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INQUEST

TRUTH, JUSTICE AND ACCOUNTABILITY

Welcome to the November edition of our newsletter

WE WON!

We were incredibly proud to be named joint winners of the [Liberty Human Rights Award](#) with Connor Sparrowhawk's family (Justice for LB) and Charlotte Haworth Hird (Bindmans solicitors and Inquest Lawyers Group member) for our *“tireless efforts to improve the standard of care provided for people with mental health and learning disabilities”*. This case highlights the impact INQUEST has by adopting a truly integrated approach to our casework, policy and campaigning work.



IN THE NEWS

Prison, police and mental health services have come under intense political and public scrutiny in recent weeks. We've had a strong presence in the media ourselves, informing the debate with our evidence-based casework. See below this weekend's article in the Times on the state of prisons.

Deborah Coles attended, and questioned, Justice Secretary Liz Truss at her much anticipated prison reform speech, with INQUEST families interviewed live on Channel 4 News for their response. We challenged her on the escalating number of self-inflicted deaths, the need for a dramatic reduction in the prison population and the inappropriateness of prison for particular groups.



THE BIG GIVE

People are often surprised to hear we are a team of just nine people, covering England and Wales. We are totally reliant on grants and individual gifts to provide a service which no other organisation does.

If you are able to support us, now is the time to do so as any donation you make to INQUEST between 12pm (midday) on Tues 29th November and midday on Fri 2nd December **WILL BE DOUBLED** by [The Big Give' Christmas Challenge 2016](#).

Plus gift aid (if eligible) will be on top.

OUR SPECIALIST CASEWORK

This is a particularly challenging time with an unprecedented demand on our five caseworkers, due to escalating prison and mental health related deaths.

We continue to be frustrated by the same repeated failings arising time and again at inquests into contentious deaths.

Delays by state appointed investigative and prosecutorial bodies, systemic failures and inadequate support for those with mental ill health in prison, hospital and the community (particularly women) continue to dominate.

Inquests held over the last three months have focused heavily around 4 key issues:

1. Self-inflicted prison deaths

INQUEST monitoring now shockingly reveals that we have reached [100 self-inflicted deaths so far this year](#) – the highest number ever on record.

Deborah Coles expressed our concerns in an [open letter to the Observer](#) last week.

There have been so many damning inquest findings, recommendations from investigation and inspectorate reports, and inquiries from Baroness Corston to Lord Harris – all of which have produced rigorous, evidence-based recommendations to protect the health and safety of prisoners and staff in British jails. Yet the vast majority of these have been systematically ignored and not actioned.

One year on from the [Harris Review into self-inflicted deaths in custody of 18-24 year olds](#) and concerns over the deteriorating prison environment and health & safety are at a high. Inquests into the deaths of [Liam Lambert](#) and [Jake Foxall](#) at HMP Glen Parva (where there have been 11 deaths since 2010) and [David Smith](#) and [Levi Cronin](#) at HMP Highpoint (these were two of four deaths at the prison in an 18 month period) all highlighted serious failings in the care of vulnerable young men with mental ill health, many of whom were on first time and short term sentences.

[Lord Harris used our briefing](#) to highlight to members of the House of Lords the acceleration in self-inflicted prison deaths and the need for families to have parity of funding at state-related inquests.

2. Deaths in police custody & following contact with the Police

Last year saw the highest number of fatal police shootings since 2010, two of those shootings involved the Metropolitan Police Service (MPS).

The inquest of [James Fox](#) concluded he had been lawfully killed, despite the jury finding James had been given no time to react before he was fatally shot five times by officers.

[Jermaine Baker](#)'s family has requested a meeting with the IPCC chairwoman, Dame Anne Owers, to discuss their concerns around the IPCC investigation and treatment of their family since Jermaine was shot dead by the Metropolitan Police last December. In October, a Met tactical firearms commander, who was facing an IPCC allegation of gross misconduct, was allowed to retire from the police, so he will avoid the possibility of disciplinary proceedings and sanction for any part his alleged failings may have played in Jermaine's death. Margaret Baker, Jermaine's mother, voiced her distress in an interview on Channel 4 News.

The families of Olaseni Lewis and Sean Rigg, two of our longest running family campaigns, have faced disappointing set backs:

- Six years since [Olaseni Lewis](#)'s death following a restraint in hospital, the CPS confirmed none of the police or healthcare staff involved will face criminal charges. Unacceptable delays in the investigative process have delayed a public inquest into Olaseni's death, which will finally go ahead early next year.
- Eight years on from [Sean Rigg](#)'s death, the 'not guilty' verdict in the perjury trial against Sergeant White (custody officer at Brixton Police Station) was a devastating blow for his family. The verdict came despite evidence that the officer had given a detailed but false version of events.

Describing the impact of failures and delays in this case, Deborah Coles said: *"Sean Rigg's family have struggled at every stage of this eight year process for honesty, truth and justice. The failure of the IPCC to conduct an efficient, robust and competent investigation and the inexcusable*

delays in CPS decision making have been exposed as a barrier to proper democratic police accountability. If left unchecked, this institutional inertia will allow abuses of power to go undeterred and continue to undermine public confidence in the police complaints system."

- For [Kingsley Burrell](#)'s family, hope now rests on the CPS's decision to charge three police officers involved with Kingsley's death with perjury and perverting the course of justice. A highly critical inquest jury concluded that an unlawful use of force was used by the police. The charges relate to accounts given in witness statements and evidence given on oath by these officers at the inquest.

3. Deaths of people with mental health/learning disabilities (in NHS trusts/private care settings)

In August it emerged that [data discrepancies](#) could mean that over 700 patients who died while being detained under the Mental Health Act could have been denied inquests, despite the law stating that all deaths in state detention should be examined by a coroner.

In our statement to the media, Deborah Coles said: *"There needs to be much greater openness and transparency of deaths in mental health detention. These figures point to continuing failures in reporting and oversight. Until there is an independent framework for deaths in mental health detention and those informally detained, this problem will persist."*

The Care Quality Commission has undertaken a review of how the NHS investigates deaths in health care settings. INQUEST was asked to organise one of our ['family listening days'](#) so they could hear first-hand the experiences of our bereaved families, many of whom lost relatives who had mental illness/learning disabilities. We submitted our own report outlining the key issues for consideration by the CQC and calling for an independent investigation framework. The CQC will announce their recommendations to Government on the 13th December 2016. We will keep you posted on this.

Inquest findings into the death of Pippa McManus who died in the care of the

Priory, as did [Amy El-Keria](#), have reinforced our serious concerns around the quality of care provided to highly vulnerable children. Approximately 47% of all in-patient child/adolescent mental health services are now run by private providers, such as the Priory.

We secured BBC/ITN/Channel 5 News coverage and across-the-board press coverage for the family of 15 year old [Christopher Brennan](#), following highly critical findings at his inquest in September. The coroner concluded that cumulative failures in risk assessment and management meant neglect contributed to Chris's death. Failures by Bethlem hospital were acknowledged as significant contributors to his continued self-harming and ultimately, his death.

4. Women's deaths

So far this year, [21 women have died in prison](#), the highest number on record, of which 10 were self-inflicted. The recent closure of HMP Holloway is further cause for worry, with prisoners relocated to other prisons likely to be further away from their support networks and children.

The [Corston Review](#), published almost a decade ago, recommended a dismantling of the women's prison system, investment in women's centres and small custodial units for the small number of women who needed to be detained. Deborah Coles, who was involved in the Corston Review, [co-signed a letter in the Times this month](#) calling for long overdue government action.

Our casework continually leaves us asking: why are many of these women being sent to prison in the first place? The recent inquests of Diane Waplington and [Michelle Barnes](#) were stark reminders of the unsuitability of prison, how inhumane the system can be when dealing with very disadvantaged and vulnerable women, and the impact on the children involved.

The inquests of [Helen Millard](#), [D'Anna Ward](#), [Marion Munns](#) and [Natalie Gray](#) further highlighted the systemic failings and inadequacy of community and NHS mental health services and housing solutions offered to those under their care.

Our media, parliamentary and policy work helps keep these issues, and the individual cases which highlight them, in the public domain.

CAMPAIGNING

The [United Families & Friends Campaign](#) and [4WardEver UK](#) held their second **Youth Voices 4 Justice** event in Birmingham on 9th September, which we attended. The event aims to shed light on young people and children who have been affected by the loss of a relative in custody and to raise funds for the [Mikey Powell Memorial Family Fund](#), which hopes to provide grants to support other family campaigns. See more details about the fund and how to donate [here](#).

We also showed our support at the 18th UFFC Annual Remembrance Procession, joining the families and friends of those who have died in the custody of police and prisons or in immigration centres and mental health settings, in a silent procession along Whitehall to present their letter to Downing Street. More information can be found [here](#).



INFLUENCING POLICY

We've continued to advise and influence policy consultations and parliamentary debates, bringing greater understanding of the issues arising from our casework and around the inquest process.

- Deborah Coles attended the Ministerial Board on Deaths in Custody this month with the new minister, where discussions were heavily focused on self-inflicted deaths in prison, restraint related deaths in police custody and deaths of children in mental health settings. The lack of Government action in response to the recommendations of the [Harris Review](#) were also debated.
- We held meetings with Inquest Lawyers Group members and the Prison and Probation Ombudsman (PPO), Independent Police Complaints Commission (IPCC) and the Legal Aid Agency (LAA) to pursue current and ongoing concerns arising from deaths in custody and funding for representations at inquests.

- We made a submission to the Farmer Review providing case evidence to demonstrate the importance of family contact to those in prison and how this can be a vital lifeline, particularly in the management of prisoners at risk of suicide and self-harm.
- We have been closely involved in the [Dame Angiolini Independent Review into deaths and serious incidents in police custody](#) and it is hoped the review will go to the Home Secretary by the end of the year.
- INQUEST and members of our lawyer's group have enjoyed a supportive relationship with the outgoing Chief Coroner, Peter Thornton, who publically expressed his support for our desire for parity of funding in state-related inquests in his annual report. With his backing, some genuine coronial reform has been possible under his tenure. He has spoken about the importance of our work:

*“I would like to express my thanks for the work which INQUEST do so valiantly on behalf of bereaved families. Your presence is marked by the fact that if you were not present there would be such a gap in the process that you would have to be created. Thank you for your excellent work.”***Peter Thornton, outgoing Chief Coroner**

With four prison ministers appointed in the last five years, and a change to the Cabinet, it has been a challenge to build trusted relationships with those in power. We look forward to appointing a new Policy Manager by the end of the year, to help us cement our existing relationships and expand our reach further in Parliament.

SUPPORTING FAMILIES

Our updated [Inquest Handbook](#) will be available online by the end of the year and is a valuable guide for anyone going through the inquest process. Our interactive [INQUEST Skills and Support Toolkit](#) is also available via our website and provides lots of practical help and advice.



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