Welcome to INQUEST’s latest E-Newsletter
The last few months have been a busy period here at INQUEST. INQUEST’s casework team has overseen a disturbingly high number of cases involving deaths in prison, police, psychiatric and other state care, alongside a high reporting of custody deaths:

- In August alone, the casework team dealt with **30 new cases**, making this one of the highest numbers of new enquiries involving deaths in state care and detention ever received by INQUEST.
- Between June and September, there have been **84 prison deaths and 10 deaths** in or following Police Custody in England and Wales. This represents a **monthly increase** in the average number of deaths compared with previous months, January to May. See Statistics below.

In other news, INQUEST continues to be involved in a number of policy developments:

- Co-director, Deborah Coles, has been appointed to the Expert Advisory Group which will help develop a **new independent patient safety investigation service** (IPSIS). This will provide guidance to health and care provider organisations on investigations into serious patient safety incidents.
- The Home Secretary Theresa May has announced an **independent review into deaths and serious incidents** in or following police custody in England and Wales. INQUEST has been asked to advise the Chair and inform the research conducted by the review.
For more details of INQUEST’s recent work see also latest news and press releases, as well as updates on our facebook page and twitter account.

News

Death in Prison

July saw the publication of the ‘Harris Review’, ‘Changing Prisons, Saving Lives’, a report of the independent review into self-inflicted deaths in custody of 18-24 year olds. Chaired by Lord Toby Harris, it involved a panel of experts including our co-director Deborah Coles. On its publication she described the report as a “devastating indictment of a flawed system that is systematically failing”, arguing the need for the report to be a “watershed moment that provides the basis for a complete transformation in policy”. INQUEST contributed to the review by submitting written evidence and providing our report Stolen Lives and Missed Opportunities (published with Barrow Cadbury Trust), based on our work with bereaved families. INQUEST also organised two family evidence sessions, publishing a report on issues raised during these ‘Listening’ days. Reference to INQUEST’s input and evidence is referred to throughout the report, including in its findings and recommendations. We await the Government response.

Following publication of the Harris report, the Justice Committee announced its inquiry into the treatment of young adult offenders in the criminal justice system. INQUEST has submitted written evidence to the inquiry.

Independent Review into Deaths in Police Custody

On 23 July Home Secretary Theresa May announced an independent review into deaths and serious incidents in or following police custody in England and Wales. INQUEST cautiously welcomed the announcement which follows discussions between the Home Secretary, the families of Sean Rigg and Olaseni Lewis, and INQUEST. Both Deborah Coles and Marcia Rigg-Samuels, oldest sister of Sean Rigg, spoke on the BB4 Radio 4 Today Programme, on the day of the announcement. Marcia Rigg-Samuels commented “there is a clear need for a
Deborah Coles insisted the review would only be effective if “bereaved families, their lawyers and INQUEST…[played] an integral role”, and that it needed to address “why so many previous recommendations from reviews, inquiries and inquests have not been acted upon”.

**Police Disciplinary Hearings**

Disciplinary proceedings brought against officers following the death of Habib Ullah concluded with all officers being cleared of gross misconduct. The 39 year old father of three died following a cardiac arrest having been stopped, forcibly restrained and searched by police in July 2008. Gross misconduct action followed conclusion of an inquest critical of the restraint used against Habib. The family were successful in their fight for the disciplinary hearing to be held in public. Since the 1 May 2015, new regulations now make general provision for all police disciplinary hearings involving allegations of gross misconduct to be held in public.

**New support fund for families**

The National [Mikey Powell Memorial Family Fund](#) appeal was launched on 7th September, the twelfth anniversary of his death in the custody of West Midlands Police. The fund will provide small grants important to giving practical help to families affected by deaths in UK state care and custody. Find out more or make a pledge to the fund here.

**Holding the state to account after fatal police shootings**

Deborah Coles accompanied the family of Jean Charles de Menezes in travelling to the European Court of Civil Rights in Strasbourg in June to challenge the UK Government’s decision not to prosecute police officers in the case. There has been no successful prosecution of a police officer for manslaughter or murder in any case in England and Wales since 1969. The court’s decision is awaited.
On 3 July, over ten years since the shooting of Azelle Rodney, the former Metropolitan police armed officer Anthony Long was found not guilty of murder by a majority verdict. Azelle Rodney was shot by Anthony Long eight times at no more than two metres distance. A public enquiry held in 2012 held that there was no lawful justification for the fatal shooting of Azelle Rodney. Speaking at the time of the enquiry, Susan Alexander, mother of Azelle Rodney, said that she “welcomed the thorough and excellent Public Inquiry” and hoped “the report would be ground-breaking and cause a shift in thinking by the police”. Following the trial verdict, she concluded “there are too few signs of any such shift”, noting that the “verdict... may be misinterpreted by officers of all ranks”. Helen Shaw, INQUEST’s co-director, added “the experience of Susan Alexander... exemplified all that is wrong about the way deaths involving police use of force are investigated”.

Following our continued support to the lawyer acting for Sheku Bayoh, a 31 year old black man who died in Fife in Scotland on 3 May 2015 following the use of restraint by police officers, Deborah Coles and Ayesha Carmouche, Policy and Parliamentary officer at INQUEST, attended the launch of the Justice for Sheku Bayoh campaign in Glasgow in July.

A new approach to investigating deaths in hospital?

In July 2015 the government announced its intention to create a new independent patient safety investigation service (IPSIS). Operating from April 2016, IPSIS will provide support and guidance to health and care provider organisations on investigations into serious patient safety incidents.

Deborah Coles has been appointed to the Expert Advisory Group, the panel set up to advise and help develop the new service. Her appointment follows considerable work done by INQUEST focusing on the failure to operate an independent investigation framework concerning the deaths of psychiatric in-patients. She will work hard to ensure the experiences of bereaved families are central to that process.

The EAG is seeking the views of stakeholders, including service users and bereaved people who have experience of investigations. If you would like to
Women in state care

Natasha Evans was a 34 year old woman who died in HMP Eastwood Park in September 2013 of kidney and heart infections which led to sepsis. She was serving a 4 month prison sentence for possessing the drug to which she was addicted. She was undergoing a detoxification programme. In September the inquest into her death found there was evidence of neglect and “serious” healthcare failures and that had her symptoms been recognised sooner they could have been treated. Natasha’s death once again raises concerns about the quality of medical care afforded prisoners.

Alarmingly there have already been five deaths of women in prison this year. Four deaths were in Foston Hall. This begs the question as to why, 8 years on from Baroness Corston’s report recommending fundamental overhaul of the way women are dealt with in the criminal justice system, courts continue to imprison vulnerable women, the majority of which have committed non-violent offences.

The case of Eleanor de Freitas raises further specific concerns regarding the treatment of women in the criminal justice system. Eleanor’s father has lodged an application with the Attorney General requesting a referral to the High Court to consider ordering a fresh inquest into her death. Eleanor was a 23 year old woman, diagnosed with bi-polar affective disorder and a community patient of her local Mental Health Trust. She took her own life in April 2014 on the eve of a trial at which she was to be prosecuted for perverting the course of justice, following a complaint of rape she made to the police that resulted in the arrest of the accused man. This case raises crucial concerns about the way the criminal justice system deals with rape complainants as well as the safeguards that are in place surrounding the vulnerability and/or mental health of alleged victims.

August - a casework snapshot

August was a shocking snapshot of the scale and vulnerability of those dying in state care and detention this year. The volume and nature of the cases has been truly disturbing. In this month alone, the casework team was contacted for help in relation to 30 deaths occurring in prison, police, psychiatric and other state care.

Of the ten prison deaths almost all involved the death of vulnerable detainees with
a history of mental health concerns. Seven of the deaths were self inflicted. One involved the death of a 21 year old. Two deaths occurred at HMP Winchester, bringing the number of deaths at Winchester to four in two months. One death possibly involved the use of force. One death was of an immigration detainee.

Of the nine police related deaths, almost all involved the death of vulnerable people, again many with mental health concerns. Three of the deaths occurred shortly after police contact. Several of the cases involved serious and basic failures of care and treatment of vulnerable detainees at police stations, including vulnerable intoxicated detainees. In two cases, the deaths occurred in police cells in circumstances where close observations should have been underway. For the first time since 2008/09, one person died after making an apparent suicide attempt while being held in a police cell. One case involved the shooting of a man with mental health concerns, only the second death from a police shooting since 2011/12. One case involved the death of a seventeen year old. One case involved the use of restraint. One case involved the death of a highly vulnerable man following his detention by Northumbria Police. According to the IPCC’s annual statistical report, two deaths in or following police contact also occurred in Northumbria in 2014/2015.

Of the other enquiries received, five involved deaths occurring in psychiatric care, four involved the deaths of people receiving care and treatment under a DOLS (Deprivation of Liberty Safeguards) arrangement, one concerned a death in a care home and one involved a military death.

It is hard to remember a more appalling month for new enquiries. The concern is that these deaths may represent a wider picture of increasingly stretched resources, falling standards of care and less humane approaches and treatment of those in the care of the state.

**United Family and Friends Campaign**

The United Family and Friends Campaign (UFFC) is due to have its annual rally on the 31st of October in London. Assembling at 12 noon at Trafalgar Square, there will be a silent procession along Whitehall followed by a protest outside Downing Street. The UFFC is a national coalition of families and friends of those who have died whilst in care of the state. Find out more about what the UFFC is about and details of the rally here.
INQUEST engagement with Ministerial Board on Deaths in Custody

Deborah Coles represents INQUEST on the Ministerial Board on Deaths in Custody, which brings together decision-makers responsible for policy and issues related to deaths in custody at the Ministry of Justice, Home Office and Department of Health. Others on the board include senior staff from inspection, monitoring, investigation and regulation bodies and a number of NGOs.

Deborah presented two recent papers to the board, one on the problems of funding family legal representation at inquests into deaths in custody and the other outlining the key findings and recommendations arising from our evidence-based report on deaths in mental health detention. Both reports generated significant debate and follow-up meetings with the relevant policy leads within government departments. These issues are key strategic priorities for INQUEST and we will report back on progress.

INQUEST contributes to coroners’ officers training

Jointly organised by the Judicial College and the Office of the Chief Coroner, a new programme of coroners’ officer training is being delivered across the country. The training is intended to improve investigative skills and provide an update on recent legal developments.

INQUEST has been pleased to deliver a short lecture at each of the first three sessions on the experience of families and our work. Further sessions are planned in autumn 2015. We hope to remain engaged with training and support initiatives to improve the experience of bereaved families and their representatives.

Family Forum
INQUEST held one of its Family Forums in June. The family forum gives bereaved families the opportunity to meet new people, to share their experiences, and to feed back to INQUEST their thoughts, feelings and ideas on a range of issues. It was a powerful day with compelling contributions from over 30 family members. The next Family Forum will be held in November. Please contact us if you are interested in attending.

“Even though we suffered the most horrendous circumstances, I left feeling uplifted.”

“Thank you for the opportunity to allow families to come together and share their experiences. It gives a sense of relief / comfort to hear others”

(comments from families attending the Family Forum)

Statistics

Deaths in prison

Throughout June, July, August and September there have been 84 prison deaths in England and Wales. Of these, 31 were self inflicted, 43 were non self inflicted and 10 are still awaiting classification. Of the total, 11 were BAME, 4 of which were self inflicted, 4 not self inflicted, and 3 awaiting classification. There have been 81 male deaths, and 3 female deaths.

These deaths represent 48% of the total year to date, with 176 total deaths in prison since the turn of the year, 67 of which were self inflicted, and 3 of which were homicides. This represents a 14% increase in the number of prison deaths per month, rising from an average of 18 deaths per month from January to May, to
21 deaths per month from June to September.

Deaths following police contact

Throughout June, July, August and September there have been 10 deaths following Police Custody in England and Wales. Of these cases the cause of death in 6 is still unknown, with 1 incident of drowning, 1 caused by swallowing drugs, and 1 caused by gunshot wounds, and 1 as the consequence of a car crash. There were 9 male deaths, and 1 female deaths.

These deaths represent 50% of the total year to date. This represents a 25% increase in the average number of deaths per month during the period June to September, from that of January to May.

Organisational News

After over 21 years Helen Shaw will be leaving as co-director at the end of the year, although remaining connected to the organisation as an INQUEST associate, working on projects as and when required. We are now advertising for a newly created post of Operations Director.

INQUEST is looking for an Operations Director

Are you passionate about social justice and effecting change? Are you interested in working within a complex and politically sensitive environment? Do you have a flair
for running organisations?

Working with INQUEST’s Director in this key senior role you will be responsible for managing the organisation and developing its capacity and operational systems. Leading on governance, fundraising, financial, team and project management you will sustain and create new and innovative opportunities to take INQUEST to the next level.

For more information and how to apply click [here](#)

Closing date: 9am Wednesday 21st October 2015.

Last, but not least, we’d like to say thank you to our volunteers Patrick and Emma, as well as expressing our appreciation to Silas, Carson, Radha and Giovanna who volunteered during the summer period but have now moved on -- we wish them well in their new endeavours.

**New Edition of Inquest Law published**

“I would just like to congratulate INQUEST on its latest edition of Inquest Law which I read with interest on a recent long train journey. It provides an excellent summary of up-to-date law, cases and issues, and is an invaluable tool for anyone who has anything to do with the coroner service of England and Wales… I look forward to the next edition.”

**HH Judge Peter Thornton QC  Chief Coroner**

In this issue, Henrietta Hill QC reviews key changes over the last two years resulting from the Coroners and Justice Act 2009 and the associated rules and regulations in. Sara Ryan gives a family view on the need for publicly funded
representation at inquests. Jesse Nichols provides an extensive legal update; and ten case reports are included on inquests covering deaths involving the police, prison deaths and deaths in care. Subscribe here.

Supporting INQUEST

“What can I say? A group of people who are dedicated, passionate, experienced and committed, bringing a shed load of expertise, networks, ideas and action. In the background, INQUEST. A remarkable organisation. Unobtrusive, non-intrusive and quietly and efficiently effective. A perfect mix for the recently shell-shocked.”

Mother of an 18 year old Connor Sparrowhawk who died in a specialist NHS unit.

People regularly express surprise that INQUEST is such a small organisation thinking we are a larger and well resourced organisation. The opposite is true – we have five full time and three part time staff and we need every penny to keep the organisation going. We are really grateful to all our donors and grant givers and your support can make a really significant difference to the work we do and the impact we have.

If you can, please make a donation or become a regular giver - any gift, no matter how small, contributes to securing INQUEST’s future. It’s easy and secure to do via our JustGiving page or via CAF online. If you are a tax payer and you Gift Aid your donation, the government will give us 25p for every pound you donate – at no extra cost to you. Thank you.