

NEWS FROM INQUEST

The Shooting of Jean Charles de Menezes

● Widespread outrage followed the shooting dead of Jean Charles de Menezes by the police on a London underground train at Stockwell tube station on 22 July. Concern and questions have rightly been raised about his death and the new “shoot-to-kill” policy that now governs police use of firearms. On 13 September members of the House of Commons Home Affairs Committee raised concerns about the new policy. Questions have been asked about how there can be a “shoot to kill” policy on the streets of London? Why has police policy changed without parliamentary scrutiny? Shouldn't the public be told the truth? As has happened repeatedly in previous cases there was a pattern of misinformation following the shooting of Jean Charles that attempted to deflect attention away from the actions of those who had killed him, misinformation that the Metropolitan Police Commissioner and the Independent Police Complaints Commission (IPCC) chose not to correct.

The death of Jean Charles de Menezes raises many crucial issues: the apparent time gap in handing over the investigation to

the IPCC; the treatment of the family and their access to advice and support; the policy governing the police operation; operational and intelligence failings and the “shoot to kill” policy and accountability to parliament.

INQUEST is also working with the family of Azelle Rodney, a 24-year-old black man who was shot dead by the Metropolitan Police following a pre-planned operation on Saturday 30 April 2005. His family wants to know why he wasn't arrested rather than shot and are calling for the immediate suspension of the police officer who still remains on duty.

The deaths of Azelle and Jean Charles are deeply controversial and once again raise serious questions about the disproportionate number of young men from black and minority ethnic communities who die following the use of force by police.

For more information and the family campaigns please visit the Jean Charles de Menezes family campaign website at www.justice4jean.com and the Azelle Rodney family campaign at www.azellerodney.co.uk ■

Another Black Death in Metropolitan Police Custody

● INQUEST is working with the family and lawyers of 32-year-old Paul Coker who died on 5 August in a police cell in Plumstead, south-east London. He was restrained by police officers and arrested for causing a breach of the peace. He died within two hours of his arrival at the station. The initial post mortem results were inconclusive and the family has instructed an independent pathologist to conduct a second examination. The IPCC are carrying out an investigation into his death.

Despite numerous deaths documented by INQUEST over the last 10 years involving dangerous

restraint techniques, yet another young black man has died following arrest by the Metropolitan Police. Inquest after inquest has examined and highlighted concerns about the use of restraint and its associated dangers. Paul's death also raises other concerns about the level of care, checks and medical intervention he received in Plumstead police station and whether he should have been taken straight to hospital. The Coker family has lost a loved son and brother. The Metropolitan Police have yet another addition to their shamefully long list of black deaths which have resulted from the use of force. ■

Statistics

● We continue to offer advice to bereaved people on the inquest system particularly following contentious deaths.

From 1 January – 1 September there have been 54 self-inflicted deaths in prison and 28 deaths in police custody. See our website www.inquest.org.uk for more details. ■

Father Found Hanging in Detention Centre

● On 15 September Manuel Bravo was found hanging in Yarl's Wood Immigration Detention Centre. He had been forcibly removed there with his 13-year-old son only hours earlier. His death raises very serious questions about the treatment of immigration detainees and medical screening and suicide prevention. ■

Reform of the Inquest System

● After the general election, the government announced that there will be a white paper on the reform of the inquest system published early in 2006 followed by a draft Coroners Reform Bill in the spring. INQUEST will be working hard to ensure the concerns of bereaved families and their lawyers are addressed in the new system. This proposed reform is long overdue and we hope that the new system will ensure better treatment of bereaved people and improved scrutiny of contentious deaths. We hope that the new system will ensure lessons are learned and that real changes are made to prevent deaths occurring in similar circumstances again and again. ■

Another Child Dies in Custody

● On 15 September 17-year-old Sam Elphick was found hanging in HMYOI Hindley. He had been identified as being at risk of suicide and self-harm and became the 29th child to die in the custody of the State since 1990. ■

Death of an Asylum Seeker

● Elmas Ozmico arrived in the UK in the back of a lorry on 8 July 2003 from Turkey with her two children and nephew. She feared persecution. On arrival she claimed asylum and was detained by the port authorities before being moved to the Dover Detention Centre. Elmas and the family requested urgent medical attention as it was becoming apparent that she was quite unwell. Her initial requests were ignored and despite asking repeatedly for medical help, she saw no doctor. It was only when she was granted temporary admission and released into the care of a voluntary organisation Migrant Helpline that an ambulance was called. She died three days later of septicaemia.

The jury at her inquest returned with a verdict of death by natural causes following two and a half weeks of evidence from over 50 witnesses, and after hearing of a number of systemic failures. This was an extremely unfortunate end. The family of Elmas Ozmico had very real concerns that the verdict did not reflect “by what means and in what circumstances” Elmas Ozmico died. ■

Parachute Jump for INQUEST

● On 13 August Carol Pounder, mother of 14-year-old Adam Rickwood, (the youngest ever recorded death in custody) who died in Hassockfield Secure Training Centre on 9 August 2004, did a parachute jump and raised over £800 for INQUEST. Carol said: “I did this jump to raise funds for INQUEST, an organisation that fights for justice for all bereaved families of children who have taken their own lives or lost them while in custodial care. I asked people to give generously to help INQUEST to continue its fight, not only for Adam, but every other child who has lost their life.” ■

Deaths of Women in Prison – Damning Inquest Verdicts

● A number of inquests have taken place into the deaths of women in prison where juries have criticised the standard of care afforded them while in custody.

In June there were two important inquest verdicts returned into the deaths of Tina Bromley who died on 4 January 2004 aged 37 at HMP Edmunds Hill and Sue Stevens who died in HMP Durham on 21 February 2003 aged 48.

Both juries found significant failings in the prison service in relation to the care of these two vulnerable women. In the case of Tina Bromley the lack of communication regarding her detoxification regime was criticised, as was moving her from a shared cell to a single cell. The jury at the Sue Stevens inquest criticised the prison for unsatisfactory planning of her move from HMP Holloway to HMP Durham resulting in an inadequate assessment of her self-harming tendencies.

Tina and Sue were vulnerable

women who needed care and medical attention. Prison was an inappropriate place for both of them. Their inquests raise issues that have arisen time and again about what a dangerous and inappropriate place prison is for women with mental health and/or drug problems.

● Emma Levey was found hanging on 4 November 2003 in HMP Downview. She was 24.

The jury at her inquest found that she took her own life whilst the balance of her mind was disturbed. They added that “Emma repeatedly requested further psychiatric care but was unable to receive this as Downview had no regular psychiatrist...” In fact the psychiatrist had left the prison in August and had not been replaced. The jury heard that because of a health service re-organisation the GP at the prison could not access any consultant psychiatric advice from the NHS. Emma’s inquest demonstrates that once again that women will

continue to die while prison is used inappropriately as a place to house those with mental health problems.

Another Woman Dies in HMP Durham

● 20-year-old Louise Giles was found hanging in her cell at HMP Durham on Saturday 20 August 2005. In May 2004, in a highly critical report of HMP Durham, the Chief Inspector of Prisons called for its closure. ■

Corporate Manslaughter

● On 6 September senior employees of Network Rail and Balfour Beatty were cleared of health and safety charges that followed the Hatfield Rail crash. Yet again this highlighted the need for the government to act swiftly to reform the law on corporate manslaughter. In September the TUC passed an emergency resolution proposed by the RMT calling for urgent action to reform the law in respect of corporate killing. The Home Affairs Committee is currently examining the proposed new legislation and INQUEST will continue its campaign alongside others for new legislation to be introduced and for it to apply to the prison service and police alongside other corporate bodies. ■

Court Orders Public Inquiry into Prison Suicide Attempt

● On 28 April a High Court Judge ordered a public inquiry into why a vulnerable prisoner was not prevented from making a suicide attempt, which left him brain damaged on 27 December 2001 at HMP Pentonville. The court also found that public inquiries will be necessary in other cases of attempted suicides in custody where the authorities were on notice that the prisoner posed a real and immediate risk to his/her own life.

Mr. Justice Munby expressed grave concerns regarding the Prison Service’s handling of this case. Prisoner D had self-harmed on three previous occasions before becoming brain damaged.

Earlier in the day he attempted to hang himself with his bed linen (a noose was found in his cell) yet his bed linen was not removed by prison staff. Since then the great majority of the Prison Service’s files have been deleted contrary to published guidance.

INQUEST is intervening in the case as we believe that the failure of the Prison Service to properly investigate serious suicide attempts has prevented the

opportunity to learn lessons. Vigorous public scrutiny to identify systemic or individual failings will help to ensure the future protection of the safety and lives of other prisoners. ■

Conferences and Meetings

- Since April INQUEST has spoken at or hosted the following:
 - 7 April – ASBO Concern campaign launch
 - 11 April – INQUEST judge Independent Legal Aid Lawyer awards
 - 29 April – Presentation at Capita conference - Deaths in Police Care
 - 8 June – INQUEST and the Institute of Mental Health Law host a seminar on Deaths in Detention – The New Approach for Inquests
 - 21 July – INQUEST launches book – *In the Care of the State? Child Deaths in Penal Custody in England and Wales.*
 - 23 August INQUEST briefs visiting Brazilian delegation on police shootings. ■

INQUEST Publishes New Book

● *In the Care of the State? Child Deaths in Penal Custody in England and Wales* written by Dr Barry Goldson and Deborah Coles and published by INQUEST was launched in Parliament in July to critical acclaim. The book is the first detailed analysis of child deaths in penal custody ever to be published and presents key conclusions and recommendations which, taken together, make a case for:

- the abolition of prison custody for children;
- a comprehensive review of child deaths in penal custody;
- the creation of an independent “Standing Commission on Custodial Deaths”;
- a full public inquiry into the death of 16-year-old Joseph Scholes who died in prison in 2002. (This campaign is well supported by key penal reform, children’s rights, human rights and mental health organisations as well as MPs and Peers.)

Lord David Ramsbotham, former HM Chief Inspector of Prisons said at the launch: “This is a splendid book and forms the most momentous part of the campaign for a public inquiry into the death of 16-year-old Joseph Scholes and will move this matter forward.” He also said that he would “entirely endorse the recommendations made in this book” particularly “the need for a Standing Commission into Custodial deaths.”

Yvonne Scholes, mother of 16-year-old Joseph Scholes who died in HMP YO1 Stoke Heath said: “*In the Care of the State?* should be compulsory reading for both ministers, and the people of power who shamelessly condone the continuing abuse of child prisoners. I say to them ‘hold the book in your hands, let your eyes read the words, but hear the message with your heart.’”

INQUEST will be continuing our parliamentary and campaigning work to take forward the recommendations in the book. ■

In the Care of the State? Child Deaths in Penal Custody in England and Wales is available from INQUEST priced £15 plus £2 postage and packaging.

To place an order please call the INQUEST office on 020 7263 1111 or download an order form from www.inquest.org.uk