



# ANNUAL REPORT 2005

## ABOUT INQUEST

INQUEST Charitable Trust was established in 1995 to complement and assist the work of its sister organisation INQUEST which was founded in 1981. In March 2004 the two organisations merged into a single charitable organisation known publicly as INQUEST. INQUEST Charitable Trust is a registered charity (number 1046650) and a company limited by guarantee (number 03054853).

INQUEST has a staff team of eight and is the only organisation in England and Wales which provides a specialist, comprehensive advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, MPs and the wider public. INQUEST has a free information pack available to any bereaved family which explains the whole inquest process and where to find emotional and practical support.

Our casework priorities are deaths in prison and police custody and in immigration and psychiatric detention. Our focus on deaths in custody and the monitoring of such deaths means that we are at the forefront of uncovering patterns and trends. Arising from this we have particular concerns about the deaths of women, black people, children and young people, and people with mental health problems. This is both in terms of the treatment and care received by the deceased in custody and the experience of bereaved relatives following the death.

INQUEST develops policy proposals and undertakes research to lobby for changes to the inquest and investigation process, reduce the number of custodial deaths and improve the treatment and care of those within the institutions where the deaths occur and that of bereaved families.

## The INQUEST Staff and Volunteer Team 2005

### INQUEST Charitable Trust Board

Louise Christian (Chair)	Partner, Christian Khan Solicitors
Adam Sampson (Deputy Chair)	Chief Executive, Shelter
Prof William Spence (Treasurer)	Department of Physics, Queen Mary, University of London
David Bergman	Director, Centre for Corporate Accountability
Prof Penny Green	School of Law, University of Westminster
Adrienne Jemmott	Customer Advisor, Planning Reception, Reading Borough Council
Rev Arlington Trotman	Chief Executive, Churches Commission for Racial Justice
Dr Tony Ward	Reader in Law, University of Hull

### INQUEST Advisory Group

Dr Joanna Bennett	Sainsbury Centre for Mental Health
Raju Bhatt	Partner, Bhatt Murphy Solicitors
Ruth Bunday	Partner, Harrison Bunday Solicitors
Jonathan Glasson	Barrister, Doughty Street Chambers
Dr Barry Goldson	Senior Lecturer, Department of Sociology, University of Liverpool

Tim Owen QC	Barrister, Matrix Chambers
Prof Mick Ryan	Law Department, University of Greenwich
Mark Scott	Partner, Bhatt Murphy Solicitors
Prof Phil Scraton	Institute of Criminology and Criminal Justice, Queen's University, Belfast
Prof Joe Sim	School of Social Science, Liverpool John Moores University
Dr Richard Stone	Panel member of the David 'Rocky' Bennett Inquiry, President of the Jewish Council for Racial Equality and Vice-Chair of the Runnymede Trust
Leslie Thomas	Barrister, Garden Court Chambers
Jane Winter	Director, British Irish Rights Watch

## Co-directors – Deborah Coles and Helen Shaw

The Co-directors are jointly responsible for leading INQUEST and ensuring its continued credibility as a high-profile human rights organisation. They are responsible for staff management and supervision as well as organisational and team development. They devise INQUEST's strategic policy on reform of the inquest system and issues arising from casework, in particular in relation to deaths in custody, and liaise with the government – frequently at ministerial level – and other relevant organisations. The Co-directors lead specific projects and undertake research to assist the organisation in achieving meaningful change in related policy and practice. They represent the organisation both orally and in writing at external events and in the media and work on individual cases ranging from inquests to evidence sessions in parliament. The Co-directors also deliver training based on INQUEST's work to a wide variety of audiences and edit *Inquest Law* magazine.

## Gilly Mundy – Senior Caseworker

### Catherine Hayes – Caseworker

The Caseworkers' primary role is to advise and support bereaved families on their rights in relation to the investigations that occur after a death. They will accompany families to meetings as time and resources allow with lawyers and with investigators from the Prison and Probation Ombudsman (PPO) and the Independent Police Complaints Commission (IPCC) as well as attend inquest hearings. The Caseworkers collate information gathered from previous deaths and from their experience of policy and practice and are a source of knowledge which is available to families and their legal teams. If appropriate they will refer or signpost families to other specialist advice agencies.

## Communications Officer – Marcie Shaoul (until November 2005)

The Communications Officer was responsible for the production of all external publications, including the annual report, newsletter and *Inquest Law* magazine. The Communications Officer was also responsible for writing and disseminating press releases and for media relations. The role included organising events, co-ordinating the volunteer scheme and working with the Information Worker to distribute information including updates to the website.

## Office Manager – Melanie Lowe (until December 2005)

The Office Manager was responsible for co-ordinating administrative matters, had direct input into fundraising and was responsible for finances for the organisation as well as having a supervisory role.

## Information Worker – Richard Fontenoy

The Information Worker is responsible for monitoring statistics and analysis of emerging trends in deaths in custody. This post includes provision of information and statistical analysis to INQUEST staff, outside organisations and other interested parties. The Information Worker is also responsible for the improvement and maintenance of existing databases and overseeing the development of new systems and monitoring, managing and distributing incoming information to the staff team.

## Researcher, Women's Deaths in Prison Project – Marissa Sandler (from April 2005)

A temporary position as part of INQUEST's 18 month project on women's deaths in prison. The post involves researching the issues arising from the individual deaths and what they highlight about the treatment and care of women in prison and the criminal justice system generally and drafting the final project report.

## Research Assistants – Adam Barty (until March 2005) Lucie Wibberley (from June 2005)

The Research Assistants worked with the Co-directors on a report which examines families' experience of the investigation and inquest system following a death in custody. They analysed raw data and conducted interviews with legal and advice practitioners; summarised reports by other bodies and organisations; and helped the Co-directors with their administration needs in relation to the project.

## Volunteers – Julia Bowater, Sabrina Coelho, Efstathios Divaris, Kajel Doshi, Daniel Harbord, Susan Hill, Imthiar Khan, Rebecca Linacre, Lauren McCann, Kate McGhee, Putri Mohd Najib, Joanna Peters, Shenna Thomas, Fiona Wallace and Lucie Wibberley

The volunteers provide vital support for the INQUEST staff team. They are an important resource, assisting staff with tasks such as press monitoring, filing, mailings, research projects and note-taking at inquests. The majority of the volunteers have come to INQUEST via schemes at both the College of Law and Inns Of Court School of Law in London. INQUEST was invited to join the pro bono panel for the College of Law to help shape their volunteer scheme for their students.

## CO-DIRECTORS' OVERVIEW OF THE YEAR

2005 was another extremely busy and challenging year. Alongside the continuing high number of deaths in custody requiring our in-depth casework service there was an increased demand for our views at a policy and parliamentary level. The key themes underpinning the year have been our continuing work on custodial deaths of children, young people, women and people from black and minority ethnic (BME) communities, the treatment of bereaved families following deaths in custody and the functioning of the current investigation systems. We have raised concerns with parliamentarians, policy makers, other organisations and the media and have again seen them acknowledged and taken up by others. The work of the new bodies who assumed responsibility for the investigation of deaths in police and prison custody in 2004 – the Independent Police Complaints Commission (IPCC) and Prisons and Probation Ombudsman (PPO) – has also come under greater scrutiny as the first inquests following their investigations took place. Ensuring both organisations are aware of our concerns and those of the families we work with has been crucial.

In the first part of the year political, media and public concern about deaths in custody – in particular of young people (see pages 7-8) and women in prison (see page 6) – continued at a high level but the spotlight was thrown onto the systems of investigation in an unprecedented manner following the shooting of Jean Charles de Menezes (see page 8). This year has also seen a consolidation of the changes heralded by the Middleton judgment, notably with inquests into contentious deaths taking longer and more narrative verdicts being returned.

### CHANGES AT INQUEST

In September we moved into new purpose-built offices which provide a better working environment for the staff team and give us an adequate space for both team and Board meetings and to host meetings with external visitors. Two staff members – the Office Manager, Melanie Lowe and Communications Officer Marcie Shaoul – moved on at the end of the year and we thank them for their contribution to our work. As the latter post was only funded until March 2006 it was not possible to recruit a permanent replacement and the role was filled by a temporary member of staff. Recruitment to replace the Office Manager proved difficult and was only resolved in 2006 by redefining the post as the Fundraising and Development Manager which added emphasis on fundraising and organisational development. Both these vacancies affected the organisation and placed additional strain on the small staff team who all shouldered additional responsibility. Despite this, the profile and reach of the organisation continued to grow, with understanding and support for our work developing to an unprecedented level.

### GOVERNMENT RESPONDS TO THE ROCKY BENNETT INQUIRY

In January the government finally published its response to the report of the Independent Inquiry (February 2004) into the death of David 'Rocky' Bennett while being restrained in psychiatric detention. The family had to wait six years and three months to hear what action was proposed to prevent others dying in similar circumstances.

In response to the Inquiry, the government had the chance to radically reform the delivery of mental health services to people from black and minority ethnic communities. It was also an opportunity to stop the practice of using physical force as the first response to violence and to

## **INQUEST's key events in 2005:**

### **January**

- Raised concerns about the government's response to the Rocky Bennett Inquiry Report
- Addressed a meeting of the All-Party Parliamentary Penal Affairs Group on deaths in prison and their prevention
- Met Hilton Dawson MP about *Prison Is No Place For Children* campaign in advance of the general election
- Met Coroner's Review Team at the Home Office
- Sarah Campbell inquest starts and lasts for two weeks – attended the inquest, assisted with legal preparation, co-ordinated media work and supported family
- Spoke at the UNISON Black Members Conference on black deaths in custody.

### **February**

- INQUEST Lawyers Group meeting with Independent Police Complaints Commission on investigating deaths in police custody
- Met the Department of Health about Rocky Bennett Inquiry and NICE guidelines
- Recruited Women's Deaths Project researcher
- Met officials from Coroner Section at the Home Office for update on current issues

confront the currently inadequate response to staff and patient racism within mental health settings. We were concerned that it took a violent death to precipitate such change and that it remained to be seen what would really happen at the point of service delivery as the issues were not new and no fundamental change had taken place in the six years since Rocky Bennett died. Nearly a year after the publication of the Inquiry report, there was still no standard policy on the use of restraint across mental health and other custodial settings.

INQUEST is concerned that there is no independent body to investigate deaths in psychiatric detention nor any central monitoring and publicly available statistics of the numbers and types of deaths that occur. We will continue to campaign for such changes to be put in place to ensure that public servants who are entrusted with the care of seriously vulnerable and sick people are held to account for their actions when someone dies in their custody.

## **WOMEN'S DEATHS IN PRISON**

INQUEST remains extremely critical of the failure of the prison service and government to address the wider questions raised by deaths of women in prison, particularly about the overuse of prison for women. A large percentage of these women are primary carers whose imprisonment has far-reaching consequences for them, their families and society in general. Throughout 2005 we worked with many of the families of the women who died and attended a number of inquests which returned highly critical narrative verdicts.

Prompted by serious concerns at the disturbing number of such deaths and the issues emerging at the inquests, INQUEST appointed a full time researcher in April 2005 to work on a Women's Deaths in Prison Project for 18 months. The project was funded by a grant from Atlantic Philanthropies.

The project is research-based and focuses on INQUEST's involvement with the families of women who have died in prison custody with the aim of preventing further deaths. It draws together the cases and extracts relevant policy issues both on the treatment of women in the criminal justice system and of bereaved people after the deaths. The researcher has built a comprehensive database based on INQUEST's case files, interviewed relevant policy makers and organisations and the women's families and friends. We hope that the report will raise public awareness about the damaging and often tragic consequences of imprisoning women and bring about fundamental changes to prevent further deaths.

## DEATHS OF CHILDREN IN CUSTODY

INQUEST's casework shows that child deaths in custody are often linked to failings in the community and the inappropriate use of penal custody for vulnerable children. They often receive inadequate treatment in institutions which are unable to care for the vulnerabilities of those that they detain. Child deaths in custody raise issues that need to be addressed through a properly resourced inquiry so that appropriate recommendations are made to ensure that safeguards are put in place to protect the lives of children.

Work continued this year on our project covering deaths of children and young people in state custody which was funded by a grant from the Diana Memorial Fund. The key areas of work on the project are detailed below.

The campaign for a public inquiry into the death of Joseph Scholes 16-year-old Joseph Scholes died in HMYOI Stoke Heath in 2002. The coroner at the inquest into his death held in April 2004 made an unprecedented call for a public inquiry to be set up in light of the issues that had arisen at the inquest. Despite the deaths of 29 children since 1990 – five of which have been since the death of Joseph – there has never been a public inquiry into the death of a child in penal custody.

The government published its response to the parliamentary Joint Committee on Human Rights' report on Deaths in Custody in February 2005. In reply to the Committee's recommendation that there should be a public inquiry held into Joseph's death – a call supported by more than a hundred MPs and peers, plus key children's rights and penal reform organisations – the government said that they had considered an inquiry but concluded that it was unlikely to bring to light any additional factors not already uncovered in the earlier investigations.

On 15 March Joseph's mother Yvonne organised a silent protest outside the court where he had been inappropriately sentenced. The third anniversary of his sentencing was used to highlight the long term and ongoing systemic abuse and deaths of children in custody. She was joined by Carol Pounder, mother of 14-year-old Adam Rickwood who died at Hassockfield Secure Training Centre in August 2004, becoming the youngest recorded death in penal custody in modern times. INQUEST worked with her family lawyer to raise our concerns about his case at ministerial level.

A list of signatories to the call for a public inquiry can be found on the INQUEST website.

### March

- Met Coroner Reform Team at the Home Office
- Draft Corporate Manslaughter Bill published and INQUEST raises concerns that public bodies such as prisons are exempt from its provisions
- Met the Deputy Prison & Probation Ombudsman
- Joined IPCC Advisory Group
- Permission refused at High Court for judicial review of the inquest into the death of Kelly Pearson (death from overdose in 1999 of 30-year old woman following release from unlawful arrest on expired warrant)

### April

- Women's Deaths Project starts
- Spoke at launch meeting of ASBO Concern
- Judicial Review of the inquest verdict by Metropolitan Police officers who shot Harry Stanley dead in 1999
- Spoke at the parliamentary launch of the *Prison Is No Place For Children* campaign

### May

- Harry Stanley judgment overturns inquest verdict of unlawful killing, followed by threat of strike by Metropolitan Police armed officers.
- Met the deputy Ombudsman and the fatal incident investigation team at the

office of the Prison and Probation Ombudsman

## June

- Crown Prosecution Service decision not to prosecute Metropolitan Police officers involved in the death of Kebba Jobe, the first black death in police custody which was investigated by the IPCC
- The CPS re-affirm their previous decision that no officers will be prosecuted over the restraint-related death of black man Roger Sylvester in Metropolitan Police custody in 1999.
- Ran joint training course *Deaths in Detention: The New Approach for Inquests* with the Institute of Mental Health Law
- Took part in *Prison Is No Place for Children* campaign during run up to election
- Co-director was a member of the judging panel for the Legal Aid Lawyer of the Year awards
- Met MPs from the State of Victoria on inquest systems in UK and Australia
- Attended IPCC Advisory Group meeting
- Responsibility for coroners moved to Department for Constitutional Affairs (DCA) from the Home Office

## July

- Launch of *In The Care Of The State?* at Houses of Parliament

## INQUEST publishes book on child deaths in custody

The key publication arising from the Diana Memorial Fund project was *In the Care of the State? Child Deaths in Penal Custody in England and Wales*, which was launched in Parliament in July to critical acclaim. Written by Dr Barry Goldson and Deborah Coles, and published by INQUEST, the book provides the first detailed analysis of child deaths in penal custody and presents key conclusions and recommendations. These include the abolition of prison custody for children; a comprehensive review of child deaths in penal custody; the creation of an independent Standing Commission on Custodial Deaths; and a full public inquiry into the death of Joseph Scholes.

Former HM Chief Inspector of Prisons Lord David Ramsbotham said at the launch: “*This is a splendid book and forms the most momentous part of the campaign for a public inquiry.*” He also said that he would “...entirely endorse the recommendations made in this book... [particularly] ... the need for a Standing Commission on Custodial Deaths.”

Nearly 200 copies of the book had been sold by the end of the year.

INQUEST continued its parliamentary and campaigning work to take forward the recommendations in the book throughout 2005. INQUEST also supported the *Prison Is No Place For Children* campaign sponsored by Hilton Dawson MP in the run up to the general election in May.

## Another child dies in custody

On 15 September 2005 17-year old Sam Elphick was found hanging in HMYOI Hindley. He became the twenty-ninth child to die in the custody of the State since 1990.

## THE SHOOTING OF JEAN CHARLES DE MENEZES

Widespread outrage followed the shooting dead of Jean Charles de Menezes by the Metropolitan Police on a London underground train at Stockwell tube station on 22 July. As has happened repeatedly in previous cases there was a pattern of misinformation in the immediate aftermath of the shooting that attempted to deflect attention away from the actions of those who had killed Jean Charles de Menezes, misinformation that the Metropolitan Police Commissioner and the IPCC chose not to correct. His death raised many crucial issues which INQUEST raised in its joint submission with the INQUEST Lawyers Group and Police Actions Lawyers Group to the Home Affairs Committee in September 2005.

Despite the exceptional context in which the shooting took place, it drew attention to many factors that arise following contentious shootings by the police. In April, Azelle Rodney was shot dead by

Metropolitan Police officers, and we have been working to advise and support his family. At the time of his death INQUEST commented that we had grave concerns about the increasing number of fatal shootings by police, noting that there had been fourteen since 2000, three of which were of black men. This death once again raised serious questions about the disproportionate number of young black men who die following the use of force by police. In May the High Court overturned the inquest verdict of unlawful killing in the death of Harry Stanley, following threatened strike action by Metropolitan Police armed officers.

## POLICY AND PARLIAMENTARY WORK

Throughout 2005 we briefed parliamentarians and policy makers about the issues emerging from our casework.

### Deaths in Custody

In June the House of Lords debated the government's response to the Joint Committee on Human Rights report on Deaths in Custody published in December 2004. Many of the issues we had raised were also raised by members of the Lords in their criticisms of the government response.

INQUEST produced a parliamentary briefing on self-inflicted deaths in prison and prison overcrowding which informed a House of Lords debate on suicide in prisons in October 2005. The briefing drew attention to the contribution to these deaths of inadequate care for the vulnerable: those with mental health problems, drug or alcohol problems, victims of physical and sexual abuse, individuals targeted for bullying once in prison and children unable to cope with separation from their family and the demands of a brutal custody regime. It also pointed out that inadequate care is regularly compounded by systemic neglect: inadequate attention to health records, failure to share paperwork that identifies an individual's high risk of self-harm or suicide, lack of communication between staff within the prison, failure to provide adequate detoxification for new prisoners with a drug or alcohol problem, lack of training in suicide awareness and failure to implement suicide prevention policies, use of segregation for those at risk of suicide and self harm, and failure to identify and address systematic bullying.

We argued that evidence arising from inquests into deaths in custody points increasingly to the fact that the system is not, in its present form, able to meet the duty of care that it has to vulnerable prisoners, thereby breaching the state's obligations under article 2 of the Human Rights Act 1998. The breach is compounded by the state's failure, because of the problems with the inquest and death

- Attended Ministerial Round Table Group on Suicides in Prison
- Spoke at Capita conference on deaths of women in prison
- Coroners reform meeting at DCA
- Shooting of Jean Charles de Menezes at Stockwell Underground station in South London

### August

- Spoke at meeting on women in the criminal justice system at the Fawcett Society
- Carol Pounder, mother of Adam Rickwood, made a sponsored parachute jump and raised £721 for INQUEST
- Following the shooting of Jean Charles de Menezes we held a meeting with a delegation from the Brazilian government – including a senior federal prosecutor, the director of the Department for the Brazilian Communities Abroad and the deputy director of the Department of International Legal Co-operation of the Ministry of Justice – to outline the process which follows police shootings.

### September

- INQUEST moves to new offices
- Asked to make a statement in the case of Prisoner "D" as part of a High Court judicial review (man in persistent vegetative state following an attempt to take his own life at HMP Pentonville)

- Attended seminar at the Fawcett Society's Commission on Women and the Criminal Justice System on women defendants and offenders
- Attended IPCC Advisory Group meeting
- Submitted evidence to the Zahid Mubarek Inquiry
- Spoke at Law Society meeting on the impact of the Middleton judgment on the inquest system
- INQUEST's Late Summer Reception at the October Gallery

### October

- Held joint ILG and Police Action Lawyers Group special meeting on police use of force
- Spoke at Northern Ireland Human Rights Commission conference on women in prison in Belfast
- CPS decides no officers will be charged over the fatal shooting of Harry Stanley
- Spoke at Nacro conference on reducing custody for young people who offend
- Spoke at public meeting on deaths in immigration custody organised by Bail for Immigration Detainees (BID)
- Attended the United Friends and Families Campaign's annual remembrance procession of relatives of people who have died in custody from Trafalgar Square to 10 Downing Street

investigation system, to adequately investigate and learn from each death in order to protect the lives of others. We argued that for these reasons the inquest system is unable to draw parallels between cases and track similarities and themes of bad practice which could be reformed, and of good practice that can be replicated. Repeating the recommendation made in our book *In the Care of the State?* we called for a Standing Commission on Custodial Deaths which would bring together all of the experts in the field, together with evidence collected from the separate investigation bodies in one place to investigate deaths in custody. Its purpose would be to identify the failings as well as moderate achievements of the present system and make recommendations by looking beyond individual deaths and/or particular state agencies at the common concerns that link each death.

### Prison Health Care

We briefed members of the House of Lords on the issues arising from our casework for a debate on prison health care in November and highlighted the following issues: access to medical services, psychiatric services, detoxification facilities, quality of medical staff and the role of Primary Care Trusts. We gave case examples to illustrate our concerns, one of which was quoted by Lord Chan, who said:

*“On the plans for provision of healthcare in prisons through the NHS, the PCT-Prison Partnership Board is the body that takes responsibility for deciding how best to provide prison health care services. There has been no clear evidence of improvement or good practice in prison health since the changes made in April 2003. Reports of problems in healthcare appear to be no different from before the PCTs took over commissioning for prison health. The lack of change suggests that prisoners are not being offered the same quality of care we would expect from the NHS outside of prison.*

*For example, a 40 year-old man died of a suspected heart attack on 28 April 2005 in Her Majesty's Prison Frankland. At 9.30 am, he complained of chest pains to his mother by telephone. She encouraged him to see a doctor, but he said that it was impossible to access medical care. Eventually, he was able to see a doctor at 3.45 pm, but the prison doctor saw nothing of immediate concern and the man was not placed in the healthcare centre of the prison. He again complained of increasingly severe chest pain, but he was told to see the doctor on the following day; but that evening he was found collapsed in his single cell by a fellow prisoner who raised the alarm. His mother has understandably raised a number of issues about this prisoner's healthcare and whether early intervention could have prevented his death.”*

## Prison Overcrowding

In November INQUEST gave written and oral evidence to the Home Affairs Committee on our concerns about deaths in prison. The Committee had decided to take evidence on Prison Suicides and Overcrowding. The aim of the session was to explore the reasons for the recent increase in self-inflicted deaths in prison and what can be done to reverse the trend, taking into account the current level of overcrowding. It was a one-off session and not part of a wider inquiry.

We gave evidence alongside the Prison Reform Trust, the Howard League for Penal Reform and Pauline Campbell, the mother of a young woman who died in prison. We drew attention to many of the concerns we had briefed members of the House of Lords about for their debate on suicide in prisons in October. In particular members of the committee wanted INQUEST's views on the new policies and initiatives of the government and we were able to draw attention to the disparity between the paper policies and their implementation. In discussing the new system for assessing whether prisoners were at risk of self-harm or suicide we said the following:

*“It is another example of something that looks very good on paper...It is a new form, it requires another layer of assessment and it talks about the importance of assessors who carry out the in-depth screening of vulnerable prisoners. The concern is, in terms of overcrowding and the impact on staff time, whether or not staff are going to have the time to implement the policy as it is written on paper.”*

## Corporate Manslaughter

INQUEST worked with Centre for Corporate Accountability in commissioning a legal submission to the Home Affairs Committee's scrutiny of the draft Corporate Manslaughter legislation in March, drawn up by INQUEST Lawyers Group members Tim Owen QC and Henrietta Hill. We also briefed the Prison Reform Trust (PRT) before they gave oral evidence to the Home Affairs and Work and Pensions Sub-Committee on the draft Corporate Manslaughter Bill in November. The PRT shared our concern that the police and prison service should not be exempt from prosecution for deaths, even if a death takes place as a result of gross failures by senior management. In our view deaths in prison and police custody which could be the result of negligence should be subject to police investigations and possible prosecutions in the same way as any other organisation.

## November

- Gave evidence to Home Affairs Committee hearing on prison overcrowding
- Attended the Nacro AGM
- Attended a stakeholders meeting at the DCA on a proposed family charter for bereaved people
- Briefed Prison Reform Trust to inform their evidence to the Home Affairs and Work and Pensions Select Committee hearing on the Draft Corporate Manslaughter Bill
- Attended Women In Prison AGM
- Met Harriet Harman QC MP, Minister of State at the DCA, on reform of the coroner's inquest system
- Presented paper at Centre for Crime and Justice Studies conference on deaths in custody
- Spoke at Children's Rights Alliance meeting on deaths of children in custody
- Spoke at Capita conference on deaths in police custody
- Unsuccessful Judicial Review at High Court of government's decision not to hold a public inquiry into the death Joseph Scholtes.

## December

- Spoke at Deepcut and Beyond meeting on legal aid for inquests
- Attended IPCC Advisory Board meeting

## Casework Service

The aim of our casework service is to advise families and empower them through the provision of information and advice about their rights. Because of the length of time from the death to the conclusion of the investigation and inquest process our support can last for a number of years.

In 2005 the casework team dealt with a total of 312 cases, with 97 of these brought forward from previous years. This workload generated close to 2,400 casework-related telephone calls.

### General Advice

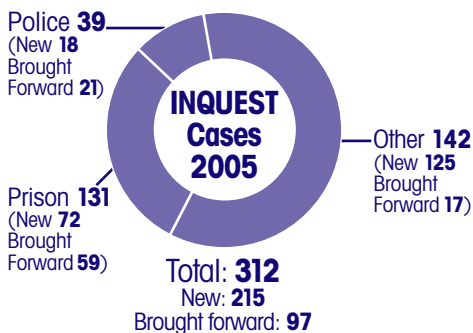
2005 was the first full year providing service with two full-time dedicated caseworkers which has enabled us to attend more inquests and to make contact with and provide advice to a greater number of families. Although the new caseworker was in post from September 2004, we were still able to provide the in-depth service described in only a relatively small number of cases.

We operate a telephone-based service offering free support, advice and information on their basic rights in the coroner's court to all bereaved people facing an inquest. There is no other organisation in England and Wales with such specialist knowledge about the inquest system. People contacting our informed casework team have access to our comprehensive Information Pack and leaflets concerning specific details of both deaths in prison and police custody. INQUEST also provides information to bereaved people about how to access other services and in many non-custody related deaths we will provide both advice and referrals to other organisations. For example, road traffic related deaths are referred to RoadPeace, work related deaths to the Centre for Corporate Accountability and deaths in hospital to Action against Medical Accidents (AvMA) for specialist advice and support. We also monitor legal issues arising from these cases that concern the inquest system.

### Deaths in Custody

INQUEST provides an in-depth casework service when an inquiry falls within one of our priority areas – prison and police custody and psychiatric or immigration detention. Our service involves arranging legal representation for a family and/or other bereaved people and then working as an integral part of the legal team, advising and supporting lawyers and providing detailed background information on similar cases. We ensure that families have access to our pool of experienced lawyers who in turn brief us on any issues arising from the death and its investigation. In a proportion of cases we arrange meetings with MPs, carry out press and media work, attend the inquest and follow up on the issues that emerge. The latter can include verbal and written submissions to parliamentary inquiries and the production of briefing papers as well as supporting individual family campaigns. However, because of the high number of prison deaths in particular during 2005 it was not possible to provide this level of service in all cases due to the small size of our staff team.

In November 2005, we learned that we were successful in our application to the Big Lottery Fund for our project *Responding To Bereaved Families – Improving The Inquest and Investigation System*. This will allow us to expand our casework team to three, which will enable INQUEST to provide an in-depth service to many more bereaved people.



INQUEST's service users include bereaved people and their legal representatives.

Cases brought forward from previous years form a significant part of our caseload. Sometimes a case can involve work by inquest with families and their legal teams for many years before, during and after the inquest proceedings themselves.

## Inquests 2005:

This list shows the inquests which have taken place in 2005 where we have worked to advise the family and or their lawyers. As the section on casework shows, we try and ensure that we raise the issues arising from inquests at a policy and parliamentary level. In all cases we monitor, collate and analyse inquest findings and verdicts.

### January

- Sarah Campbell (self-inflicted death of 18-year old woman at HMP Stryal in 2003)
- Kebba Jobe (restraint-related death of black man in Metropolitan Police custody in 2004)
- April Sherman (self-inflicted death of 27-year old woman in Edmunds Hill Prison in 2004)

### February

- Paul Day inquest opens (self-inflicted death in segregation unit of mixed-race man at HMP Frankland in 2002)
- Helena Price (self-inflicted death of 27-year old woman in New Hall Prison in 2003)
- Jolene Willis inquest (self-inflicted death of young woman at Stryal prison in 2003)
- Kwame Wiredu inquest (death of black man in Metropolitan Police custody in 2002)
- Hayley Williams inquest (self-inflicted death of 41-year old woman at HMP Stryal in 2003)
- Julie Lewis inquest (death of woman at HMP Eastwood Park in 2004)

- Stephanie Horrocks (non-self-inflicted death of 27-year old woman in Eastwood Park Prison in 2004)
- Alan Brittan (self-inflicted death of 56-year old man in Birmingham Prison in 2003)
- Steven Hampson (self-inflicted death of 19-year old man in 2002 at Hindley YO)
- Kevin McSweeney (self-inflicted death of 35-year old Irish man in Wandsworth Prison in 2003)
- Fiona Gale (self-inflicted death of female detained psychiatric patient in 2004)

### March

- Paul Day inquest verdict returned
- Ann-Marie Bates inquest (self-inflicted death of young woman in Brockhill Prison in 2001) opened and then adjourned
- Rickki Scears (self-inflicted death of 42-year old man in Wandsworth Prison in 2004)
- Christopher Hewitt (self-inflicted death of 50-year old man in psychiatric detention in 2004)

## April

- Julie Walsh inquest (self-inflicted death of woman at Styal prison in 2003)
- Stuart Horgan (self-inflicted death of 39-year old man in Woodhill Prison in 2004)
- Nariman Tahmasebi (self-inflicted death of Iranian man in Lewes Prison in 2002)
- Julie Lewis (non-self-inflicted death of 44-year old woman in Eastwood Park Prison in 2004)

## May

- Elmas Ozmiko inquest (death of asylum seeker in immigration detention at Dover in 2003)
- Joey Jackson inquest (restraint-related death of man in Essex police custody in 2002)
- Maurice Skinner (self-inflicted death of 52-year old man aboard The Weare prison ship in 2004)

## June

- Keith Larkins inquest (man shot dead by Metropolitan Police in 2003)
- Tina Bromley inquest (self-inflicted death of 37-year old woman in Edmunds Hill prison in 2004)
- Sue Stevens inquest (self-inflicted death of 48-year old woman in HMP Durham in 2003)
- Emma Levey inquest (self-inflicted death of 25-year old woman at HMP Downview in 2003)
- Miranda Cox (self-inflicted death of 41-year old woman at New Hall Prison in 2002)
- Colin Holcombe (death of 50-year old man in Wiltshire Police custody in 2003)
- Brian Carter (self-inflicted death of 34-year old man in Shrewsbury Prison in 2004)
- Steven Davies (self-inflicted

death of 49-year old man in Pentonville Prison in 2004)

- John Chester (self-inflicted death of 26-year old man in psychiatric detention in 2004)

## July

- Dimuka Bijoux inquest (death of Congolese asylum seeker at Haslar Detention Centre in 2004)
- John McFarlane (self-inflicted death of 26-year old man in HMP Liverpool in 2003)

## September

- Daniel Mootaz inquest (death from overdose of mixed-race man in HMP Parkhurst in 2003)
- Hugh Edwards (self-inflicted death of 30-year old man in HMP The Verne in 2004)
- Terry Sawford (self-inflicted death of 23-year old man in HMP Nottingham in 2004)

## October

- Trial of officers in Robin Goodenough case (man who died following contact with Oxfordshire police officers)
- Marcus Downie Junior inquest (self-inflicted death of 20-year old mixed-race man in HMP Chelmsford in 2002)
- Vincent Shem inquest (self-inflicted death of 32-year old Ghanaian man at HMP Wandsworth in 2005)
- Kwame Wiredu inquest (death of 25-year old black man in Metropolitan Police custody in 2002)
- Carol Savage (self-inflicted death of 50-year old woman in psychiatric detention in 2005)

## November

- Fosta Thompson inquest (20-year old black man shot dead by Metropolitan Police in 2002)
- Daniel Sutcliffe inquest (restraint-related death of man in

psychiatric detention in 2002)

- Andrew Barclay inquest (self-inflicted death of 20-year old man in HMP Norwich in 2003)
- Stephen Green inquest (self-inflicted death of 34-year old man in HMP Leicester in 2004)
- John Baxter inquest (self-inflicted death of 25-year old man in HMP Hull in 2004)
- Wendy Booth inquest (self-inflicted death of woman in HMP Durham in 2003) opens
- Jessica Adam inquest (self-inflicted death of young woman in HMP New Hall in 2003)
- Philip Prout inquest (53-year old man shot dead by Devon & Cornwall Constabulary in 2005)
- Stephen Marsden inquest (death of 56-year old man in West Yorkshire Constabulary custody in 2001)
- Brian Brown inquest (death of 69-year old man in Littlehey Prison in 2005)
- Phillip Powell inquest (death of man hit by taxi while being chased by Cheshire Police officers in 2003)

## December

- Hannah Kirkham inquest (self-inflicted death of young woman following bullying at work)
- Wendy Booth inquest concludes

## INQUEST Lawyers Group

The INQUEST Lawyers Group (ILG) is a national pool of committed, experienced barristers, solicitors and law students – including the leading inquest and human rights practitioners in the country – who provide preparation and legal representation for bereaved families at inquests. We work in partnership with the ILG to provide our high-quality casework service, working together on procedural and tactical matters.

ILG members have access to an email group in which ideas and questions are discussed and information on developments in inquest law is exchanged. Members receive *Inquest Law*, the only specialist journal of its kind, published three times a year and also available to non-member subscribers. The journal is edited by the INQUEST staff team and is written by members of the ILG and other invited parties. A number of coroners have subscribed, and the magazine has received praise for its coverage of significant cases, inquests and judgments.

## Statistics and Monitoring

INQUEST is the only independent organisation in England and Wales to collate statistics on deaths in custody. We monitor all deaths in custody and identify themes, trends and patterns that arise from these deaths and our casework priorities reflect these concerns.

Our statistics are aggregated from casework and information received from official and other sources and are used widely across the media. Although the statistics are regularly updated on our website, we will often get requests for specific statistics regarding a particular institution or type of death.

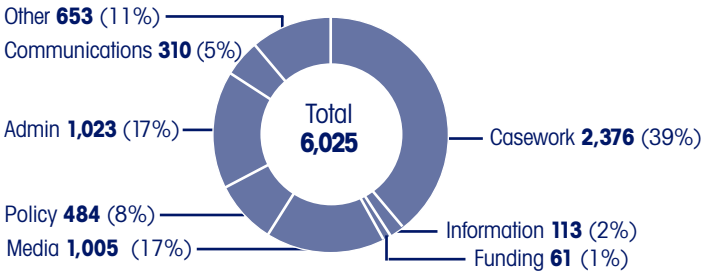
During 2005 there were 174 deaths in prison in England and Wales. Of these, 7 were women, 14 were young people and 29 were from Black and Minority Ethnic (BME) communities. There were 48 deaths in police custody in England and Wales in 2005, while another 45 deaths occurred as a result of Police Vehicle Incidents (PVI). Seven were deaths of BME people, in custody or as a result of police shooting, with 5 of these involving the Metropolitan Police.

Up to date detailed figures of deaths in prison and police custody by year is available on our website.

## Information Pack

INQUEST's comprehensive and highly-regarded Information Pack is freely available on our website, and was downloaded over 3,800 times in 2005. There were nearly 66,000 visitors logged to the website overall in 2005.

## INQUEST telephone work 2005



## Treasurer's Report for the year ended 31 March 2005

For INQUEST 2005 has been a year of consolidation. Income increased largely because of the large grant from Atlantic Philanthropies that we actually received in our 2004 financial year. We continued to monitor our expenses closely and were able to end the financial year to March 2005 with a net income of £82,598 enabling us to increase our unrestricted funds by almost £30,000 to £47,000.

The enormous amount of work that our staff team has been able to deliver has been due in large part to the generous donations of our funders, and we are grateful for their support. During the year, we received funding from the Association of London Government, the Atlantic Philanthropies, Two Garden Court, the Department of Health, the Diana, Princess of Wales Memorial Fund, the City Parochial Foundation, the Tudor Trust, the Joseph Rowntree Charitable Trust and Action for Prisoners Families. We also would like to recognise the significant contributions made by our subscribers and well-wishers.

Through the year, our staff team has been ably supported by a number of volunteers whose in kind support has been invaluable to the service that we have been able to provide in 2005.

# INQUEST CHARITABLE TRUST

## STATEMENT OF FINANCIAL ACTIVITIES

### FOR THE YEAR ENDED 31 MARCH 2005

<b>Summary Income and Expenditure Account</b>				
	<b>Restricted Funds £</b>	<b>Unrestricted Funds £</b>	<b>Total 2005 £</b>	<b>Total 2004 £</b>
<b>Incoming Resources</b>				
Grants	200,488	1,000	201,488	363,402
Deferred from last year	158,785	-	158,785	-
Deferred to next year	(5,861)	-	(5,861)	(158,785)
Donations	-	15,007	15,007	15,497
Memberships	-	8,196	8,196	7,364
Other Income	-	3,043	3,043	2,443
Investment Income	-	3,974	3,974	655
<b>Total Incoming Resources</b>	<b>353,412</b>	<b>31,220</b>	<b>384,632</b>	<b>230,576</b>
<b>Resources Expended</b>				
Costs of Generating Funds:	8,166	-	8,166	6,497
<b>Direct Charitable Expenditure:</b>				
Project Costs	240,742	-	240,742	200,366
Support Costs	46,205	-	46,205	34,760
<b>Other Expenditure:</b>				
Management & Admin	4,779	2,142	6,921	8,534
<b>Total Resources Expended</b>	<b>299,892</b>	<b>2,142</b>	<b>302,034</b>	<b>250,157</b>
<b>Net Incoming/(Outgoing) Resources for the Year</b>	<b>53,520</b>	<b>29,078</b>	<b>82,598</b>	<b>(19,581)</b>
<b>Fund Balances Brought Forward at 1 April 2004</b>	<b>37,319</b>	<b>17,922</b>	<b>55,241</b>	<b>86,417</b>
Transfer from Inquest	-	-	-	(11,595)
<b>Fund Balances Carried Forward at 31 March 2005</b>	<b>90,839</b>	<b>47,000</b>	<b>137,839</b>	<b>55,241</b>

# INQUEST CHARITABLE TRUST

## BALANCE SHEET AS AT 31 MARCH 2005

	2005 £	2004 £
<b>Fixed Assets</b>	<b>6,090</b>	<b>3,042</b>
<b>Current Assets</b>		
Debtors and Prepayments	18,597	19,656
Cash at Bank and in Hand	134,939	217,654
	<b>153,536</b>	<b>237,310</b>
<b>Creditors: Amounts falling due within one year</b>	<b>(21,787)</b>	<b>(185,111)</b>
<b>Net Current Assets</b>	<b>131,749</b>	<b>52,199</b>
<b>Total Assets less Current Liabilities</b>	<b>137,839</b>	<b>55,241</b>
<b>Reserves</b>		
Restricted Funds	90,839	37,319
Unrestricted Funds	47,000	17,922
	<b>137,839</b>	<b>55,241</b>

### Statement by Auditors:

As auditors to the charity we have reviewed the summarised accounts above and consider that they are consistent with the full accounts, on which we gave our opinion.

Barcant Beardon LLP  
Chartered Accountants and Registered Auditor  
8 Blackstock Mews  
Islington  
London  
N4 2BT

### Statement by Trustees:

The above accounts are a summary of information extracted from the audited annual accounts, on which the auditor's opinion was unqualified. The full report and accounts were approved by the board of trustees on 21 December 2005 and have been submitted to the Charity Commission. These summarised accounts may not contain sufficient information to allow for a full understanding of the financial affairs of the charity. For further information and copies of the accounts, please contact INQUEST.

# INQUEST

Working for truth, justice and accountability

- **Advice** • **Support** • **Information**
- **Policy** • **Research** • **Campaigning**

89-93 Fonthill Road, London N4 3JH

Tel: 020 7263 1111 Fax: 020 7561 0799

Email: [inquest@inquest.org.uk](mailto:inquest@inquest.org.uk)

Website: [www.inquest.org.uk](http://www.inquest.org.uk)

Copyright and published by INQUEST 2006

ISBN 978 0 9468 5820 0

Designed by Smith+Bell Design ([andymss@aol.com](mailto:andymss@aol.com))

Printed by Oldacres Ltd, London EC1

Community  
Legal Service



LONDON  
COUNCILS



LOTTERY FUNDED