerned about the ongoing lack of equality of arms for families during the investigation and inquest process. This is both about the current arrangements for funding

for legal representation and also about the way the families are treated by the investigated organisation. At present INQUEST has to assist families with travel expenses in order for them to attend meetings with their lawyers.

### **The mother of Joseph Scholes**

In addition to the slow response in relation to the inquest verdict and the coroner's concern, we are also critical of the treatment of Yvonne Scholes by the Prison Service. On the final day of the inquest the Governor of HMYOI Stoke Heath was not present to hear the jury verdict and Coroner's Rule 43 recommendation. In our view this showed a lack of respect to Yvonne Scholes and the inquest process generally. The Treasury solicitor has also refused to cover the accommodation costs for Yvonne and her daughter incurred during the two week inquest on the grounds that she had suffered 'no hardship'. These costs totalled £400 – she did not claim for either travel costs or subsistence during this period and her accommodation was basic being the local Travel Lodge. The costs of the lawyers' fees and their accommodation and subsistence in one of Shrewsbury's nicest hotels were paid for by the taxpayer. This case does raise serious questions about whether the refusal to pay families' travel, accommodation and subsistence costs prevent 'next of kin and effective participation' as recognised as being an essential part of the state's obligation under Article 2.

### **The mother of Gareth Myatt**

We are very concerned about the way Gareth Myatt's mother was treated following her son's death. Until INQUEST's contact with the mother (after she was referred to us via the local media who were covering the Joseph Scholes inquest) she had received no information whatsoever about where she could go for advice and support, despite being in contact with various state agencies, the police, the Youth Justice Board and Social Services. She was unaware of her legal rights both in relation to a second post-mortem and in terms of instructing a solicitor. Our intervention meant that at a time when she was emotionally distraught about Gareth's death we were able to arrange a second post-mortem and the subsequent release of her son's body so that she could arrange the

funeral. We were also able to explain the legal processes that were operating and put her in contact with other families bereaved in similar circumstances.

This underlines once again to the need for families to be provided at the earliest possible opportunity information about INQUEST's casework advice and support service so that families can make an informed choice about whether to contact us.

### **Government response to the review of Coroners Services**

On 12<sup>th</sup> March the Government announced proposals on reforming the coroner and death certification service in response to the report of the Fundamental Review of Coroner Services and the Shipman Inquiry. A position paper was published that proposes a national system with oversight of all deaths based around full time independent legally-qualified coroners. INQUEST welcomes the paper's commitment to make the system sensitive to the needs of the bereaved. However the paper is very aspirational with no clearly stated commitments to many of the fundamental reforms necessary. We remain concerned that any new system is expected to operate within current costs and involve a re-allocation of existing resources rather than any new money. The proposed timetable for reform includes a proposal for a draft Bill and White Paper within a year. We hope that this will remain a continuing political priority for Government in the run up to a general election. The problems with funding, inquest delays, inadequate court provision etc. cannot be resolved without additional resources.

### **The inquest system**

In the House of Lords cases of Middleton and Sacker (11 March 2004) their Lordships affirmed that Article 2 of the ECHR required there to be an effective official investigation into a death involving the state. Both cases concerned prisoners who had hanged themselves in prison in circumstances where prison officers and health care staff might have done more to prevent the death.

INQUEST's third party intervention in the Middleton case was important in drawing the Lords' attention to the escalating number of self inflicted deaths in custody and the fact that aside from hospitals there is no other area of state responsibility where so many people die from potentially preventable causes; and the shortcomings of the inquest system in delivering meaningful conclusions about the responsibility and accountability of state agencies in relation to those deaths. Their Lordships were clearly concerned about the scale of the problem of suicides in custody and said that as a result the statistics;

*...highlight the need for an investigation regime which will not only expose any past violation of the state's substantive obligations already referred to but also, within the bounds of what is practicable, promote measures to prevent or minimise the risk of future violations.*

Inquest juries will now have more opportunity to draw attention to any failings in the circumstances surrounding the death through the use of more narrative verdicts, or in answers to questions put to them on factual matters by the coroner.

This recent ruling signifies a major breakthrough for inquest law. The essence of these decisions is that they require an inquest to return verdicts which properly reflect:

- a. Whether a person takes their own life in part because the dangers of their doing so were not recognised by the prison authorities;
- b. Whether appropriate precautions could have been taken to prevent the death.

These two judgements have the power to open up the inquest system and we hope that the spirit and actuality of the judgments will be reflected in the proposed reforms of the system. INQUEST commends the decision made by the House of Lords and hopes that this will result in a more meaningful inquest system where the prison service is held accountable for its actions and learns the lessons. No family should have to endure a death that does not result in a thorough scrutiny of individual and systemic failings.

The significance of this judgement was seen most recently in April at the conclusion of the inquest into the death of 16 year old Joseph Scholes. The jury returned a verdict of ‘accidental death in part contributed because the risk was not properly recognised or appropriate precautions were not taken to prevent it’. They also answered a long questionnaire given to them by the coroner in agreement with all parties, which drew attention to system failings they had identified. The coroner then publicly announced that he was bringing the circumstances and issues arising from Joseph’s death to the attention of the Home Secretary through the provision of the inquisition, questionnaire and various expert reports. In an unprecedented move he also recommended that a public inquiry be set up to examine in particular sentencing policy with regard to children as this was an area that was outside of the inquest’s remit. This was a meaningful conclusion to an inquest that heard very disturbing evidence about systemic failings to protect a vulnerable and damaged child while in the care and custody of the State.

## **Funding**

We are dealing with ongoing problems in obtaining public funding for legal representation for families. The reforms to the system that have provided for public funding for representation at inquests were welcome but their operation is proving an additional stress for already distressed families who find themselves enmeshed in a legal system following a death in custody about which they have no choice. INQUEST Lawyers Group members are constantly engaged in huge amounts of work to obtain funding for legal representation with little uniformity of approach to decision making in the various Legal Services Commission (LSC) offices across England and Wales. Frequently lawyers are being given very limited money for preparation of cases. Currently we are awaiting a decision from Ministers in the Department of Constitutional Affairs (DCA) about changes to the guidance following a short consultation that concluded in May 2004 in the aftermath of the Khan<sup>7</sup> case that raised questions about Article 2 related cases and the discretion to waive financial eligibility criteria. We are hopeful that some of the most iniquitous aspects of the current system will be addressed but remain concerned about the ‘exceptional cases’ formula as there appears to be no clarity about what constitutes an exceptional case. The

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<sup>7</sup> R v Secretary of State for Health ex p Khan 2004

use of the word “exceptional” and the requirement on the applicant to prove that they will assist the inquiry represent a fundamental misunderstanding of the law on Article 2 and will be unworkable in practice.

INQUEST and its Lawyers Group believe that the DCA and LSC are mistaken in relation to the Court of Appeal’s conclusions in Khan and the Middleton<sup>8</sup> definition. In Khan the requirement of funding was expressed by reference to the exceptional nature of the case. However, the Court of Appeal relied on i) the need to call independent medical evidence and ii) the possibility of a neglect verdict in finding the case was exceptional.

We believe a fairer approach would be for the LSC/DCA to look again at the Middleton definition and set out the hurdles that an applicant needs to overcome to meet that test. We do not believe that relying on Middleton rather than the current proposal will bring more cases in scope than the Court of Appeal envisaged in Khan. We think the DCA/LSC should focus on the preparation of a modified merits test whereby an applicant had to demonstrate the likelihood of a finding that state agents were implicated in the death (through action or inaction) whether with regard to direct responsibility in the death or a failure to establish a framework of laws, precautions, etc.

The problems relate not only to representation at inquests but also occur if inquest verdicts are challenged by way of judicial review as demonstrated below. In the case of Roger Sylvester<sup>9</sup> the Metropolitan Police Authority (MPA) decided to provide public money to assist the Police Federation to represent eight police officers in a judicial review to challenge the unlawful killing verdict returned at his inquest. After extensive lobbying by INQUEST to overturn the controversial decision, the MPA voted to only fund the police officers’ legal costs if they were granted the right to fund the Sylvester family also. It later transpired that this would be the case.

INQUEST believes that this further highlights the lack of clarity in terms of funding for inquests and related legal proceedings and we would like to draw the Committee’s

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<sup>8</sup> R(Middleton) v West Somerset Coroner [2004] 2 WLR 800

<sup>9</sup> See INQUEST briefing

attention once more to the fact that it has often been the lawyers instructed by the family who have pushed these boundaries to secure funding for some families. But this funding is sporadic and needs to be consistent. It still remains the case that despite the welcome reforms there is unlimited public funding for experienced, good- quality lawyers to represent the police and other bodies, while those representing families in their struggle for truth, justice and accountability have to make lengthy and time-consuming representations to the Legal Services Commission for the little funding they receive. We are also concerned that the introduction of limited public funding has not been accompanied by a concurrent introduction of appropriate quality standards for those representing bereaved people. We have witnessed and heard of lawyers representing families sitting through weeks of inquest hearings and making little or no verbal intervention at all.

### **Conclusion**

In concluding we want to reiterate our view that a Standing Commission on Custodial Deaths be set up which would bring together the evidence collected from the separate investigation bodies in place to investigate deaths in custodial settings. Our monitoring of deaths in custody this year further illustrate concerns about the number of cases raising concerns concerning degrading and inhuman treatment and the failure of the State to learn the lessons arising from the cases and the lack of joined up thinking between government agencies. Such a Commission could play a key role in the promotion of a culture of human rights and promote measures to prevent or minimise the risk of future violations of Article 2 of the Human Rights Act.

Deborah Coles, Helen Shaw

Co-directors INQUEST, September 2004

## Appendix 1. Deaths In Custody 2004

### Deaths In Police Custody 2004

All Deaths In Police Custody 2004	
Type	Number
Custody	18
Pursuit	10
RTA	1
Shooting	2

Black deaths in Police Custody 2004	
Type	Number
Custody	1
Pursuit	1

Restraint-related deaths in Police Custody 2004	
Force	Number
All Forces	2

Date of Statistics: 14<sup>th</sup> September 2004; Source: INQUEST monitoring

## Deaths In Prison 2004

<b>All Deaths in Prison by Classification 2004</b>	
<b>Classification</b>	<b>Number</b>
Self-Inflicted	72
Non-Self-Inflicted	76
Homicide (NSI)	1
Awaiting Classification	6

<b>Black Deaths in Prison 2004</b>	
<b>Classification</b>	<b>Number</b>
Self-Inflicted	8
Non-Self-Inflicted	7
Homicide (NSI)	1
Awaiting Classification	1

<b>Youth Deaths in Prison 2004</b>	
<b>Classification</b>	<b>Number</b>
Self-Inflicted	4
Awaiting Classification	1

<b>Deaths in Secure Training Centres 2004</b>	
<b>Classification</b>	<b>Number</b>
Self-Inflicted	2

<b>Deaths of Women in Prison 2004</b>	
<b>Classification</b>	<b>Number</b>
Self-Inflicted	11
Non-Self-Inflicted	6

<b>Immigration Deaths in Prison Custody 2004</b>	
<b>Classification</b>	<b>Number</b>
Self-Inflicted	2
Non-Self-Inflicted	1

Date of Statistics: 14<sup>th</sup> September 2004; Source: INQUEST monitoring

NB – Deaths in Secure Training Centres are not included in the overall total for deaths in prison.

Total deaths in Prison and Police Custody in the last 10 years (1993-2004) now stand at 2019 (NB - not including Police pursuits and Road Traffic Accidents).