

INQUEST  Annual Report 2004

INQUEST

Inquest Charitable Trust was established in 1995 to complement and assist the work of its sister organisation INQUEST that was set up in 1981. In March 2004 the two organisations merged and the single charitable organisation is known publicly as INQUEST. The 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 that provides a specialist, comprehensive advice service to bereaved people, lawyers, other advice and support agencies, the media, MPs and the wider public on contentious deaths and their investigation. INQUEST has a free information pack for *any* bereaved family that explains the whole process and where to find emotional and practical support.

Our casework priorities are deaths in custody (police, prison, immigration detention and deaths of detained patients) and 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.

We develop policy proposals and undertake 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.

Staff

Helen Shaw – co-director

Deborah Coles – co-director

Gilly Mundy – senior caseworker

Catherine Hayes – caseworker from September 2004

Melanie Lowe – office manager

Marcie Shaoul – communications officer

Richard Fontenoy – information worker

Adam Barty – research assistant from December 2004

Volunteers*

Administration:

Adam Barty

Benjamin Coleman

Laura Hale

Benedict Irwin

Parvin Jeyaraj

Farhaz Khan

Gladys Maimbolwa

Mano Mazhowu

Ugochi Okoronkwo

Sundeep Pankhania

James Plant

Lata Singh

Calvin Thomas

Maria Stevenberg

Hannah Kemp

Putri Mohd Najib

Lucie Wibberley

Kate McGhee

Rebecca Linacre

Women's Deaths in Custody Project volunteer researcher:

Fiona Wallace – one day per week from October 2004

*most volunteers work at INQUEST for six weeks only

Inquest Charitable Trust Board

Louise Christian (Chair) Partner, Christian Khan Solicitors

Adam Sampson (Deputy Chair) Director, Shelter

Dr William Spence (Treasurer) Reader, Department of Physics, Queen Mary, University of London

Reverend Arlington Trotman Secretary, Churches Commission for Racial Justice

Dr Joanna Bennett Family member, Workforce Development Manager, Breaking the Circles of Fear, Sainsbury Centre for Mental Health

Adrienne Jemmott Family member, Customer Advisor, Planning Reception, Reading Borough Council

Dr Tony Ward Reader in Law at the University of Hull

David Bergman Director, Centre for Corporate Accountability

Professor Penny Green School of Law, University of Westminster

INQUEST Advisory Group

Professor Joe Sim School of Social Science, Liverpool John Moores University

Professor Phil Scraton Institute of Criminology and Criminal Justice, Queen's University

Raju Bhatt and Mark Scott Partners, Bhatt Murphy Solicitors

Jonathan Glasson Barrister, Doughty Street Chambers

Tim Owen QC Matrix Chambers

Professor Mick Ryan Law Department, University of Greenwich

Ruth Bunday Partner, Harrison Bunday Solicitors

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, 2 Garden Court Chambers

Dr Barry Goldson, Senior Lecturer, Department of Sociology, University of Liverpool

January

- Give oral evidence to the parliamentary Joint Committee on Human Rights Inquiry into Deaths in Custody following on from a comprehensive written submission
- Paddy O'Connor QC addresses the INQUEST Lawyers Group on 'The Future of Inquest Law' in light of the Amin, Middleton and Khan cases

Chair's Report Louise Christian

Once again this year INQUEST has been at the forefront of exposing a human rights scandal and tragedy – the number of preventable deaths in our overcrowded prisons, particularly of women and of children. The shameful failure of the government to take seriously the deaths of children in its care and its failure to set up a public inquiry into the death of Joseph Scholes despite calls by the coroner, cross party MPs and peers and the Parliamentary Joint Committee on Human Rights raises hard questions about its real moral priorities.

INQUEST's scarce resources are stretched by demands for comment and response from government and public bodies. Campaigns and casework are always the central focus of our organisation which is led as it always has been by the concerns of families and the issues arising from the deaths. INQUEST is unique in its ability to combine its casework service and its work at a strategic and policy level. But the lack of any focused approach by government

creates an impression that INQUEST is always being consulted but never listened to.

In the meantime INQUEST's public profile has never been higher and it continues to take centre stage in important public debates about accountability for controversial deaths and the nature of the inquest procedure. We await the response to the White Paper on Coroners Reform with the very real fear that lack of government resources will inhibit any will for substantive reform.

INQUEST's dedicated staff have continued to serve it well this year and there has been a very modest increase in the size of the organisation. Once again Deborah Coles and Helen Shaw have led on a range of important policy issues and on the most controversial cases. Gilly Mundy has continued to cope with the ever increasing mass of urgent casework, joined from September 2004 by Catherine Hayes. Marcie Shaoul, communications officer, has maintained excellent links with the media and the campaigning profile. From December 2004 Adam Barty is assisting on a research project. Information worker Richard Fontenoy ensures incoming information is analysed and monitored and Melanie Lowe, the administrator, continues to hold it all together. My heartfelt thanks to all of them and to all who support INQUEST in the important work it does.



Banner of Rocky Bennett campaign at UFFC March, October 2004

February

- Launch of the Report of the Independent Inquiry into the Death of David 'Rocky' Bennett in psychiatric detention which finds NHS mental health services institutionally racist and recommends a three-minute time limit on prone restraint
- INQUEST makes crucial third party intervention into the Middleton case in House of Lords on self-inflicted deaths in prison and the need for meaningful conclusions following inquests
- Attend the Ministerial Round Table on Suicide in Prison at HMP New Hall

Co-Directors' Report Deborah Coles & Helen Shaw

"Someone is either killed, kills themselves or dies in otherwise questionable circumstances – every other day. That – quite frankly – is shocking".

Parliamentary Joint Committee on Human Rights (JCHR)
Report – Deaths in Custody, December 2004.

We have had an extremely busy, challenging and contradictory year. Alongside the continuing high number of deaths in custody requiring our in-depth casework service we have seen an increased demand for our response at a policy and parliamentary level. Political, media and public concern about deaths in custody – in particular of young people and women in prison – has never been higher. The high number of deaths of children

and women has involved significant parliamentary, policy and media work to raise public awareness about the issues involved. Increasingly this year we have seen our concerns acknowledged and reflected by others in the field. Significant legal and policy decisions have also impacted on the investigation of contentious deaths.

The staff team has grown, the profile and reach of the organisation has been unprecedented and the collaborative work we have engaged in has also been very successful. The numbers of people accessing our service has increased in part due to the successful redesign of the website making on-line material available to a wide audience. Our seminars have reached staff working with bereaved people and given them an increased understanding of the issues affecting families attending inquests. New systems of investigation have started for deaths in both prison and in police custody.

Parliamentary Inquiry into Deaths in Custody

The parliamentary JCHR Inquiry into Deaths in Custody was a key area of work in 2004 as we made ongoing contributions to the Committee during their year long deliberation highlighting areas of concern as they

emerged. We made two substantial and detailed written submissions and gave oral evidence to the Inquiry. We co-ordinated a meeting for bereaved families, whose relatives had died in custody, to meet members of the Committee and to tell them personally about their experiences. This clearly impacted on the final report. Their findings and recommendations published in December 2004 are a vindication of INQUEST's long held and expressed concerns about deaths in custody and their investigation.

INQUEST believes that the failure to learn the lessons from deaths occurring in different custodial settings and the lack of joined up learning and thinking between agencies has resulted in more deaths and the ongoing poor treatment of families. We recommended to the JCHR Inquiry the setting up of a Standing Commission on Custodial Deaths to bring together the experiences from the separate investigation bodies as the most effective way to prevent or minimise future violations of Article 2 of the European Convention on Human Rights (ECHR). In its conclusions the Committee acknowledged our views, recommending that the government should "establish a cross-departmental expert task-force on deaths in custody. This should be an active, interventionist body, not a talking-shop, with its membership drawn from people with practical working experience of the problems associated with deaths in custody."

Submission to the Joint Committee on Human Rights - Inquiry into deaths in custody

House of Lords
House of Commons
Joint Committee on Human Rights
Deaths in Custody
Third Report of Session 2006-07

Women and Offending

INQUESTLAW
Journal of Forensic Lawyers Group 11 Issue 7 14 May 2008

Middleton & Sacker: major development in inquest law

LEGAL AID of the **LAWYER**

Supported by **LAPG**

March

- Lobby Metropolitan Police Authority regarding funding for Roger Sylvester family's legal representation at the police officers' challenge by way of judicial review of the unlawful killing verdict
- Host first Sudden Death Forum – bringing together key voluntary organisations working in the area to discuss casework processes
- Meet Rosie Winterton MP, Minister of State at the Department of Health about taking forward the Bennett Inquiry recommendations

- Speak at a National Bereavement Partnership workshop on consent and post-mortems
- Attend the launch of the report of the Fawcett Society Commission on Women and Criminal Justice after giving oral evidence on the deaths of women in custody

David 'Rocky' Bennett

In February, following the publication of the Independent Inquiry Report into the [restraint related] Death of David 'Rocky' Bennett, the government began a process that should result in fundamental changes in the delivery of services to people from black and minority ethnic communities within mental NHS health services. Working alongside the family to ensure the government acts upon the recommendations of the inquiry has been a key task this year.

Deaths of Women in Prison

In April we started a key two-year project looking at the issues arising from the deaths of women in prison. We have systematically raised our concerns in a number of public forums including the JCHR Inquiry, various academic conferences and the Fawcett Society Commission on Women and the Criminal Justice System. Alongside this we have continued to ensure the issue has been addressed at the regular Ministerial Round Table on

Suicide in Prison and have frequently briefed MPs for parliamentary debates and questions. We have also achieved high profile media coverage of the issue.

Breakthrough in Inquest Law

In March the ruling in the House of Lords in the cases of Middleton and Sacker relating to two self-inflicted deaths in prison was a major breakthrough for inquest law. INQUEST's third party intervention was important in drawing the Lords' attention to the context in which these deaths take place; the escalating number of self-inflicted deaths in custody; 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 of State agencies in relation to those deaths. It has already resulted in a change in the way inquests are conducted, particularly in the way verdicts are formed. Inquest juries now have more opportunity to draw attention to any failings in the circumstances surrounding the death through the use of more narrative verdicts. This could result in a more meaningful conclusion to the inquest for families and all other parties.

The significance of this judgment was seen at the conclusion of the inquest into the death of 16-year-old Joseph Scholes who died in Her Majesty's Young Offenders Institute (HMYOI) Stoke Heath. 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". In an unprecedented move the coroner 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 failures to protect a vulnerable and damaged child while in the care and custody of the State. We ran a hard hitting and highly successful campaign with Nacro throughout the year to lobby government to set up the public inquiry.

Investigation of Deaths in Prison and Police Custody

Since 1 April, the Independent Police Complaints Commission (IPCC) and the Prisons and Probation Ombudsman (PPO) have taken over the investigation of deaths in custody. We have concerns about the independence of the PPO and their ability to appropriately communicate and consult with those representing bereaved families. This is particularly a matter of concern in relation to family liaison and the PPO has also refused to distribute our specialist leaflet *What to do when someone you know*



April

- Present paper at Nacro Race Advisory Committee on black deaths in custody
- Provide background briefings for House of Lords debate on Joseph Scholes
- Present paper on 'deaths of women in prison: the issues' alongside mother of Sarah Campbell who died in Styal prison at the European Group for the Study of Deviance and Social Control – Crime, Justice and Punishment and the City: Global, Transnational and Local Perspectives
- Attend press launch and conduct media work on BBC programme Death on Camera – Christopher Alder. Screening generates huge publicity for INQUEST
- Speak at Roger Sylvester Justice Campaign public meeting
- Joseph Scholes inquest starts and lasts for three weeks – attend the inquest, assist with legal preparation, co-ordinate media work and support family
- Attend launch of anti-racist festival RESPECT at City Hall

dies in prison to bereaved families. This is in stark contrast to the IPCC. Following some initial resistance, INQUEST gave a presentation to the IPCC after which they agreed to give families our specialist advice leaflets following any deaths in police custody. This will enable families to access advice from INQUEST and our Lawyers Group members at an early stage.

Justice? What Justice?

The outcomes of two legal processes towards the end of 2004 seriously undermined any sense of progress and families' confidence in the legal system to deliver justice.

Harry Stanley

In October the jury in the **second** inquest into the death of Harry Stanley returned an unlawful killing verdict. Harry Stanley was shot dead by Metropolitan police officers in September 1999.

The Stanley family had already had to endure an inquest in June 2002 where the coroner denied the jury the

opportunity to hear from firearms experts and to consider whether Mr Stanley had been unlawfully killed. The October 2004 inquest has revealed the truth about how an unarmed man could be shot dead and has held those responsible properly to account.

But following the verdict police officers from SO19 Firearms Unit ceased carrying their firearms in response to the inquest verdict. This caused a media furore and led to public calls to change the law when applied to police officers.

SO19 officers appear to have been misled by the Police Federation into seeing the verdict as a jury second-guessing a split second decision taken by officers who opened fire believing themselves to be in imminent danger of being shot at. That was simply what these officers claimed in their evidence. Had the jury accepted the officers' evidence (i.e. that the officers believed they were under imminent threat) the jury would never have returned a verdict of unlawful killing. The coroner gave a clear summing up, explained in the fullest terms the seriousness of such a verdict and the high standard of proof required. The jury considered their verdict for over seven hours.

No-one is beyond the law. SO19 officers and their

leaders should not have tried to apply pressure on the Crown Prosecution Service (CPS), IPCC or their employers to give some kind of immunity to the officers in the Stanley case or any person who does not act in lawful self-defence. Where police officers kill members of the public they must be held to account openly and transparently. The rule of law must be seen to apply equally to all citizens, including those in police uniform.

Roger Sylvester

On 26 November the unlawful killing verdict returned by an independent jury at the inquest into the death of Roger Sylvester in 2003, was formally quashed in the High Court by Mr Justice Collins. He said the summing up by the coroner was defective and that some of the reasons the jury gave for their verdict were inconsistent. Roger Sylvester died as the result of being handcuffed and restrained for around 20 minutes by up to six Metropolitan police officers who had detained him under the Mental Health Act. On the evidence heard at the inquest the judge accepted that the jury *could* have returned an unlawful killing verdict, finding that Roger had died from brain damage and cardiac arrest related to his unlawful and excessive restraint. But, because of errors by the coroner and jury, the verdict has been quashed. In other words the family has had an unlawful killing verdict taken away by a legal technicality. Once again the message is sent out that



Roger Sylvester Justice Campaign banner

May

- Family of Christopher Alder picket the Home Office to demand public inquiry
- Co-ordinate meeting of families bereaved by deaths in custody with members of the parliamentary Joint Committee on Human Rights
- Host first INQUEST seminar *Bereaved People and Inquests – working with clients affected by the inquest system* – in London
- Meet with Prisons and Probation Ombudsman about their investigation of prison deaths
- Meet with senior Department of Health officials and again with Rosie Winterton MP, Minister of State, about the government response to the Bennett Inquiry
- Speak on black deaths in custody at the 'Criminology in the New Millennium' Conference – Race, Criminal Justice and Gender
- Meet with Chris Ruane MP about the call for public inquiry into the death of Joseph Scholes

police officers involved in fatal restraint are seen to be above the law and families whose loved ones have died as a result of excessive and unlawful force can get no justice and accountability. The Roger Sylvester Justice Campaign continues to highlight the injustices suffered by the family.

Families' Experiences of Deaths in Custody

INQUEST's Nuffield Foundation funded project on families' experiences following deaths in custody has drawn extensively on the work outlined. The report will be published in 2005 and will draw attention to continuing thematic problems across all areas of custody.

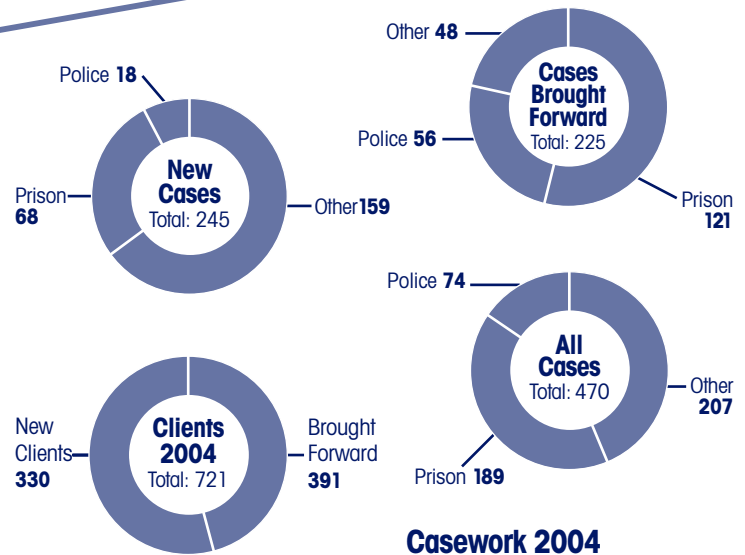
Reform of the Inquest System

During the year we have been in an ongoing dialogue with the Home Office about the proposed reform of the inquest system. In 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

based around full time independent legally qualified coroners. INQUEST welcomed the commitment to make the system sensitive to the needs of the bereaved. How much of a continuing political priority this is for the government in the run up to a general election in 2005 remains to be seen.

Significant legal developments are having a positive impact on the conduct of inquests that engage Article 2 of the ECHR and many coroners are embracing the current opportunities for change. But this is being hampered by the lack of progress in implementing the necessary policy changes. Many coroners are suffering acute problems with a lack of resources resulting in considerable delay in inquests being heard; there are still too many hurdles in the way of public funding for legal preparation and representation for bereaved families and in some circumstances the new investigation systems do not allow families to effectively participate.

The government is expected to publish a White Paper on reform of the inquest system in the spring of 2005. We hope the government will rise to the challenge of ensuring the new inquest and investigation systems can deliver a 21st Century service that acknowledges and respects the needs of bereaved families and the truth.



Casework

Casework forms the core of INQUEST's work. This year our casework focus has been particularly on the deaths of children and young people and the deaths of women in prison because of the high numbers and also because we are working on two significant projects due for completion in 2006.

Casework Service

INQUEST monitors all deaths in custody and identifies themes and patterns that arise from these deaths: subsequently our casework priorities reflect these issues of concern.

The charts above show the number of people we have advised and the number of cases we are working on.

WHAT TO DO IF SOMEONE YOU KNOW DIES IN POLICE CUSTODY

INQUEST Survey of Families' Experiences Following Death & Coronial Inquest in England & Wales

CONFIDENTIALITY

Inquests - the experience of bereaved families

INQUESTS
AN INFORMATION
PACK FOR FAMILIES,
FRIENDS AND
ADVISORS

June

- Meet with the Coroners Reform Team at the Home Office
- Host second INQUEST seminar *Bereaved People and Inquests – working with clients affected by the inquest system* in Manchester
- Stephen Cragg addresses the INQUEST Lawyers Group meeting on 'Putting Middleton and Sacker into Practice'
- INQUEST Chair Louise Christian wins Independent Legal Aid Lawyer of the Year Award
- Meet with Department of Health officials about progress on government response to Bennett Inquiry Report
- Jointly host Family Forum with United Friends and Family Campaign in Birmingham

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.

General Advice

We operate a telephone based service offering free support, advice and information to all bereaved people facing an inquest on their basic rights in the coroner's court. There is no other organisation in England and Wales with such specialist knowledge about the inquest system. Our informed casework team provides this specialist advice as well as sending out written information – our comprehensive Information Pack and leaflets concerning specific circumstances of death. We also provide 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 e.g. road traffic related deaths to RoadPeace, work related

deaths to the Centre for Corporate Accountability, deaths in hospital to Action against Medical Accidents (AvMA). We also monitor any legal issues arising from these cases that concern the inquest system.

Deaths in Custody

We provide an in-depth casework service when an inquiry falls within one of our priority areas – prison and police custody and psychiatric or immigration detention.

We have a particular focus on the deaths of people from black and minority ethnic communities, young people, women and people with mental health problems. This service involves arranging legal representation for a family and then working as an integral part of the legal team, advising and supporting lawyers, providing detailed background information on similar cases. In some cases we arrange meetings with MPs, carry out press and media work, attend the inquest and follow up the issues that emerge. This 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 continuing high number of prison deaths it is not possible to provide this level of service in all cases due to the size of our staff team.



All deaths in Prison 208 Of which were black deaths **21**

New Caseworker

Although in September we employed a new full time caseworker which has enabled us to attend more inquests, make contact with and provide advice to more families we are still unable to provide the in-depth service described in anything but a small number of cases. We do ensure that families have access to experienced lawyers who we are in regular dialogue with and brief us on any issues arising from the death and its investigation.

Family Forum

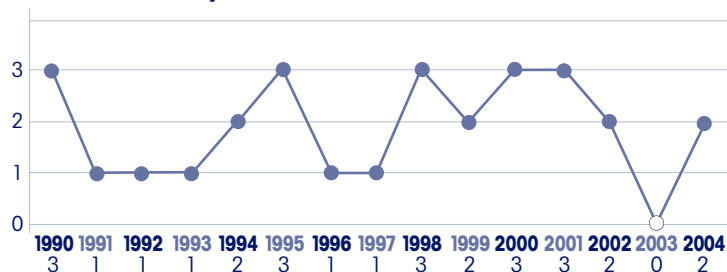
We held two Family Forums this year, one in London and the other in Birmingham. The Family Forum is an informal meeting that brings together those who have received assistance from INQUEST to meet others who have faced similar experiences and for mutual support.

Deborah Coles, co-director, INQUEST, Hilton Dawson MP, Lord Navnit Dholakia

July

- New caseworker appointed
- Meet with Rosie Winterton MP, Minister of State about the government response to Bennett Inquiry Report
- Present a paper on working with bereaved families at the Ministerial Round Table on Suicide in Prison held at HMP Nottingham
- Assist in drafting of the Early Day Motion calling for a public inquiry into the death of Joseph Scholes which is then tabled by Chris Ruane MP
- Questionnaire sent to families bereaved by deaths in custody for research project
- Host Family Forum in London
- Make a presentation to members of the Independent Police Complaints Commission on INQUEST's work with families following deaths in police custody
- Meet with MPs regarding the death of 15-year-old Gareth Myatt in a secure training centre
- Attend funeral of Paul Foot, longstanding friend and patron of INQUEST

All Children's Deaths (aged 17 and under) in Penal Custody 1990 – 2004*



* two of these deaths occurred in secure training centres

Deaths of Children and Young People in Custody

As we are working on a three year project on the deaths of children and young people in custody and because of ongoing and rising concern about these deaths this has been a priority area of work during 2004. The continued call for a public inquiry into the death of 16-year-old Joseph Scholes who died on 24 March 2002 in HMYOI Stoke Heath and the restraint related death of 15-year-old Gareth Myatt on 19 April 2004 in Rainsbrook Secure Training Centre underlined the need for this work. This

was exacerbated by the death of 14-year-old Adam Rickwood on 9 August 2004 in Hassockfield Secure Training Centre. Adam became the youngest ever child to die in penal custody in recent times. Within days of hearing about these two deaths, the casework team at INQUEST had managed to find the families of Adam and Gareth experienced solicitors. We also responded to extensive media interest in the cases.

Until we made contact with the two families, neither had been given access to any independent advice and support from any of the official agencies involved. It became apparent that the Youth Justice Board – who are responsible for secure training centres – had no protocols in place to deal with the aftermath of a death including no procedure about family support. Gareth Myatt's mother 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 also put the families involved in contact with each other for mutual support.

Parliamentary Meeting

In November INQUEST and Nacro held a joint parliamentary briefing meeting to call for a public inquiry into the death of 16-year-old Joseph Scholes who died in HMYOI Stoke Heath. The meeting was chaired by Lord Navnit Dholakia with speakers Hilton Dawson MP, Deborah Coles, co-director of INQUEST and Yvonne Scholes, mother of Joseph. The meeting focused on the shocking issues surrounding Joseph's death and the treatment of children in the criminal justice system. INQUEST and Nacro produced a comprehensive briefing paper in October highlighting the key issues. It was widely disseminated and downloaded from our website 102 times. We also briefed the media prior to the meeting and attendance on the day was high. 111 MPs signed an Early Day Motion tabled by Chris Ruane MP after much lobbying by email, letter and telephone. This campaign has received widespread cross party support in the Commons and Lords and from children's rights and prison reform organisations and was endorsed by the JCHR in December 2004. We continue to lobby the government for a public inquiry into Joseph's death and an examination into all deaths of children in penal custody. For a full list of supporters please look at www.inquest.org.uk

As part of our work around the deaths of young people INQUEST attended a vigil to mark the 20th birthday of Anthony Redding. Anthony was 16 years old when he was found hanging in HMYOI Brinsford. The vigil was attended by other bereaved families including the mothers



Pauline Campbell and others protest about women's deaths in prison. Picture: Manchester Evening News

August

- Issue press release following the death of 14-year-old Adam Rickwood, the youngest person to die in penal custody and respond to significant media interest
- Meet with Nigel Hancock from the Safer Custody Group to raise ongoing concerns about deaths in prison

Deaths Of Women In Prison 2004



of Joseph Scholes and Gareth Myatt. The families laid flowers in memory of Anthony and released 27 balloons representing each child who had died in custody since 1990. The vigil received good press coverage and provided an opportunity for families to meet each other.

Deaths of Women in Prison

In April we started a two-year research project on the deaths of women in prison which coincided with a record 14 self-inflicted deaths of women in 2003 and continuing high numbers of deaths in 2004 when 13 women took their own lives. Women account for only 6% of the average daily prison population and yet made up 14% of the self-inflicted

deaths in prison in 2004. Because of our concern about the number of deaths and the start of the project we were proactive in ensuring that our information reached those families that needed it and we have sent letters accompanying Information Packs via the prison service and coroner's courts. As a direct result 17 of those families have contacted us and we are now working with them. Some of them are families of women who died in 2003 who had not previously been made aware by official sources of INQUEST's service.

The Inquest System

Narrative verdicts

INQUEST is monitoring all narrative verdicts returned at inquests following the Middleton case mentioned earlier in the report. This is an extremely useful resource for lawyers and others as there is no central official collation and monitoring of such verdicts. Many lawyers are unaware of the significance of the judgment and how it is being applied at inquests and the important contribution it can make in highlighting individual and systemic failings. This is an evolving area of inquest law and our monitoring of the verdicts should reveal its impact. Below are two examples of cases where narrative verdicts were returned.

Anna Baker

Anna Baker was the second of six women to die in a 12-month period at HMP Styal. Anna died in November 2002 and the inquest into her death took place in November 2004. Anna was on remand and was recognised as being at risk from suicide and self-harm. Anna was withdrawing from drugs. The day before her death she was moved from her shared cell to a single cell. The jury's critical narrative verdict found the initial admission assessment into the prison was inadequate in light of Anna's vulnerability and that there appeared to be a total lack of awareness and staff training in the management of her being at risk of suicide and self-harm.

John Hinde

Greater Manchester Police approached John Hinde's vehicle which they had seen driving erratically and stop on a slip road of the M6 in Lancashire. During a struggle in which John was restrained in the prone position he lost consciousness. The officers were aware that John had concealed a package they believed to be illicit drugs in his mouth. The inquest heard evidence that the arresting officers, despite knowing that he was unconscious and in possible danger from the package in his mouth, failed to provide adequate first aid. The jury returned a critical narrative verdict highlighting concerns about the police officers' treatment of John and in particular about the inadequacy of their first aid training and implementation of their own procedures.



September

- INQUEST debate with the Prisons Minister on Radio 5 Live about deaths of women in custody
- Attend recording of INQUEST's BBC Radio 4 Charitable Appeal with Benjamin Zephaniah
- New caseworker starts
- Attend Inns of Court School of Law pro bono student fair to recruit volunteers
- Join delegation from the Law Society and Action against Medical Accidents (AvMA) to meet officials from the Department of Constitutional Affairs and the Legal Services Commission about ongoing problems with public funding and inquests
- Attend Judicial Studies Board coroners training day on inquests into deaths in prison post the Middleton and Amin judgments
- Meet with MPs to brief them on the issues arising out of the deaths of children in custody
- Attend and speak at a Children's Society Fringe meeting at Labour Party conference on children's deaths in prison
- Meet with the Youth Justice Board on the death of Adam Rickwood

Delays in Inquests

One of INQUEST's key concerns about the way in which deaths in custody are investigated is the serious delay that can occur from the time of death through to the subsequent inquest. Delays of over a year are not uncommon – in part due to the length of time investigations can take and the lack of resources available to coroners.

These delays cause bereaved people great distress and the casework team have identified the detrimental effects of these delays on the physical and mental health of family members. The opportunity for identifying what went wrong, learning the lessons and preventing other deaths also become seriously prolonged. We have raised our concerns about this at a policy and parliamentary level.

Funding for Families' Legal Representation

We continue to deal with ongoing problems in obtaining public funding for legal preparation, representation and subsistence for families and inconsistent practice around the country. The reforms to the system that have provided

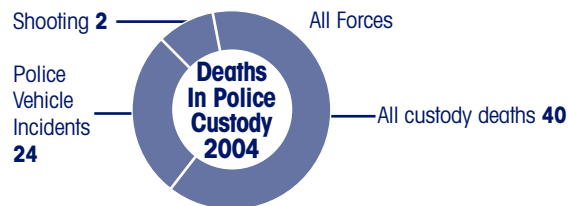
some public funding for representation at inquests into deaths in custody are welcome, but they are not enough. Although public funding is now available for these inquests families still have to go through means testing, though even to get to this stage there is a protracted and intrusive legal process. This is in stark contrast to the State whose lawyers have unlimited and unrestricted access to State resources. Increasingly prison officers and prison doctors are represented through their union or professional funding.

Deaths in Police Custody

This year there has been a fall in the numbers of deaths in police custody although 2004 saw a number of important inquests and judicial reviews of cases of deaths from previous years.

Restraint Related Deaths

Our casework this year has highlighted the continued use and dangers of prone restraint in police custody as illustrated by the death of John Hinde, already detailed above, and the three week inquest into the death of Giles Freeman. Giles died in November 2002 whilst being restrained at Slough police station after he had been sectioned under the Mental Health Act. The inquest raised



All deaths 66 Of which are black deaths **3**

a number of concerns relating to the use of prone restraint, the management and care of mentally ill patients and the unsuitability of police stations as a place of safety.

Medical Care in Police Stations

We have also monitored the quality of care provided in police station custody suites. A number of cases raised the inadequate provision of medical care to those vulnerable due to their drug and alcohol use. The police still fail in their duty to call Forensic Medical Examiners (police doctors) to cells to assess the needs of these detainees leaving many of them to suffer the symptoms of withdrawal without early medical intervention.

Deaths Involving Police Vehicles

Incidents of deaths as a result of police vehicles remain disturbingly high despite a drop from the record number in 2003. INQUEST welcomes the increased use of 'black box' technology in police vehicles. However this remains inconsistent and sporadic across all forces.



UFFC on the march

October

- Stephen Shaw Prisons and Probation Ombudsman addresses the INQUEST Lawyers Group meeting on Investigating Deaths in Prison
- Hold well attended workshop at the European Social Forum on the struggles of families for justice following deaths in custody
- Meet with Prison Inspectorate on issues arising from recent inquests into deaths in prison
- Dr Joanna Bennett, sister of David 'Rocky' Bennett and INQUEST Board member wins Mental Health Media Award
- Christopher Alder's family win permission to judicially review the Home Secretary's decision not to hold public inquiry
- Present paper on the issues arising from INQUEST's work on deaths in custody at Capita Conference 'Deaths in Police Care'
- Attend sixth annual UFFC procession
- Attend vigil in memory of 16-year-old Anthony Redding at HMYOI Brinsford
- Harry Stanley unlawful killing verdict returned and armed police officers in Metropolitan Police SO19 Firearms Unit lay down weapons in protest at verdict

INQUEST Lawyers Group

We advise lawyers on both procedural and tactical matters and we encourage those we advise to become members of our INQUEST Lawyers Group (ILG), a national pool of solicitors and barristers who are willing and able to provide preparation and legal representation for bereaved families. Our Lawyers Group is made up of committed, experienced barristers, solicitors and law students including the leading inquest and human rights practitioners in the country. ILG members now have access to an email group in which ideas and questions are raised with other members. Work has been carried out to expand the INQUEST Lawyers Group membership which has resulted in a membership increase of 25%. ILG members receive *Inquest Law*, the in-house journal published three times a year for subscribers. The journal covers cutting edge cases, inquests and judgments and is written by members of the ILG or other invited parties. This year we approached all coroners to subscribe to *Inquest Law* and so far a quarter have subscribed.

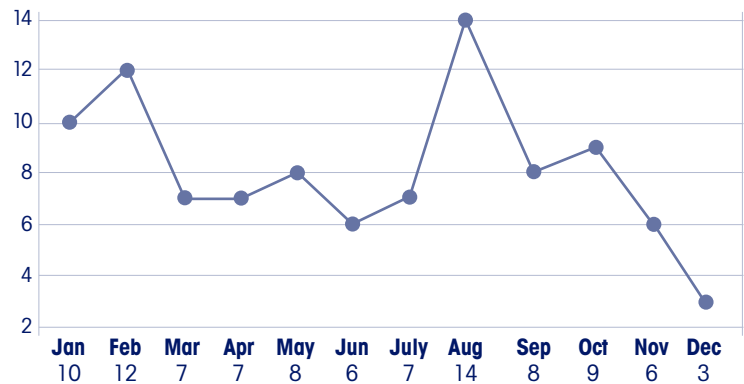
Statistics

INQUEST is the only independent organisation in England and Wales to collate statistics on deaths in custody. Our statistics are aggregated from information received from official and other sources and are used widely across the media. Although the statistics are available on our website, very often we will get requests for specific statistics regarding a particular institution or type of death. In monitoring and analysing these statistics we are able to uncover patterns and trends emerging. A detailed breakdown of statistics is available on our website www.inquest.org.uk

Communications and Publicity Media

INQUEST has always seen media coverage of the issues arising from deaths in custody and the inquest system as a crucial part of our work to prevent unnecessary deaths and campaign for reform. Raising public awareness and generating media interest and scrutiny of the issues ensures policy makers cannot ignore the serious concerns that emerge. INQUEST deals with the print and broadcast media on a daily basis fielding their queries and circulating information. In 2004 we dealt with over 1,500 telephone

Self-inflicted Deaths in Prison by Month, 2004



enquiries. Following the death of Adam Rickwood we responded to over 70 media calls. Our co-directors have been widely quoted in the national and local press and are frequently called upon for comment in the broadcast media. We are most often asked to comment for news programmes or news articles but also work with journalists on documentaries and feature articles. This year the programme *Death on Camera* about the death in custody of Christopher Alder and the articles in 'The Times' about deaths of women in prison were good examples of this. We had been involved with the programme makers of *Death on Camera* for over two years. We were interviewed on the programme, provided extensive background briefing and attended the press conference alongside Christopher Alder's sister Janet. The feature article in 'The Times' arose from a series of discussions with the journalist, providing extensive



Helen Shaw and Deborah Coles, co-directors of INQUEST, at INQUEST's seminar, 'Bereaved People and Inquests'

November

- INQUEST and Nacro host a Parliamentary Briefing into the death of Joseph Scholes chaired by Lord Navnit Dholakia
- Third successful INQUEST seminar *Bereaved People and Inquests – working with clients affected by the inquest system* held in London
- Attend Southall Black Sisters conference and contribute to a workshop about the inquest system
- Attend Joseph Rowntree Foundation seminar – Safeguards for Children Living Away from Home
- BBC Radio 4 Appeal broadcast by Benjamin Zephaniah on behalf of INQUEST
- Attend launch of the re-brand Racial Justice Fund hosted by the Churches Commission for Racial Justice
- Roger Sylvester unlawful killing verdict overturned in judicial review

background written material and arranging interviews with the bereaved families. Often interviews need to be set up between families and the media and INQUEST helps facilitate these. We will only do this when families want to engage with the media. There are many families who use our service without this kind of involvement. INQUEST will always determine the suitability of a programme or article by talking at length with the journalists and making sure that families are comfortable with and understand the whole process. In particular cases where INQUEST has been lobbying the media we will telephone key journalists to ensure maximum coverage. INQUEST also sends out press releases to targeted audiences to maximise coverage for the organisation or a particular campaign or case. In 2004 we sent out 50 press releases and we also had a number of letters published in the national press. This year we have received unprecedented coverage in the national and regional press across television, radio and print. Examples can be found on our website, www.inquest.org.uk Highlights have included an hour long debate on BBC Radio

5 on their Sunday morning show between INQUEST and the Prisons Minister, Paul Goggins, 'The Independent' front page story on Adam Rickwood, 'The Guardian' G2 article on Joseph Scholes and Channel 4's in-depth report on the death of David 'Rocky' Bennett.

Events and Seminars

INQUEST has identified a need to increase awareness amongst the voluntary advice and statutory sectors to those working with bereaved people facing inquests. It is crucial that access and information to and about the processes for bereaved families are improved.

In 2004 we hosted three seminars, *Bereaved People and Inquests – working with clients affected by the inquest system*, to improve skills and the quality of support and advice to bereaved people following sudden and unnatural deaths. We held two in London and one in Manchester. A significant number of participants were those working in a range of posts within the NHS. The feedback was very positive with 95% of overall expectations being met. In March we also held a Sudden Death Forum which was an opportunity for voluntary sector organisations working with people affected by the inquest system in a wide range of circumstances to network, share experiences and improve the way we all work together.

Publications

INQUEST produces a number of regular external publications each year including the Annual Report and *Inquest Law*. Other publications in 2004 included a newsletter which was handed out at the European Social Forum in October reaching an estimated 3,000 people, the BBC Appeal postcard and our submission to the parliamentary Joint Committee on Human Rights Inquiry into Deaths in Custody – *Deaths in Custody – the current issues*. In the pipeline for 2005 are several key research documents, information leaflets and an update of our Information Pack.

Website

In August 2004 and after a six month overhaul INQUEST, with the help and expertise of web designer Brian Baldwin, proudly launched its new website. An important external face of the organisation, the website is now an important way of getting help and information to those who need it. It has easily accessible information for all bereaved people facing an inquest, members of the media and the public needing statistics and policy information and details about how to support the organisation's work. The website is updated regularly and all INQUEST's publications are available to buy or download. The Information Pack has been downloaded 833 times illustrating a continuing and growing need for our service. We also receive a significant number of subscriptions and donations after people have



December

- Meet Department of Health officials about progress on Bennett Inquiry recommendations
- Provide background briefing to MPs for adjournment debate on coroner's courts
- Parliamentary Joint Committee on Human Rights publishes report of Inquiry into Deaths in Custody and calls for public inquiry into death of Joseph Scholes
- Giles Freeman inquest, restraint related death returns narrative verdict concluding that he died following police restraint

used the website. For the latest news from INQUEST, how to support our work and what campaigns are coming up, to read about key cases and for up to date statistical monitoring visit www.inquest.org.uk

Finance and Administration Office Systems

March saw the installation of a completely new network, software and personal computers in the INQUEST office. The fast computers and connection have improved the working conditions immeasurably. Alongside this the entire INQUEST database has been updated in advance of hopefully replacing it with a new tailor made system in 2005. The filing system has been overhauled and updated and with the assistance of volunteers over twenty years of material has been archived, catalogued and indexed. The library has been catalogued and is searchable on our computer system making reference material readily available.

Volunteers

This year the system of volunteer recruitment has been very successful. INQUEST has an ongoing relationship with the College of Law whose students work at the INQUEST office on a voluntary basis for four hours per week. Recently INQUEST was invited to be on the board of the Legal Advice Centre Advisory Group to help shape the college's award winning pro bono work for the future. We have also recruited volunteers from the Inns of Court School of Law after attending their pro bono fair. Most volunteers come to the organisation for six weeks, but there are a few who stay longer. In October we implemented a new scheme which gave the volunteers specific tasks and projects to do in the hope that this offers them more stability and security. Volunteers are currently working on overhauling our press cuttings system and might for example be tasked with collating all the press cuttings in a particular case. They are also responsible for ensuring that they are all filed and indexed. Volunteers also assist with coordinated mail outs which includes collating addresses from our databases, stuffing envelopes and franking mail. The work that the volunteers do is invaluable.

BBC Radio 4 Appeal

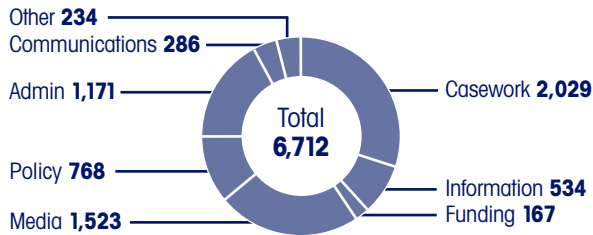
Every week the BBC Radio 4 Appeal highlights the work of a charity and appeals for donations to support its work. INQUEST was successful in applying to broadcast an appeal and on 28 November 2004 and again on 2 December, poet and author Benjamin Zephaniah made an appeal for INQUEST. We were able to use the appeal to publicise our service and new website by distributing 1,200 postcards which we sent to our supporters and friends. We also created new dedicated pages on our website to help generate publicity. The appeal generated £8,270 directly and a significant increase in individuals and organisations becoming paid supporters of the organisation or joining the INQUEST Lawyers Group.

Finance

2004 has given more financial security to INQUEST but we are conscious of the need to remain focussed on working to fund the organisation. Our area of work is still sometimes perceived as unpopular and controversial because of the nature of the issues involved and the headlines that arise from some of our cases. INQUEST receives funding from varied sources including numerous individuals, charitable trusts and legal establishments. We are extremely grateful for their support. This year we have implemented a Gift Aid scheme which means all the donations made can go further towards helping us in our work. Funders in 2004 have

Benjamin Zephaniah records INQUEST's BBC Appeal

INQUEST telephone work 2004



included the Association of London Government, The Atlantic Philanthropies, The Nuffield Foundation, the Ajahma Charitable Trust, Two Garden Court, the Department of Health, The Diana, Princess of Wales Memorial Fund, the Allen Lane Foundation, the City Parochial Foundation, the Tudor Trust, Unison, the Law Society Trustees, the Lloyds TSB Foundation for England and Wales and the Joseph Rowntree Charitable Trust

This year we have made key applications to potential funders in order to conduct further research projects, hold more seminars for official organisations and further support families through their inquests.

Treasurer's Report 2004

Since 2003 the treasurer has been working to bring all transactions under the umbrella of the Inquest Charitable Trust and put in place a transparent system for tracking the overall income and expenditure.

It was agreed in April 2003 that the Trust should become the main operating wing of the organisation and

that all of INQUEST's activities and assets and Liabilities be transferred to Inquest Charitable Trust. This amounted to a net liability of £11,595.

The table (right) illustrates the fair value of assets and liabilities at that time that were transferred to Inquest Charitable Trust.

A rationalisation of bank accounts has made it possible to budget and make reliable predictions about future finances and has made clear what support levels are needed and when, in order for the organisation to maintain its work. This provides the organisation with stability and protection against unexpected income fluctuations. The final changes in finances were to proceed to implement a system which makes it possible to budget and monitor spending under different categories for individual grants.

A full signed copy of the most recent accounts is available from the office.

	£
Current Assets	5,650
Current Liabilities	(17,245)

	(11,595)

	£
Represented by:	
Unrestricted Funds	(11,595)

Statement by Auditors:

As auditors to the charity we have reviewed the summarised accounts below 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 accounts shown below are summary 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 January 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, contact INQUEST.



Melanie Lowe, office manager, INQUEST, Benjamin Zephaniah, Deborah Coles, co-director, INQUEST

INQUEST CHARITABLE TRUST

STATEMENT OF FINANCIAL ACTIVITIES

FOR THE YEAR ENDED 31 MARCH 2004

Summary Income and Expenditure Account

	Restricted Funds £	Unrestricted Funds £	Total 2004 £	Total 2003 £
Incoming Resources				
Grants	-	362,902	500	363,402
Deferred to next year	(158,785)	-	(158,785)	-
Donations	-	-	15,497	15,497
Memberships	-	7,364	7,364	-
Other Income	-	2,443	2,443	-
Investment Income	-	655	655	-
Total Incoming Resources	204,117	26,459	230,576	119,721

Statement of Other Recognised Gains and Losses

The company has no recognised gains or losses other than the surplus for the above two financial years.

Summary Income and Expenditure Account continued

	Restricted Funds £	Unrestricted Funds £	Total 2004 £	Total 2003 £
Resources Expended				
Direct Charitable Expenditure:				
Grants Payable	-	-	-	35,500
Project Costs	206,682	34,941	241,623	-
Other Expenditure:				
Management & Admin	-	8,534	8,534	613
Total Resources Expended	206,682	43,475	250,157	36,113
Net Incoming/(Outgoing) Resources for the Year	(2,565)	(17,016)	(19,581)	83,608
Fund Balances Brought Forward at 1 April 2003	39,884	46,533	86,417	2,809
Transfer from Inquest	-	(11,595)	(11,595)	-
Fund Balances Carried Forward at 31 March 2004	37,319	17,922	55,241	86,417

Continuing Operations

None of the company's activities were acquired or discontinued during the above two financial years.

INQUEST CHARITABLE TRUST
BALANCE SHEET AS AT 31 MARCH 2004

	2004 £	2003 £
Fixed Assets	3,042	-
Current Assets		
Debtors and Prepayments	19,656	-
Cash at Bank and in Hand	217,654	87,616
	237,310	87,616
Creditors: Amounts falling due within one year	(185,111)	(1,199)
Net Current Assets	52,199	86,417
Total Assets less Current Liabilities	55,241	86,417
Reserves		
Restricted Funds	37,319	39,884
Unrestricted Funds	17,922	46,533
	55,241	86,417

INQUEST

Working for truth, justice and accountability

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

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Legal Service



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