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31st January 2007

Briefing for the Report Stage of the
Corporate Manslaughter and Homicide Bill
2006 for the House of Lords

1. About INQUEST

INQUEST is the only charity in England and Wales that works directly with the families and friends of those who die in custody. This includes deaths at the hands of state agents and in all forms of custody; police, prison, young offender institutions, secure training centres and immigration detention centres. We provide a free, confidential advice service to all families who go through an inquest process including those families whose relatives have died at work or following major disasters. In 2005 we worked on 282 cases advising over 1000 family members.

Through our casework over the last 25 years, INQUEST has a unique overview of how the inquest system operates from the perspective of bereaved families and their advisers. We extract policy issues arising from contentious deaths and their investigation and campaigned with and on behalf of bereaved families and their legal representatives for changes in practice to prevent deaths. Our casework service informs our research, parliamentary and policy work and we are widely consulted by; Government Ministers and Departments, MPs, lawyers, academics, policy makers, the media and the general public.

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2. Executive Summary

1. Between 1995 – 2005 INQUEST’s casework and monitoring service has highlighted over 2000 deaths in police and prison custody. Many of these deaths have raised issues of negligence, systemic failures to care for the vulnerable, institutional violence, racism, inhumane treatment and abuse of human rights.
2. The state has a duty of care towards people it takes into it’s custody under Article 2 of the Human Rights Act 1998. If this duty is violated, consideration should be given to prosecution of those responsible.
3. The Government’s decision to exclude public bodies including prisons, the police, emergency services and child protection services from the remit of this legislation has no logical, legal or moral case where grossly negligent practices have caused fatalities.
4. The decision means a public body may contribute to the death of member of the public in a grossly negligent way and avoid criminal prosecution - unlike a private body. This is fundamentally wrong and brings the law into disrepute as equality before the law is a key element of the rule of law.
5. Our monitoring and casework has revealed serious shortcomings in the existing mechanisms of legal and democratic accountability following deaths in custody. There are no mechanisms for monitoring, auditing or publishing investigations and inquest findings and no statutory requirement to act on the findings of these investigations.
6. The current investigation systems into a death in custody by the Prison and Probation Ombudsman; the Independent Police Complaints Commission; or the inquest process are not about determining *liability* and it is disingenuous to present them as being so.
7. There is a pattern of institutionalised reluctance to approach deaths in custody as potential homicides even where there have been systemic failings and gross negligence has occurred. A corporate manslaughter offence could go some way in challenging this.
8. A corporate manslaughter offence for deaths in custody would not only plug a vital gap in the law but could have a deterrent effect, preventing future deaths. It could also have a key role in maintaining confidence in public bodies. Excluding deaths in custody from the Bill would have the opposite effect and would give the impression that those working for the State are above the law.
9. We note that the Work and Pensions Select Committee, the Home Affairs Select Committee and the Joint Committee on Human Rights have scrutinised the Bill and all have concluded that there is no justification for excluding deaths in custody.

3. INQUEST's recommended amendments to the Bill:

Page 2, line 34, at end insert –

“(d) a duty owed to anyone held in custody”

(e) a duty owed to anyone who dies as a result of contact with the police”

Page 3, line 18, at end insert –

“"custody" includes being held in prison, secure mental healthcare facilities, secure children's homes, secure training centres, immigration removal centres, court cells and police cells, and being subject to supervision by court, prisoner and detainee escort services;”

Clause 3

Page 3, line 43, leave out “or (b)” and insert “(aa), (b), (c), or (d)”

Clause 5

Page 5, line 12, leave out “or (b)” and insert “, (aa), (b), (c) or (d)”

Briefing

Unwillingness to prosecute for deaths in custody

- A) INQUEST's monitoring has shown how the state uses the inquest and not criminal prosecution for the public examination of deaths in custody. It is extremely rare for there to be a prosecution after a death in custody even where there has been an inquest verdict of unlawful killing. Despite a pattern of cases where inquest juries have found overwhelming evidence of unlawful and excessive use of force or gross neglect, no police or prison officer has been held responsible for institutional and systemic failures to improve training and other policies. This is even the case when inquests return ‘unlawful killing’ verdicts. Since 1990, 10 ‘unlawful killing’ verdicts have been returned by inquest juries but none of them has led to a successful prosecution.
- B) In light of this unwillingness to treat any death in custody as a potential homicide, we had hoped the Government would use this opportunity to reform the law and afford a

further protection to those it detains in its custody. Instead it appears that every attempt has been made to ensure that issues related to deaths in custody are excluded from future corporate manslaughter offences.

- C) The number of custodial deaths is a public scandal. Many of INQUEST's cases reveal a catalogue of failings in the treatment and care of vulnerable people in custody or otherwise dependent on others for their care. Many of these cases highlight the failure of the state to fulfil its duty under Article 2 of the Human Rights Act 1998 to protect the right to life of those in its care and prevent inhuman and degrading treatment.
- D) Recommendations made by inspection bodies alerting state authorities to the potential risks to the health and safety of people in custody are often not implemented and can result in death or serious injury. Despite critical investigation reports and detailed narrative verdicts returned at inquests highlighting systemic failings, action is almost never taken either at an individual or senior management level.

Article 2 and a corporate manslaughter offence

- E) Article 2 imposes on the State:
 - (i) a negative duty not to deprive a person of his/her life save in the limited circumstances outlined in Article 2(2);
 - (ii) a positive duty to take reasonable steps to safeguard the lives of individuals, especially in circumstances where there is a known real and immediate risk to their lives; and
 - (iii) a procedural duty to investigate a death where it is arguable that either the negative or the positive duty to protect life has been breached.
- F) On some occasions Article 2 *requires* a criminal remedy regardless of the other remedies available, and regardless of whether the Government considers it "appropriate". In several recent high-profile cases the domestic courts have held that the other principal remedy, the inquest regime, is not a sufficient means of the state discharging its Article 2 liabilities making all the more reason for a corporate manslaughter offence which would plug this gap.

Lord Bingham emphasises this point in the judgment in the Amin case (brought by the family of Zahid Mubarek murdered in Feltam YOI in 2000 by a racist cell mate):

“The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.”¹

¹ R v. Secretary of State for the Home Department ex parte Amin [2003] UKHL 51 para 31

- G) A corporate manslaughter offence which would ensure grossly negligent practices are scrutinised and penalised could have a significant role in ensuring that the dangerous practices and procedures are rectified and therefore could have a preventative role in protecting the future health and safety of people in custody.
- H) In the case of *Oneryildiz v Turkey*, App. No. 48939/99 the Strasbourg Court concluded that the failure to ensure that those responsible for a death are criminally prosecuted, (irrespective of the other remedies that may be available) may amount to a violation of Article 2.

Existing mechanisms of investigation

- I) We note that both the Independent Police Complaints Commission (IPCC) and the joint report from the Home Affairs and Work and Pensions Committees have stated that having the option of a corporate manslaughter prosecution is important to maintain public confidence.
- J) We note that in the Government's Reply to the First Joint Report (March 2006), they reiterated their confidence in the strong framework for investigating and securing accountability for deaths in custody, emphasising the independence of the IPCC and PPO investigations. The Government's response noted that all deaths in police custody are subject to a Coroner's inquest and that individual prosecutions can be brought under criminal law where appropriate.
- K) Such an argument fails to recognise the reality that existing mechanisms of accountability are failing. This is exemplified by the lack of any monitoring, collation, auditing and publication of inquest verdicts and the lack of a duty for the State to act on investigation and inquest findings and recommendations. INQUEST believes that the investigations and inquest process can have a role to play in preventing avoidable deaths but the current system is unable to do this. It was expected that the government would introduce a Coroners Reform Bill in this parliamentary session to deal with the crisis in the system. The fact that it has not done so further emphasises the need to introduce further mechanisms for accountability after a death in custody. Furthermore the PPO, IPCC and inquests proceedings are not about determining *liability* and it is disingenuous to present them as doing so.
- L) For these reasons we urge the government to remove the exemptions in the Bill to allow public bodies (and private bodies performing state functions) to be equally covered in the proposed legislation and for deaths in custody to be included in the Bill.

4. CASE STUDY

The following case highlights where a corporate manslaughter prosecution could have made a difference had it been applied.

STYAL PRISON

The six deaths of women at Styal prison, Manchester between Aug 10th 2002 and Aug 12th 2003 provide 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. Repeated warnings were given to the authorities about the problems faced at Styal but were never acted upon. In 2001 an inquest held into the death of a woman in Styal prison resulted in a coroners recommendation that a methadone programme be implemented. This did not happen. In 2002 the Chief Inspector of Prisons conducted a full inspection of Styal prison and identified systemic failings particularly in the treatment and care of women withdrawing from drugs and the detoxification facilities available. Further Independent Monitoring Board reports also drew attention to problems concerned with overcrowding, shortages of professional staff and insufficient detox facilities. The Governor of Styal also gave evidence at the inquests about her unsuccessful bids to secure funding for a dedicated detoxification unit and acute problems with staff sickness, recruitment, and shortages. No action was taken as a result of all of these identifiable problems and this led directly to these women's deaths. Had a mechanism existed to penalise gross negligence and systemic failures in the form of a corporate manslaughter offence some of these deaths could have been prevented.