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## NEWS

- **INQUEST NEEDS YOUR HELP!**



Looking back over the last year whilst reporting to one of our major funders, I was struck by the incredible amount of work INQUEST has done with such a small team. Thanks to those who have supported us over almost thirty years INQUEST has consistently punched above its weight. We need that ongoing support even more now. We receive a lot of admiration and recognition for the work we do on behalf of bereaved families, but we don't have the resources to match the increasing demand.

Thirty years ago Blair Peach's family and friends were founder members of INQUEST (see below). Thirty years on we are working with them to get the report into his death made public, and in the years between we have supported thousands of family members in their search for answers about how and why their loved ones died. Sadly, the need for the organisation remains as urgent today as when it was founded and in a difficult economic climate, your support is needed even more as the demands on our services are not matched by our resources.

We have had other successes and the Coroners and Justice Bill which is now making its way through parliament is testament to our drive and determination to improve the inquest and coronial system on behalf of bereaved families.

If you are in a position to support us in any way, now is the time to do so by setting up a supporter membership or standing order, making a one-off donation, joining our INQUEST Lawyers Group, purchasing our publications or encouraging someone who you think can help us to do so. You can do all that safely online or by cheque. And if you are a tax payer and you Gift Aid your donation the government will give us 28p for every pound you donate – at no extra cost to you.

If you are unable to donate but have ideas for raising funds on our behalf, then get in touch and we will provide supporting information to help you in your efforts.

Steve Roberts, Fundraising & Development Manager ([steveroberts@inquest.org.uk](mailto:steveroberts@inquest.org.uk))

► [Make a donation to support INQUEST](#)

- **Three decades of campaigning for justice for Blair Peach**

Thirty years ago on 23 April 1979, Blair Peach died after being hit over the head by police while demonstrating against the National Front in Southall, west London. No police officer was ever charged or prosecuted despite serious concerns about the use of excessive force and the lawless behaviour of officers from the Metropolitan Police Special Patrol Group at the demonstration. The report of Commander Cass into Blair's death was withheld and has remained unpublished for three decades.

It was the negative experience of Blair Peach's family and friends that led them to join with others and set up INQUEST in 1981.

In June 2009 INQUEST wrote to the Commissioner of the Metropolitan Police urging the publication of the Cass Report. We also met Metropolitan Police Authority member Jenny Jones with Blair's ex-partner Celia Stubbs and his brother Philip Peach to brief her prior to the MPA meeting on 25 June where she proposed a resolution arguing that the Cass Report should finally be made public. The MPA voted unanimously to do so and we wait to see when and how much of the report is eventually released.

*"My congratulations to all involved in this 30 year battle for disclosure ... it was this awful state of affairs which led those of us who founded INQUEST to set it up. But it is mind-boggling to think that we were still arguing over this report 30 years later."*

**Terry Munyard**, barrister at Garden Court Chambers and founding member of INQUEST, speaking in July 2009 on the decision to release the Cass report on the death of Blair Peach

Ian Tomlinson died in similarly controversial circumstances nearly 30 years later, when he was caught up in the police response to the G20 protests as he tried to walk home in the City of London on 1 April 2009. INQUEST is working with his family and legal team and has written an extensive briefing on his death.

Among the issues featured in the briefing is the role of the IPCC, where concerns mirror those arising in other cases, including that of Sean Rigg who died in Brixton police station in August 2008. INQUEST attended the Lambeth Police Consultative Committee meeting with his family where Nick Hardwick, Chair of the IPCC, spoke and the local community had an opportunity to question him on the case.



INQUEST's first book, *Death and Disorder*, published in 1986, examined deaths involving the police during - or which sparked - public disorder: Kevin Gately (who died during a protest in Red Lion Square in 1974); Blair Peach; and Cynthia Jarrett, whose death during a police raid prompted the notorious Broadwater Farm disturbances in 1985 during which PC Keith Blakelock was killed. *Death and Disorder* looks at these three deaths in the context of others involving public disorder, from the infamous Peterloo Massacre of 1819 to the sometimes fatal use of troops and police against strikers in the first half of the twentieth century.

*Death and Disorder - Three case studies of public order and policing in London* by Tony Ward is also available for its original cover price of **£1.95** (+£1 P&P in the UK) from [INQUEST's website](#), or **free** with any order for books made through the INQUEST website before 1 August 2009.

- ▶ [30 Years on INQUEST remembers Blair Peach](#)
- ▶ [INQUEST's briefing on the death of Ian Tomlinson](#)
- ▶ [The political legacy of Blair Peach \(\*Institute of Race Relations\*\)](#)
- ▶ [Open Blair files, say campaigners \(\*Ealing Gazette\*\)](#)
- ▶ [Time to release secret information on deaths of protestors \(\*The Guardian\*\)](#)
- ▶ [Call to publish 1979 death report \(\*BBC\*\)](#)
- ▶ [Partner of man killed by Met officers' calls for investigation to be made public \(\*The Guardian\*\)](#)
- ▶ [Blair Peach death secrecy review \(\*BBC\*\)](#)
- ▶ [Met police chief willing to release Blair Peach report \(\*The Guardian\*\)](#)
- ▶ [G20 death: Why can't the IPCC learn? \(\*The Guardian\*\)](#)

### ● **INQUEST wins campaign against secret inquests**

Since January 2008 INQUEST has been working with a broad coalition of different groups and individuals to ensure that government proposals for 'secret' inquests were not made law. On 15 May 2009, two days after INQUEST's co-directors met the Justice Secretary Jack Straw MP, he announced that he would be withdrawing the proposals from the Coroners and Justice Bill 2009. The struggle against these proposals has taken over 16 months and would not have been possible without the network of families, organisations and parliamentarians who have worked with INQUEST.

- ▶ [Straw abandons secret inquest plans \(\*The Guardian\*\)](#)
- ▶ [Government fails to make the case for secret inquests \(\*The Guardian\*\)](#)

- ▶ [Listening and learning: lessons from the sorry saga of Clause 11 \(\*The Times\*\)](#)
- ▶ [Inquests into Troubles deaths to be kept secret \(\*Guardian\*\)](#)
- ▶ [The Sketch: Holding inquests in secret: that'll shut everybody up \(\*The Independent\*\)](#)

- **Coroners and Justice Bill makes progress through parliament**

The [Coroners and Justice Bill 2009](#) was published on 15 January 2009 and has been making its way through parliament. INQUEST has been working to ensure that the needs of bereaved people are at the forefront of parliamentarians' minds.

INQUEST has published nine detailed [briefings](#) on the Bill and proposed amendments to it (which are available on our website) and has been quoted widely in the press:

- ▶ [Listening and learning: lessons from the sorry saga of Clause 11 \(\*The Times\*\)](#)
- ▶ [Comment: Coroner system is unfit for purpose \(\*Politics.co.uk\*\)](#)
- ▶ ['Coroner system unfit for purpose', INQUEST comment on the Coroners and Justice Bill \(\*BMH UK\*\)](#)
- ▶ [Coroners Bill: now the battle begins for legal aid and juries \(\*The Times\*\)](#)
- ▶ [Does the Coroners and Justice Bill go far enough - and is there enough money \(\*Law Society Gazette\*\)](#)

We issued the following press releases on the Bill:

[15 May](#) INQUEST welcomes government climb-down on 'secret inquests'

[18 March](#) INQUEST and Liberty hold parliamentary meeting on government plans for secret inquests

[23 January](#) MPs to debate the Coroners and Justice Bill 2009

- **Timeline of INQUEST's policy work on the Coroners & Justice Bill**

**3 February** INQUEST's Co-Directors gave oral evidence to and take questions from the House of Commons Bill Committee.

**11 March** Co-directors met Jack Straw MP, Lord Chancellor and Justice Secretary, with two members of the INQUEST Lawyers Group to discuss the problems with the government's proposals for 'secret' inquests.

**18 March** Joint INQUEST/Justice/Liberty parliamentary briefing meeting on 'secret' inquests held in the House of Commons. Chaired by Frank Dobson MP, the meeting heard from our Co-director Helen Shaw, [Liberty](#) Director Shami Chakrabarti, Susan Alexander (mother of Azelle Rodney, who was shot dead by police in 2005) and her solicitor Daniel Machover, chair of INQUEST.

**24 March** Helen Shaw and Sian Griffiths attended the Local Government Association conference 'The Coroners and Justice Bill – improving

services for bereaved people' where Helen delivered a paper – *Families' rights: will the coroners' charter make a difference?* considering the impact of the Bill and discussing what more needs to be done to tackle the shortcomings in the system.

**18 April** Letter published in the Guardian referring to disclosure of documents to the families bereaved by the Hillsborough disaster and calling for the matter to be resolved in the Coroners and Justice Bill

**20 April** Lord David Ramsbotham hosted INQUEST's briefing meeting 'Scrutinising the Coroners and Justice Bill' on Monday 20 April in the House of Lords, which was well-attended by parliamentarians. Speakers included Deborah Coles, Co-Director of INQUEST on *Issues arising from INQUEST's casework: does the Bill provide a remedy?*; Helen Shaw, Co-Director of INQUEST spoke on *The Bill as amended in the Commons: what is missing and what can be strengthened?*; Raju Bhatt, Partner, Bhatt Murphy Solicitors and member of the INQUEST Lawyers Group offered *The perspective of lawyers representing bereaved people*; while Sue Freeth, director of welfare for the Royal British Legion discussed *Issues for families of military personnel*.

You can contact your MP and other elected representatives if you would like to express your opinion on the Coroners & Justice bill by visiting [www.writetothem.com](http://www.writetothem.com)

- **Chickenshed performances of "As the mother of a brown boy..."**



Two after-show panels featuring contributions from INQUEST and families of people who have died in custody took place at performances of Chickenshed Theatre Company's "As the Mother of a Brown Boy..." The first took place on 7 May at the Bernie Grant Centre in north London and heard from the mother of Lexy Williams who was killed locally following a police pursuit. At The Drum Theatre in Birmingham, Garden Court North Chambers sponsored a post-performance reception which included a panel discussion with INQUEST's co-director Deborah Coles, Caroline Bailey, the mother of Michael Bailey who died in Rye Hill prison, and Micha Niering's Aunt Christine Niering.

INQUEST will be working with Chickenshed again later in 2009, and this partnership has helped highlight the issues raised by our work to a different audience.

- ▶ [2008 benefit performance for INQUEST](#)
- ▶ [Details of the May 2009 performances](#)

- **Ministerial Council on deaths in custody launched to encourage collaboration and cross-sector learning to reduce deaths in custody**

INQUEST attended the last Ministerial Round Table on Suicide in February, securing information requested by INQUEST on the cost of Prison Service legal representation at inquests, which totalled over £6 million in the years 2004-2008.

The creation of a new three-tier Ministerial Council on Deaths in Custody was announced by the Ministry of Justice in July 2008, following publication of the Fulton Review and replaces the Ministerial Roundtable on Suicide and the Forum for Preventing Deaths in Custody. It is jointly funded by the Ministry of Justice, Department of Health and the Home Office.

The first-tier consists of a Ministerial Board on Deaths in Custody, which has replaced the Roundtable and has wider terms of reference to include all types of death in state custody (prison; approved premises; police; revenue and customs; immigration; psychiatric hospitals). INQUEST is an independent member of the Board and at its first meeting held in June raised its concerns about the ongoing problems faced by families both in delays to inquests being held and in obtaining public funding for their legal representation.

The second tier of the Council is the Independent Advisory Panel (IAP) whose role is to provide independent advice and expertise to the Board. The IAP will be supported by a broadly-based group representing practitioners and stakeholders to be formed on an ad hoc basis. The appointment of the six members of the IAP was announced in June, and includes Deborah Coles.

INQUEST has campaigned for a properly resourced, independent standing commission on deaths in custody and will be closely monitoring the new structure and its impact. If anyone is interested in more information about the Ministerial Council please contact [deborahcoles@inquest.org.uk](mailto:deborahcoles@inquest.org.uk)

- ▶ [Justice Minister appoints members of the new Independent Advisory Panel on Deaths in Custody](#)
- ▶ [New Independent Advisory Panel on Deaths in Custody](#)

- **Working to prevent the dangerous consequences of imprisoning children**

INQUEST's work in highlighting the dangerous and sometimes fatal consequences of imprisoning children has continued.

In January the High Court ordered that a fresh inquest be held into the death of 14 year old Adam Rickwood who was found hanging hours after being restrained by staff using state-sanctioned violence in the form of a strike to the nose. The coroner refused to rule on the legality of the force used on Adam shortly before his death and Mr. Justice Blake considered that this resulted in a

flawed inquiry and verdict. He also ruled that the force used against Adam constituted assault and breached article 3 of the European Convention on Human Rights.

INQUEST has also been assisting in a judicial review of the Youth Justice Board decision to close down four local authority secure children's homes. Our fear is that this will lead to more vulnerable children being held inappropriately in Young Offender Institutions.

- ▶ [Coroner overruled in child death in custody case](#)
- ▶ [Future insecure - Mary O'Hara on opposition to the threatened closure of secure care homes \(\*The Guardian\*\)](#)
- ▶ [Fresh inquest ordered into teenager's death in prison \(\*Guardian\*\)](#)
- ▶ [Youths in custody: our duty of care \(\*Guardian\* letters page\)](#)

## ABOUT INQUEST

- **Inquests and casework**

There have been a number of significant inquests into deaths in custody since January raising criticisms about the treatment and care of those who died. These inquests shine a particular light on the treatment of men from black and minority ethnic communities in custody and illustrate key thematic concerns, including the use of segregation in prisons, use of restraint, and failures in the treatment of those with mental health problems. Also in this period several families have had to deal with the emotional impact of further postponement of delayed inquests, including those into the custodial deaths of **Rebecca Smith**, **Peter Kirkwood** and **Nadeem Khan**.

- ▶ [Inquest opens into death of black prisoner Peter Kirkwood at HMP Chelmsford](#)
- ▶ [Inquest to be held at last into prisoner's death \(\*Rochdale Observer\*\)](#)

Since January INQUEST has been involved in a number of these inquests including those of:

- **Michael Bailey** was a young black man who died in the segregation unit of the privately-run Rye Hill prison in March 2005, after developing severe mental health problems. The jury concluded that *“there was a failure on the part of all staff to take responsibility for Michael’s safety.”* This inquest raised shocking concerns about the inadequacy of care by both prison and medical staff for someone with a serious mental health problem and the issue of private prisons.
  - ▶ [Overwhelming failings by prison and healthcare staff contributed to death of vulnerable black prisoner at HMP Rye Hill](#)
  - ▶ [Hanged inmate was failed by prison staff, says coroner \(\*The Guardian\*\)](#)
  - ▶ [Mentally ill inmate commits suicide after catalogue of failings in the prison system \(\*Black Mental Health UK\*\)](#)

- **Anthony Mola** died in the segregation unit in HMP Durham in June 2005. The inquest identified “*serious and worrying failures*” in the care of a young black man suffering from serious mental health problems and fundamental flaws in the prison’s policy on managing fires in cells, which the jury found contributed to Anthony’s death. The coroner’s rule 43 report raised not only issues relating to fire safety but also to proper risk assessment in the segregation unit.

▶ [INQUEST opens into fire cell death at HMP Durham](#)

- **Simon Allen** was a black man with serious mental health problems who died on the healthcare wing at HMP Brixton in March 2006. The jury found that Simon’s death by hanging was contributed to by neglect because the prison failed to adequately assess or supervise him when his high risk of self-harm was obvious. Despite serious previous self-harm attempts Simon had been placed in a cell with easy ligature points. The jury also highlighted that Simon’s severe illness meant he should not have been in prison but transferred to a mental health facility. Further criticisms included the poor training of prison staff, the lack of staff on the healthcare wing overnight and the continued use of cells identified by the Prisons Inspectorate as unsuitable for habitation.

- **Callum Mclean** died in April 2008 after being detained by Greater Manchester Police, who failed to ensure he received urgent treatment for a head injury he had sustained before his arrest. The thorough investigation and inquest were completed just over a year after Callum died. This prompt and thorough process demonstrates that even within the current system effective investigations can take place that should result in more meaningful learning. At the end of the inquest the police took the unusual step of issuing a full public apology for their failings. This public acknowledgement of responsibility was of significant value to Callum’s family.

▶ [Inquest into death of Callum McLean following detention at Ashton under Lyne police station](#)

- **Faisal al-Ani** suffered from mental health problems and was detained by Essex Police in Southend in July 2005 and was subjected to a prolonged restraint prior to his death. CCTV footage of that restraint has now been made public and demonstrates powerfully why the family are unhappy with the disappointing and surprising verdict given the evidence heard.

Disturbingly, the restraint methods used by police were described by a police trainer as being “in contravention of all guidance.”

▶ [Inquest to open into death of Faisal Al-Ani following restraint in the custody of Essex Police](#)

▶ [Jury returns verdict at inquest into the restraint-related death of Faisal Al-Ani in Southend](#)

▶ ['Officers actions caught on CCTV' \(BBC News\)](#)

- **Godfrey Moyo** was a 25 year old black man who died in HMP Belmarsh in January 2005. The two week inquest exposed appalling failings in his care and concluded that his death had been contributed to by restraint and neglect. The jury heard shocking evidence about the way in which Godfrey was restrained following and during a series of epileptic fits, including being

held in the prone position for 30 minutes and then left unconscious and unmonitored in a cell. The coroner will be writing to ministers about a system which he described as “*fundamentally flawed.*”

▶ [Jury find restraint and neglect caused death of Belmarsh prisoner Godfrey Moyo](#)

- **Mikey Powell** died in West Midlands Police custody in Handsworth, Birmingham, in September 2003. His family won an important victory in the High Court on 2 July ordering police to allow them access to previously undisclosed 4,000 documents relating to the investigation into his death. His inquest is due to be held in November 2009, more than six years after he died.

▶ [Family press statement for the \*Birmingham Mail\*](#)

▶ [Friends of Mikey Powell website](#)

INQUEST will be raising the issues arising from these cases at a policy and parliamentary level.

- **Caseload**

INQUEST has taken on 123 new cases in the first six months of this year. Our complex casework and policy work on the deaths of vulnerable detainees in custody has continued and 51 of the new cases are custodial deaths. Our current open caseload – including those from previous years - is 228 including 18 non-custody cases.

- **Deaths in custody in England & Wales 2009**

Deaths in prison		Deaths in police custody	
<i>Classification</i>	<i>2009</i>	<i>Type</i>	<i>2009</i>
Self Inflicted	33	Custody deaths	9
Non-Self Inflicted	52	Pursuits	3
Other non-natural causes	1	Road Traffic Incidents	5
Awaiting Classification	3	Shootings	2

Source: INQUEST casework and monitoring to 30 June 2009

Further statistical information can be found [on our website](#).

- **In brief**

As well as work on individual cases team members frequently attend relevant meetings and conferences.

**10 March** Legal Services Commission Conference – Deborah Coles and INQUEST Lawyers Group members Marcia Willis Stewart, Harriet Wistrich and Henrietta Hill addressed the Legal Services Commission Special Cases Unit annual conference on the Jean Charles de Menezes inquest and the problems families face in obtaining funding for legal representation.

**18 March** Casework Service Manger Sian Griffiths and Fundraising & Development Manager Steve Roberts attended an event launching the play *The Hounding of David Oluwale* at the Hackney Empire, which tells the story of one of the first black deaths in police custody, in Leeds in 1969. Members of Sean Rigg's family also attended providing a current perspective on the continuing concerns about the deaths of black men in police custody. A number of other family members as well as staff from INQUEST went to the performance itself later that month.

**30 March** Deborah Coles attended and contributed to a roundtable meeting of the Corston Coalition – a group of funders interested in taking forward the agenda outlined in Jean Corston's report on vulnerable women in the criminal justice system.

**1 April** Helen Shaw attended and contributed to the third seminar and meeting of the Project Management Board of the Manchester University Arts and Humanities Research Council-funded project *The Impact of the Criminal Process on Health Care Ethics and Practice*.

**7 May** Deborah Coles attended a meeting at the Ministry of Justice with representatives of the Safer Custody & Offender Policy Group, the Ministerial Council on Deaths in Custody, the Coroners Unit of the Ministry of Justice, the Coroners Society, the Prison & Probation Ombudsman and the Prison Reform Trust to discuss the issue of delay in holding inquests into deaths in prison. INQUEST provided background material to the meeting on inquest delays in its casework and the impact this has on families and how delay frustrates the process of learning lessons from deaths.



**May** INQUEST is referenced in the Fawcett Society's report of their Commission on Women and the Criminal Justice System, *Engendering Justice*. In the report, the Commission expresses concern about the government's rejection of Baroness Corston's recommendation that non-means tested funding should be available for families bereaved by deaths in custody. The Commission strongly reiterate their support for INQUEST's position that funding should be provided to these families. We attended the launch of the report and asked a question of Prisons Minister Maria Eagle MP about the issue of funding, and while her response was negative, she did question the amount of money paid by the state to lawyers representing the Prison Service at inquests.

**15 May** INQUEST and Garden Court North organised a training event in Manchester for lawyers who represent families at inquests. The day was chaired by Ian Macdonald QC and included a presentation by Nigel Meadows, HM Coroner for Manchester. The event was attended by 30 solicitors and barristers and feedback about the course was excellent.

**10 June** Deborah Coles chaired the morning session and gave an overview of INQUEST's work at a conference on Sickle Cell and Deaths in Custody at de Montfort University, Leicester.

- **LATEST PUBLICATIONS FROM INQUEST**



The latest edition of *Inquest Law* was published April 2009. It is available as part of membership of the INQUEST Lawyers Group, or by stand-alone subscription from the INQUEST website. Highlights include reports and analysis of recent judicial reviews and the lessons of the inquest into the death of Jean Charles de Menezes.

Other publications are available to download and order from INQUEST's website.

- **PEOPLE**

INQUEST welcomes casework intern Damilola Eniola who started working with us part-time at the end of June. We are also sorry to say goodbye to Catherine Hayes, who has been a key member of the Casework Team since 2004 and left INQUEST at the start of July. She has made a significant contribution to the work of the organisation particularly with her dedication to the families with whom we work.

For further information about any of the issues contained in this newsletter please contact [inquest@inquest.org.uk](mailto:inquest@inquest.org.uk)

