

NEWS FROM INQUEST

Coroners reform: a wasted opportunity?

● This autumn, the Government is expected to introduce the Coroners Reform Bill into the House of Commons. INQUEST has been tracking the draft Bill through its consultation stages and is working to ensure that the interests of bereaved families are central to the Government's reforms.

The draft Bill includes some positive measures such as the introduction of a charter for bereaved persons, but overall, it does very little to change the archaic and failing inquest system.

- There is nothing in the draft Bill to tackle delays, no extension of public funding for families' legal representation and no requirement for mandatory disclosure of information.
- In some areas the Government is reducing rights that are currently available such as; reducing the numbers of jury

inquests, abolishing the automatic right to a jury inquest in cases of deaths at work and allowing coroners to prohibit information about an inquest being put in the public domain.

Most crucially there are no substantial proposals in the Bill to record the pattern of inquests; make recommendations to relevant statutory bodies following inquest findings; and to follow up on these recommendations to ensure action is taken. Until these measures are in place there will be no lessons learned from deaths in state custody and more unnecessary deaths will occur.

Unless the government amends the Bill they will simply be tinkering at the edges of the system and will fail to deliver an improved service. INQUEST joins the Constitu-

Number of deaths in police and prison custody so far in 2006: **124** (correct at 22.9.2006)

Deaths in Prison 2006		Police Custody Deaths 2006	
Classification	Deaths	Force	Number
Self-Inflicted	48	Metropolitan	
Non-Self-Inflicted	60	Police	2
Awaiting Classification	1	Other Forces	13
All deaths	109	All forces	15

Of the self inflicted prison deaths, 2 were women, 7 of people from black and minority ethnic communities and 2 young people 21 and under. Six deaths have occurred this year in segregation units. The 2 deaths in Metropolitan police custody were of black men. Source: INQUEST casework and monitoring. Further details can be found at www.inquest.org.uk

tional Affairs Committee who are scrutinising the Bill in parliament in calling the Bill "a wasted opportunity for reform".

INQUEST is working with a broad coalition of groups such as Liberty, the Centre for Corporate Accountability and the National Union of Journalists regarding our concerns about the Bill.

We will be developing our coalition work in the coming months and will be organising a meeting for interested organisations in late October. We will also be organising a meeting with

families to discuss their comments on the Bill and met Harriet Harman MP, Minister of Justice, to express our concerns.

For further information on the draft Bill and to get involved in our lobbying work please contact policy@inquest.org.uk. If you are a family member and would like to attend the INQUEST Family Forum meeting planned for this Autumn, please email caseworker@inquest.org.uk. Copies of our response to the Bill can be found on www.inquest.org.uk ■

Menezes family mount legal challenge to CPS and IPCC

● The family of Jean Charles de Menezes, shot at Stockwell tube on 22nd July last year, are judicially challenging the decision by the Crown Prosecution Service (CPS) not to bring criminal charges against anyone involved in his killing.

The CPS has started a prosecution against the Metropolitan Police as an institution, under health and safety legislation, the first time the legislation has been used for a death in custody. Under this offence no individual can be held responsi-

ble and the maximum penalty is a fine, a sanction ultimately paid by the taxpayer. The Menezes family will be arguing that this is a misuse of the legislation and not appropriate for a death in custody case.

It is unacceptable that no individual will be held accountable and that over a year after Jean's death there has been no public or judicial scrutiny despite the fact that police officers used fatal force resulting in an innocent man being shot seven times in the head.

The ongoing refusal of the Independent Police Complaints Commission will also be judicial reviewed. INQUEST remains concerned about non-disclosure of information in cases of deaths in custody and the withholding of critical documents and believes that it is in the public interest to have all the facts pertinent to the case in public as soon as possible. We will continue to raise awareness of the importance of disclosure in our campaigning work and will be closely monitoring the use of health and safety legislation to determine its impact on future cases. ■

Yet again, no successful prosecutions for deaths in police custody

● INQUEST has long campaigned on the scandal that is police impunity after a death in custody. The last few months saw a series of decisions which yet again point to failure of the criminal justice system in being able to successfully hold police officers

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accountable for a death in their care.

In July, the CPS announced its decision not to prosecute police officers for the killing of Azelle Rodney, shot seven times in a pre-planned Metropolitan Police operation in 2005. This was followed in August by the acquittal of the West Midlands police officers who were prosecuted for offences relating to the death of Mikey Powell. They were

cleared of 'battery' and of not treating Mikey 'with due care and attention' after he died in police custody in 2003. The Powell family stated after the verdict, "We are like any other family who have lost a loved one as a result of a death in police custody. All we are seeking is justice... Mikey has become just another statistic, another person added to the growing list of deaths in custody where no police officer has been held accountable." ■

Child deaths in custody

● INQUEST held a highly successful parliamentary briefing on child deaths in custody on 4 July 2006. The meeting heard MPs, peers and bereaved families call for a public inquiry into the death of Joseph Scholes, whose case raises serious concerns about the ways in which vulnerable children are treated by the criminal justice system.

The briefing was hosted by

the Scholes family's constituency MP Chris Ruane and chaired by former Chief Inspector of Prisons, Lord Ramsbotham. It was addressed by Joseph's mother Yvonne, Deborah Coles, co-director of INQUEST, and Baroness Stern, a member of the Parliamentary Joint Committee on Human Rights. The briefing also heard powerful testimony on the

Women in prison

● A highly critical narrative verdict was delivered in July at the inquest into the death of Anne Marie Bates, a young mother of three found hanging in her cell at HMP Brockhill in 2001. The verdict delivered by the jury clearly stated that Anne Marie did not receive the care she needed in the final days and hours of her life. The jury also recognised that there

were a number of contributory factors to Anne Marie's death such as her unsuitable placement on A Wing of the prison due to her vulnerability; the inadequate support for Anne Marie to deal with the bullying on A Wing; and the evidence of an inappropriate relationship between a prison officer and a prisoner that was the driving force behind Anne

Marie's transfer to A Wing.

INQUEST is very concerned about the lengthy delay in the investigation into Anne Marie's death – it took five years for the inquest and investigation to conclude – placing extreme distress on her family. As there was no public scrutiny of the death for such a long period of time, opportunities for identifying what went wrong and seeking to prevent recurrences in the future were set back.

Later this year we will be publishing the report of our *Women's Deaths in Custody* research project. The report unveils shocking research into the number of deaths of women in custody, tracks experiences of their families and loved ones and outlines recommendations for urgent action to tackle the issues surrounding women's deaths in custody. To order a copy of the publication please contact info@inquest.org.uk ■

Zahid Mubarek: a case of "institutional murder"

● The official inquiry into the murder of 19 year old Zahid Mubarek by his racist cellmate reported in July and branded the prison service as institutionally racist.

The inquiry was set up only after a long legal battle – resisted at every level by government – and its report found a litany of failures and endorsed the Mubarek family's assertion that the Prison Service was guilty of 'institutional murder'. It found that 186 separate failings led Robert Stewart to be placed in a cell with Zahid at Feltham young offenders' institution and made 88 recommendations to the Home Secretary including

demands that either more money be found for prisons or fewer people should be sent to jail. The report was published on the day official figures showed the prison population in England and Wales had hit an all-time high of 77,865.

INQUEST welcomes the fact that the report recognises "there are lessons to be learned from every death in prison" and specifically mentions our proposal for a Standing Commission on Custodial Deaths.

The lack of accountability following prison deaths has resulted in a culture of impunity and complacency ("Mubarek inquiry judge lam-

basts prisons policy", *The Independent*, 30 June). Will the recommendations of the Zahid Mubarek inquiry report vanish into the ether like those of previous inquiries that have alerted government to systemic and individual failings within the prison system?

Our casework and monitoring has shown that there have been a further nine homicides and 544 self-inflicted deaths in prison in England and Wales since Zahid Mubarek's death. Of these, two homicides and 63 self-inflicted deaths have been of people from black and minority ethnic communities.

Deaths in prison are all too often linked to the inappropriate use of penal custody for vulnerable people and institutional neglect, racism and indifference.

The Government resisted the holding of the Mubarek inquiry and is abolishing the post of Chief Inspector of Prisons. It also proposes to exempt prisons from new corporate manslaughter legislation. The closed nature of the prison system means that it is vital that it is open to independent inspection and investigation and held to account when human rights abuses occur.

INQUEST will be taking up these concerns through our parliamentary work over the coming year. We will be campaigning to ensure that any new corporate manslaughter legislation applies to the prison service. ■

campaign update

urgent need for a public inquiry from the families of children who have died in custody.

On 18 July, Yvonne Scholes took an application to the Court of Appeal challenging the refusal of the Government to hold a public inquiry into the death in prison of her son. Following a two-day legal challenge, the Court reserved their

judgment and is likely to return its decision in October.

On 18 September the Home Office finally published the Lambert Report into the issues arising from his death. The Lambert Review was conducted behind closed doors and the family had no opportunity to meaningfully participate. Yvonne Scholes felt disgusted that she was unable

to have any meaningful input into the review and pointed to the fact that the report *‘does not address the key issue which is why Joseph was sentenced to what was in effect a death sentence’*.

The key question that needs to be answered is why so many children continue to be sent to damaging and dangerous institutions that cannot meet their complex needs. Yvonne Scholes’ need to know why her son died and to prevent future deaths of children has inspired

a nation-wide campaign for justice, winning support from all the major penal reform, child welfare and human rights groups.

Early Day Motion 2410 was tabled in the House of Commons by Chris Ruane MP in June 2006 renewing the call for a public inquiry. It has received 73 signatories to date. A list of MPs who have signed the EDM is available via INQUEST’s website. To contact your MP and ask them to sign the EDM, visit www.writetothem.com ■

Deaths in prison: horrendous catalogue of failings

● The number of deaths in prison continues and we are concerned that the escalating prison population and plans to expand the number of prisons will only result in more deaths. Recent inquests into deaths in prison have revealed a horrendous 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 beg questions about the inappropriate use of custody for some of the most vulnerable people in society, but they also highlight the failure in many cases to fulfil the state’s duty to protect life –

repeatedly inquests highlight the failure to implement existing guidelines on the care of ‘at risk’ detainees. Two deaths that clearly demonstrate these failings are those of David Hull and Wesley McGoldrick.

Following the inquest held in July into the death of 32 year old David Hull who died in the segregation unit of HMP Kingston in October 2004 the jury returned a damning narrative verdict concluding that *“David Charles Hull killed himself while the balance of his mind was disturbed and we the jury agree that David Hull’s death could have been avoided”*.

They raised many issues of

concern about the regime including: inappropriate use of segregation for someone at risk of suicide/self harm; inadequate training and a failure to implement suicide prevention procedures.

At the inquest into the death of Wesley McGoldrick, a 24 year old man who was found hanging in HMP Brixton on 19 April 2005 the jury heard how Wesley, who was identified as very vulnerable, gave information to police and prison staff on three separate occasions that should have given rise to very serious concerns about his state of mind and well-being, and indeed about the

risk he posed to himself. An appalling catalogue of communication failures within the police station and between the prison and the police meant that when Wesley was assessed by healthcare staff on arrival to HMP Brixton they did not have the benefit of any information he had given previously. Having once again disclosed his suicidal history, nursing staff seemingly failed to refer him for a mental health assessment and he was not placed on a self harm/suicide watch. Wesley died less than 24 hours after being remanded into the custody of the prison. ■

Deaths of immigration detainees

● Two recent inquests into deaths of immigration detainees demonstrate the devastating consequences of locking up asylum seekers.

Kenny Peter died in November 2004 as a result of serious injuries sustained when he jumped from the second floor landing with a noose tied round his neck at Colnbrook Removal Centre. He was born in Liberia or Nigeria in 1980. He claimed asylum in October 2003 but by April 2004 his claim had been refused and all appeal

rights exhausted. He was detained in Colnbrook in September 2004 and suffered from depression which was made worse by his situation. He had previously attempted suicide. Unsuccessful efforts were made to trace his family and from information given by Kenny it appeared that he was abandoned by parents when young and that his brother drowned whilst fleeing Nigeria to Gabon by boat.

The jury at the inquest returned a long narrative verdict which included detailed

criticism of the standard of medical care he received at Colnbrook and the quality and extent of communication between staff at the Centre and immigration officials.

As he had no family the coroner was asked to consider allowing INQUEST to represent Mr Peter’s interests but she refused. However she did accept written submissions from INQUEST about our concerns and our intervention was important in ensuring broader scrutiny of the death. We will be raising this issue

during the process of reform of the inquest system so that when someone dies who has no family it should be easier for an independent person or NGO to be appointed to represent their interests at the inquest.

On 20 September the jury at the inquest into the death of Angolan man Manuel Bravo returned a verdict that he had killed himself “in the belief that, in doing so, he would secure his son’s future in this country”. Mr Bravo and his young son had been detained after unsuccessful asylum

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applications and appeals. Staff at Yarl's Wood did not consider Mr Bravo a suicide risk even though he had a coil of washing line cord in his bag when he arrived and had been on antidepressants for months. The jury saw CCTV evidence of him walking from his cell to a stairwell and hanging himself.

INQUEST is working with the Institute for Race Relations on their report on recent deaths of asylum seekers. ■

New staff

● INQUEST is proud to welcome two new members of staff. Scarlet Granville joins our casework team and Yasmin Khan is our new policy and parliamentary officer. These appointments will enable us to improve our work advising and supporting families and raising the profile of INQUEST's research and lobbying work. ■

Support us

● INQUEST is the only independent advice and campaigning organisation that works directly with bereaved families and friends following a death in custody and develops policy proposals and undertakes research to lobby for changes to the inquest and investigation process, reduce the number of custodial deaths, and improve the treatment and care of those within the institutions where the deaths occur. Your support is crucial in enabling us to continue our work. We urge all supporters to join INQUEST, encourage friends and colleagues to join and donate money to enable us to continue fighting for truth, accountability and justice. If you would like to donate money to help INQUEST carry out its work please send a cheque made out to INQUEST to 89-93 Fonthill Road, London, N4 3JH. ■

INQUEST at TUC Congress

● INQUEST attended the Trades Union Congress in Brighton where we contributed to debates on 'human rights and trade union rights' and raised awareness of the draft Coroners Reform Bill's impact on inquests into workplace deaths. INQUEST welcomes the motion passed at Congress welcoming the recommendations of the Zahid Mubarek Inquiry and demanding that the Govern-

ment adopts a rigorous zero-tolerance approach to racism and violence with prisons. We will be continuing to work with the trade union movement in campaigning on issues related to contentious deaths.

In other trade union work, INQUEST has been working with public sector trade union UNISON on a pamphlet documenting the Roger Sylvester Campaign. We will be launching this in the autumn. ■

Annual UFFC demonstration

● The annual United Friends and Family Campaign demonstration will take place on Saturday 28 October 2006. This is an opportunity for families and friends of those who have died in state custody and their supporters to demonstrate their continued struggle for justice. Assemble at noon in Trafalgar Square and join the procession to 10 Downing St. ■

New groundbreaking research

● In November INQUEST will be publishing a report on families' experiences after a death in custody. The report, funded by the Nuffield Foundation, will be the first of its kind charting the experiences of families

through every step of the post-death investigations process. The report will call on the government to improve the process of action following the conclusion of an inquest by making sure that analysis, publica-

tion and action arise from coroners' reports and jury findings. It will also recommend establishing a Standing Commission on Custodial Deaths. To order a copy of the publication please contact info@inquest.org.uk ■

Don't miss INQUEST LAW

Published three times a year INQUEST LAW is a vital resource for anyone working on the investigation of sudden deaths. INQUEST LAW is distributed widely amongst lawyers, coroners, academics and policy makers.

Written by INQUEST Lawyers Group members and invited contributors it informs practitioners about recent legal developments relating to the inquest system and the investigation of sudden deaths.

It also keeps practitioners informed of policy developments in related areas. INQUEST is the only organisation working specifically on contentious deaths and the inquest system and as such INQUEST LAW is a uniquely valuable publication.

For details of subscription rates and membership of the INQUEST Lawyers Group, please contact the INQUEST office on 020 7263 1111 or by email to lawyers@inquest.org.uk