

# DEATHS IN CUSTODY: REDRESS AND REMEDIES

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PROTECTING CIVIL LIBERTIES PROMOTING HUMAN RIGHTS

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## FOREWORD

*by Vera Baird QC MP, Chair of the advisory committee for this research*

It was a pleasure to be asked to chair this important experts' committee, established by Liberty. From the start it was clear not only that all the participants were indeed very expert, but also that each in different ways and from different perspectives cared immensely about trying to get this difficult topic right. The discussions were of the highest calibre and ranged over a wide field of experience.

The result is a very sound and thought-provoking report which analyses contentious deaths in custody and their often flawed investigation. Its criticism of the State's present treatment of bereaved families is no more than common sense but it carries behind it intimate acquaintance with the real effects of that treatment on individuals.

The report gives an overview of the historical issues which have given rise to the problems we see with the investigation of, most notably, deaths in police custody. But there is proper coverage too of the other circumstances during which a person's wellbeing is the responsibility of the state – deaths in prisons and in mental health institutions.

An excellent summary and analysis is provided of the recent decisions in the European Courts which have driven the development of the law in relation to contentious deaths. The recent impact of the European Convention on Human Rights under Article 2, by establishing the principle of the State's positive obligation to prevent a real and immediate risk to life, continually informs the analysis throughout the report.

The authors consider the functioning of the investigation of contentious deaths and they deal separately with the current procedure for police, coroners and pathologists. The authors also offer suggestions for reform – including in their analysis the expected impact of the Independent Police Complaints Commission, which ensures this report will remain relevant for the duration of that transition and beyond.

A detailed consideration of the long recognised, and long overdue, need for an overhaul of the inquest system and coroner's law follows. The government-appointed coroners law review team, expected to report imminently, are anticipated to make suggestions for radical reform of the inquest system. I hope that the thoughtful recommendations of the authors will contribute towards any subsequent debate, and, hopefully, this momentum will be a precursor to reform in this area of the law.

In the section entitled 'Other Remedies', the authors consider, most notably, the work of the Crown Prosecution Service and recourse to civil litigation. Again, they bring a carefully considered perspective to reform which is already underway.

The authors' recommendations will, I have no doubt, prove invaluable reading for anyone with an interest in this area of the law and public policy.

Vera Baird QC  
Member of Parliament for Redcar

January 2003

## ACKNOWLEDGEMENTS

This research has benefited throughout from the supervision of an Advisory Committee. The members of the Committee have agreed terms of reference for the research, attended regular meetings, suggested lines of research, advised on the viability of proposals, and substantially contributed to this final report. We are deeply grateful for their help and guidance at every stage.

Nevertheless, the views contained in the report are those of Liberty, and do not in every respect reflect the opinions of all the individual members of the Committee.

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We are particularly grateful to **INQUEST**, and to co-director **Deborah Coles**. **INQUEST** helped us to think about the structure of this research before we started. Despite being very busy in trying to assist the relatives of all those that died, they also gave us substantial access to their files and their time.

We are also deeply grateful to **Danny Friedman**, *Matrix Chambers*, and **Daniel Machover**, *Hickman and Rose*, for their special efforts and valuable contribution to sections of this report.

We have been assisted in the course of our research by a great number of people in England, Scotland, Ireland, Australia and Canada, at a variety of levels.

Some are listed in the Appendix; we extend our thanks to them all.

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## EXECUTIVE SUMMARY

### Introduction

There are severe shortcomings in the current systems for investigating and providing remedies after deaths in custody. Article 2 of the European Convention on Human Rights enshrines the right to life. The positive duty it places on the state to secure life is particularly important for those in custody, who have a substantially reduced capacity to take care of themselves and are often particularly vulnerable as a result of physical or mental illness. The consequence is that the state must be presumed to have failed if a person dies in its custody. Therefore there needs to be a thorough investigation of any death, because any fault in the system for protecting the right to life could very well lead to other loss of life.

The state has failed in its role not only if it does not investigate the death properly but also where criminal offences have been committed, if it does not prosecute those responsible.

This report assesses the current processes of investigation, the subsequent inquest, and the availability of other remedies. It highlights shortcomings and offers recommendations for change.

### The investigation

The system as a whole does not create public confidence. The investigation of deaths in police and prison custody is too often ineffective, secretive, slow and insufficiently independent. The authorities involved in such cases too often do not take responsibility for their actions and appear defensive.

The parallel, overlapping, conflicting and confusing roles of the police, the Police Complaints Authority (PCA) and the coroner create problems and reduce both the effectiveness of the system and the confidence that others might have in it. Coroners do not, and cannot, supervise investigations – they do not have sufficient resources, experience or training. In theory, the police have a supportive role to the coroner, but in practice they are not subject to the coroner's direction.

The relatives of the deceased are too often excluded and marginalised. To them, the investigation can often appear less a search for truth than an attempt to avoid blame,

frustrate disclosure, restrict the remit of the investigation and denigrate the deceased. As a result, relatives and their supporters have little confidence in the system.

The new Independent Police Complaints Commission (IPCC) will in future investigate all 'controversial' deaths in police custody itself. Before it starts work in April 2004, however, the IPCC needs to find and train enough experienced staff to make sure that it does not rely exclusively on seconded police officers in its investigations. But the IPCC will only investigate deaths involving police officers, (or 'non-officer' members of the police). Deaths in prisons and secure hospitals will still be investigated by the police and by inadequate internal mechanisms. Similar independent investigation is needed here too.

Deaths in all forms of custody should be investigated independently. A separate and parallel complaints mechanism to the IPCC should be developed for the independent investigation of deaths in prisons and hospitals (where people have been compulsorily detained).

In addition, a separate, over-arching commission should be established – not as an investigative body, but with a mandate to bring together findings on police, prison and secure hospital deaths. Such a 'Standing Commission on Custodial Deaths' could identify key issues and problems, develop common programmes and research, promote best practice etc. It would not usually investigate individual cases, but should have powers to intervene in any inquest, to hold a wider inquiry where it sees a consistent pattern of deaths, to insist on access to documents and to summon witnesses.

### The inquest system

The current inquest system has several flaws. The system does not provide families and the public with what they want – to find out the truth about what happened, as a step to seeing that those responsible are held liable. There is also a lack of transparency – because disclosure is not provided as of right, it is not provided early enough and there are too many exceptions which allow material to be kept secret. The process is in effect adversarial in these cases, but confusingly it still purports to be inquisitorial.

The jury is too restricted in its ability to frame verdicts and cannot make recommendations. The verdicts do not

identify who is responsible, or provide for accountability and liability. The 'judgments' given by the inquest jury as to responsibility do not lead to any form of legal liability. This creates anomalies and a lack of consistency within the system as a whole.

There is a failure to learn lessons from deaths because the findings and recommendations of coroners are not published, and these recommendations are not monitored or followed up in any systematic way. Riders have been abolished. Lastly, the lack of sufficient funding for lawyers for the relatives violates the principle of 'equality of arms'.

However, abolishing the inquest system and replacing it with an alternative system would risk losing the experience and expertise of coroners and others. Neither civil nor criminal legal processes offer an adequate replacement – either a reformed version of the present inquest system or a direct replacement is needed.

Giving coroners extra powers to act as investigators was considered. But this would make the coroner both investigator and adjudicator – a controversial and potentially damaging mix of roles.

Liberty believes the current inquest system should be retained but radically improved – still, where possible, using the expertise that has been developed so far by coroners. However, substantial amendment is needed if the current system is to tackle problems such as inconsistencies in the adjudication of coroners, in the standards being applied and in the experience (or lack of it) of coroners in dealing with controversial deaths.

One option is to integrate coroners into the civil justice system – replacing them with (or re-appointing them as) district, circuit or High Court judges. The seniority of the judge sitting as a coroner would depend on the level of seriousness of the case involved. There would be a new right of appeal to the High Court on a point of law (rather than families and others having to rely on judicial review). We agree with the Review Team that the requirement for the Attorney General's "fiat" (permission), before cases can go to the High Court seeking to quash an inquest decision, should be abolished.

Inquests need clearer rules of procedure. The relatives of the deceased should be a formal party and have a right to representation, plus the powers of a party to civil litigation – to cross-examine, to address the jury, and to call

witnesses. The inquest system should be generally adversarial, providing the coroner with an adjudicative role (although retaining some inquisitorial powers such as the ability to call witnesses). The usual civil rules of disclosure and legal safeguards should apply to the inquest. District judge coroners should be selected via an open process, should be properly trained and should be subject to regular monitoring. A proper complaints mechanism should be established.

All controversial deaths in England and Wales should be heard by a coroner and a jury. This option will result in fairer inquests and a more open system. However, the inquest should not double up (as it has in the distant past) as the committal stage in the criminal process.

The privilege against self-incrimination should be abolished so that police officers and others can be forced to give evidence and answer questions in the inquest. But any evidence thus given should not be admissible in any subsequent criminal proceedings against that officer.

There should be a full review of existing verdicts, with a verdict indicating negligence or a failure in a general duty of care introduced to the prescribed list. The parties could draw up and the coroner could agree specific questions for juries to answer. Juries should be allowed to use narrative verdicts – allowing expression of issues of concern in those cases not suited to prescribed verdicts. Where the jury considers that negligence or a failure in a general duty of care contributed to a death, this could be added as a rider to the principal verdict.

Properly interested persons should have the right to legal representation at inquests in death in custody cases. Means testing for public funding should be abolished, because of the importance of the issues involved, and because of the crucial importance of representation.

The report rejects integration of the inquest system into the criminal system on the basis that the underlying aims of the two systems are quite different. The verdict after an inquest is concerned with whether the system failed as a whole. The criminal system focuses on the prosecution or the establishment of liability of individuals, and as such is more personal.

Liberty is aware of the ongoing coroners' review undertaken by the Home Office and hopes that the ideas in this report will be considered by the review team.

## Other remedies

The inquest procedure should be part of a consistent legal system, working in harmony with the civil and criminal systems. However, unlawful killing verdicts at inquests have led to very few prosecutions and no convictions of police officers. Existing remedies available in civil litigation or as a result of internal disciplinary procedures are neither appropriate nor sufficient for these very serious cases. Public inquiries are rare and so do not constitute a standard or regular statutory system of redress.

Criminal prosecution is the most appropriate “other” remedy for deaths caused by agents of the state. It holds those individually responsible directly liable. Currently the Crown Prosecution Service (CPS) is responsible for prosecuting these cases.

Theoretically decisions not to prosecute can be judicially reviewed on the basis that they were made in breach of the law (including of course the European Convention on Human Rights) or are so perverse that no reasonable prosecutor could have made them. Nevertheless, in practice this rarely results in a successful challenge: and even where a judicial review is successful and the original decision not to prosecute is quashed, it rarely results in a different decision subsequently by the CPS.

The report considers three options for improving the criminal prosecution system after deaths in custody.

Creating a completely separate body responsible for these prosecutions could increase public confidence in the independence of the process, but there are significant difficulties setting up such a body solely to prosecute police officers.

Transferring responsibility for charging to another existing body (with the CPS then pursuing the case) offers largely symbolic value if the decision is transferred to the IPCC; and if the decision is passed to the coroner’s court (so the verdict could act as the committal stage for any subsequent criminal trial) risks an uncomfortable mix of powers for the coroner. The (coroner’s) investigation and criminal prosecution should remain separate and independent.

The favoured option is to leave the system as it is but to improve the performance of the Crown Prosecution

Service. This option offers continuity – and the use of experience and expertise acquired so far – and consistency – suspects would be treated just as for other alleged crimes. It could involve the creation of a special unit, perhaps directly responsible to the Director of Public Prosecutions and separate from the rest of the CPS; or based in the office of the Attorney General and responsible to him.

Whatever system is adopted, enhanced scrutiny of the decision-making process needs to be introduced. There must be a clear statutory requirement to give extensive reasons for non-prosecution in such cases. Families must be kept informed throughout the decision-making process and during the prosecution itself. In this respect Liberty welcomes the Attorney General’s review of the CPS system for prosecutions following deaths in custody.

It has been suggested that there should be the possibility for appeal if the CPS decides not to prosecute – allowing an examination of the merits of the decision not to prosecute, and not just of the legality of the decision (as under judicial review). However in practice, every single decision not to prosecute would probably be appealed – thus shifting the decision on whether to prosecute in all controversial cases to the appeal body. There are also issues about who would sit on such an appeal body, and who would prosecute cases where the appeal body overturned a CPS decision not to proceed.

Several other detailed options for change are considered in the report. These include the following:

An amendment to the Code for Crown Prosecutors could either create a presumption that there should be a prosecution or could make it virtually automatic after an unlawful killing verdict. Cases would however still have to be screened as they progressed to avoid them failing at a later stage – no-one benefits from flawed cases proceeding only to collapse at trial.

All deaths in custody should be investigated at the very start as homicides. The securing of evidence is the basis both for the inquest proceedings and for any criminal prosecution. Any flaws during the investigation will jeopardise the later process. Liberty believes this may help ensure better investigations pending the time when the IPCC takes over the role from the police.

The possibility of widening the range of criminal sanctions to cover more categories of incidents and



different degrees of blame in death in custody cases was considered but rejected. While the current limited options in the criminal law may contribute to the difficulties in securing convictions following deaths in custody, that does not necessarily justify watering-down the law itself. The law should be the same for all: the police should not be subject to a different form of criminal liability to other members of the public. The creation of a different offence would constitute such differential treatment.

Improvements need to be made in the use of pathologists. One way to do this would be to set up a legal framework to structure their procedures in these cases. The work of pathologists itself also needs to be more effectively monitored. The coroner and the pathologist should proceed with their duties quickly in order to enable the release of the body to the bereaved as soon as possible after the death.

### **Overall conclusion and recommendations**

The system for investigating deaths in custody needs fundamental reform. In particular:

- The dominant link with the police in investigations must be broken
- Every death in custody must be investigated as a possible homicide
- All custody deaths must be investigated independently. The IPCC must be in charge of the investigation into police custody incidents; a reformed and more independently-organised prison ombudsman system should be in charge of the investigation into prison deaths; and an equally independent system must be created for deaths in psychiatric hospitals
- An over-arching standing commission should be created to learn lessons from deaths in any institution in which a person has been detained; to monitor progress on preventing deaths and recommendations from inquests; and to spread good practice
- Liberty re-emphasises that, in the long term, the majority of investigating personnel in the IPCC must not be police-related: the ratio of non-police to police must be at least 3:1.

Further:

- Coroners should have a more judicial role,

adjudicating over an adversarial process – but they should retain some inquisitorial powers (e.g. to call witnesses)

- There must be a right to legal representation: means testing for legal aid in inquests concerning deaths in custody should be abolished
- Relatives of the deceased should have the rights of a formal party to civil litigation
- The inquest must be more accessible, language must be simplified, and a designated person must be assigned responsibility for the welfare of the family and for explaining the process
- The inquest jury must be retained for all inquests into controversial deaths
- The jury must have more powers
- Recommendations must be a regular component of the inquest verdict. These must be published, their implementation must be monitored, and a publicly accessible database must be created
- Pre-inquest disclosure must be compulsory
- The process must be speedier
- The role of the Attorney General in giving fiats as a preliminary to overturning inquest decisions should be abolished
- CPS performance must be improved – possibly through creating a separate, specialist deaths in custody unit reporting directly to either the Director of Public Prosecutions or the Attorney General
- Coroners could be integrated into the civil justice system. A new right of appeal to the High Court on points of law should be established
- The privilege against self-incrimination should be abolished – but evidence thus given should not be admissible in any subsequent criminal trial
- Clearer procedures and monitoring are needed for the work of forensic pathologists
- A Chief Coroner or President of Coroners could help implement monitoring, raise standards, ensure regular training, publish guidance on good practice and deal with complaints.
- There should be a presumption in the Code for Crown Prosecutors that a prosecution will follow a verdict of unlawful killing, subject to the evidence test.

## I. INTRODUCTION

According to INQUEST,<sup>1</sup> 627 people have died in police custody since 1990. In the year from April 2001 – March 2002, 35 people died in police custody (in the year 1998–99, that number was 65). These figures are based on a particularly broad definition of ‘in custody’ (see box), which encompasses almost all situations where people die and some form of policing action was involved. This statutory definition perhaps goes beyond most people’s understanding of the term.

But whatever the definition adopted, one fact remains beyond dispute: the numbers and the circumstances in which people continue to die in contact with the police must be a cause for the most serious concern. This research examines the system for investigating all controversial deaths that involve the police. It is clearly essential that such a study take the broadest possible view, of how all such deaths ‘in police custody’ are investigated and what improvements can be made. That is what we endeavour to do here.

Many of the issues raised, conclusions found, and recommendations made in this report are also relevant to deaths in prison custody and under detention in mental health institutions. However, the main focus of this report is on deaths in police custody – because such incidents illustrate the problems involved very clearly.

Statistics published by the Home Office, the Police Complaints Authority and INQUEST all differ on numbers of deaths in police custody – because all adopt a different definition. The PACE definition of deaths in custody used by INQUEST and by this report is extremely broad – so much so that most of the deaths in these statistics do not occur in ‘custody’ in the narrow sense of the word.

### Definition of deaths in police custody

Deaths in police custody include situations where the deceased was in police detention as defined by section 118(2) of the Police and Criminal Evidence Act 1984, i.e.

where the deceased was arrested or detained in charge of a constable, and where the deceased was otherwise in the hands of the police.

### This, *inter alia*, covers deaths:

- when suspects are being interviewed by the police but have not been detained
- when persons are actively attempting to evade arrest
- when persons are stopped and searched or questioned by police
- when persons are in police vehicles (other than whilst in detention)
- when there is a siege situation or ambush
- when persons are in care of police having been detained under the Mental Health Act
- when children or young persons are in police protection under the Children’s Act 1989.

### The Home Office is proposing to define four categories of deaths:

- Fatal road traffic accidents involving police officers
- Fatal shooting incidents involving police officers
- Deaths in police custody
- Deaths following other types of contact with the police.

This research looks at the system for investigating all controversial deaths involving police contact that require investigation. This includes all the above categories.

The issue of contentious deaths in custody, their investigation and the treatment of bereaved people, must remain firmly on the political agenda. Since the early 1990s, INQUEST has found that people from minority ethnic groups are disproportionately represented amongst those whose deaths have involved the use of force or serious medical neglect.<sup>2</sup> This is now acknowledged by the Police Complaints Authority.<sup>3</sup> It was not until April 1996 that the police service monitored the ethnic origin of those who die in custody. The disproportionate number of black

<sup>1</sup> INQUEST is the only non-governmental organisation in Britain that works directly with the families and friends of those who die in circumstances requiring an inquest, providing an independent free legal advice service on inquest procedures, the rights of bereaved people in the Coroner’s Court and the investigation of contentious deaths. In the ten years from January 1992 to December 2001, INQUEST worked with the families of over 2,100 people who died in circumstances requiring an inquest. Its cases break down as follows: deaths in police custody (15%), deaths in prison custody (32%), deaths involving psychiatric custody and/or care (9%), deaths involving clinical negligence (12%), and miscellaneous deaths (at work, road traffic accidents, CO gas, murder, etc., 32%).

<sup>2</sup> See appendix.

<sup>3</sup> Annual Report 1997:20

people, in particular, dying in these circumstances has caused considerable disquiet in the black community and led to several campaigns for justice.

Public confidence in the police has been undermined by years of controversy. The deaths in Brixton of Wayne Douglas (after being restrained by police officers in 1995) and Derek Bennett (shot by police in 2001) were followed by angry street disturbances. The deaths in police custody of Joy Gardner, Brian Douglas, Wayne Douglas, Shiji Lapite, Richard O'Brien, Ibrahim Sey, Roger Sylvester, Glen Howard, Harry Stanley and Christopher Alder have seen high-profile campaigns by family and friends to bring the circumstances of the deaths into the public domain.

The failure to prosecute police officers following unlawful killing verdicts has been and remains one of the most contentious issues in relation to the approach by the State to deaths in custody.<sup>4</sup>

In 1988, the United Friends and Families Campaign was set up by families of black people who had died in custody, to make the voices of families and friends heard over the failure to bring police to account for custody deaths. The 2001 film 'Injustice' followed families' struggles for justice for their relatives who have died in police custody. Despite threats of legal action claiming defamation by a number of police officers supported by the Police Federation, it was widely shown.

Reports and lobbying by Liberty and INQUEST were instrumental in leading to the conclusion by the United Nations Committees on the Elimination of Racial Discrimination (CERD) and Against Torture (CAT) that there are serious problems relating to deaths in custody and

the lack of a fully independent investigatory process.<sup>5</sup>

The inquiry into the death of Stephen Lawrence also acknowledged this issue:<sup>6</sup>

*45.21... "Deaths in Custody". We are clear that this issue is outside our terms of reference. But we cannot fail to record the depth of the feelings expressed. There is a need to address the perceptions and concerns of the minority ethnic communities in this regard. Such an issue if not addressed helps only to damage the relationship between police and public, and in its wake there is an atmosphere which hinders the investigation of racist incidents and crime.*

The limited ambit of investigations, ineffective inquiries, and the failure to prosecute those responsible have all been issues for the bereaved families of those who have died, especially in the context of deaths in custody.<sup>7</sup> They have also increasingly become an issue in law, with the arrival of the Human Rights Act 1998 and the run of cases that the government has lost, in both the European Court of Human Rights and the domestic courts, in relation to Articles 2 and 3 of the European Convention on Human Rights.<sup>8</sup>

Reform is long overdue. In the past there has been a failure to reform the coroner system. The Brodrick report, the product of over eight years' work,<sup>9</sup> went largely unimplemented. There has been resistance among some coroners to examining the system closer as a first step towards reform.<sup>10</sup> There have to date been no successful prosecutions of police officers following deaths in custody<sup>11</sup> – not even since the Butler inquiry<sup>12</sup> examined the decision-making process of the Director of Public Prosecutions in such cases.

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<sup>4</sup> *Deaths in police custody: the issues for London*, INQUEST forthcoming

<sup>5</sup> Coles, Shaw, *Deaths in Police Custody: the issues for London*, INQUEST report to CERD covering 1996-2000, forthcoming.

<sup>6</sup> Report of the Inquiry into the Death of Stephen Lawrence, January 1999.

<sup>7</sup> For more detail see Howard Davis, Phil Scraton, *Beyond Disaster – Identifying and Resolving Inter-Agency Conflict in the Immediate Aftermath of Disasters*; Phil Scraton, Ann Jemphrey, Sheila Coleman, *No Last Rights – The denial of justice and the promotion of myth in the aftermath of the Hillsborough Disaster*; Sir Louis Blom-Cooper, Comment, P.L. autumn 2000, 560.

<sup>8</sup> *Keenan v United Kingdom* [2001] 10 BHRC 315; *R (Wright and Bennett) v. SSHD*, [2001] EWHC Admin 520; *Jordan v United Kingdom*, 11 BHRC 1; *McKerr v United Kingdom*, [2002] 34 EHRR 20; *McCann v United Kingdom* [1995] 21 EHRR 97; *Kelly and Others v United Kingdom*, no. 30054/96, 4 May 2001; *Shanaghan v United Kingdom*, no. 37715/97, 4 May 2001; and most recently *McShane v United Kingdom*, [2002] 35 EHRR 23. The recent series of Article 2 cases which the government has lost in Strasbourg originated in Northern Ireland where the problems in relation to the inquest system have perhaps been at their most acute. While the system is largely comparable to that in England and Wales, there are some aspects which are crucially different, most particularly that in Northern Ireland juries are not empowered to reach verdicts. Instead they can merely record findings which are strictly limited to the name of the deceased, where s/he died, and how s/he died, i.e. by what means. The system is so flawed that many of the approximately 360 killings by the state in Northern Ireland have received scant public scrutiny. It is this lack of official accountability which led to the judgments in *Jordan*, *Kelly*, *Shanaghan*, and *McKerr*, and also most recently in *McShane*.

<sup>9</sup> *Report of the Committee on Death Certification and Coroners*, 22 September 1971, Cmnd. 4810, chaired by Norman Brodrick QC.

<sup>10</sup> For more detail, see the inquiries into the Ashworth Hospital or the Marchioness Inquiry.

<sup>11</sup> Successful prosecution is used here to mean a prosecution leading to a conviction.

<sup>12</sup> Gerald Butler QC, *Inquiry into Crown Prosecution Service Decision-Making in Relation to Deaths in Custody and Related Matters*, August 1999.

The lack of a genuinely independent mechanism to investigate deaths in custody has meant the police effectively investigating themselves (under the eye of the Police Complaints Authority).<sup>13</sup> Not surprisingly, this has created an issue of confidence for many people. The new Independent Police Complaints Commission will, from 2004, go some way to tackling this problem. But the formation of the IPCC is not a panacea to cure all the many failings of the inquest system with regard to deaths in custody.

This report examines those shortcomings – in the investigation, the inquest procedure, and at the prosecution stage. The following historical background and discussion of the requirements of Article 2 of the European Convention on Human Rights set the scene for determining the extent of obligations on the Government to put in place an effective and efficient form of inquiry.

## 2. Background

The coroner was established by law in 1194,<sup>14</sup> to look after cases in which the Crown was interested. Coroners also sat as judges to hear criminal cases from time to time:<sup>15</sup> this function was eliminated by the 16th century, but the inquest jury continued to apportion blame for murder, manslaughter or infanticide.<sup>16</sup>

The inquisitorial function of the coroner progressively became dominant and the judicial role obsolete. The Brodrick Committee<sup>17</sup> extensively examined the role of the coroner in modern society and in 1971 made numerous recommendations. Since then the inquest has

remained a fact-finding exercise and (generally) not a method of apportioning guilt.<sup>18</sup>

The controversy surrounding some high-profile inquests has led to calls for the introduction of statutory public inquiries. In the Marchioness riverboat disaster, for example, the original coroner was criticised by the Court of Appeal in relation to his decision not to resume the inquest (a full inquest was eventually held five years after the accident, following other legal proceedings and under a different coroner).<sup>19</sup> Growing dissatisfaction with the current system, and the number of cases that the British Government has recently lost in the European Court of Human Rights in Strasbourg (and in the domestic courts) in relation to Article 2 and 3, make a reform pressing.

Developments in the European Court of Human Rights and the introduction of the Human Rights Act as well as recommendations from a number of high-profile inquiries such as those into the death of Stephen Lawrence and the Marchioness riverboat disaster have also pushed forward the impetus for change.

These pressures may have helped lead to the current series of reviews with an eye to reforming the system. Dame Janet Smith is investigating the role and function of investigations as part of the Shipman Inquiry.<sup>20</sup> This inquiry was established by Parliament in January 2001, to consider and examine issues surrounding the deaths of the patients of Dr Harold Shipman and to make recommendations to avoid such incidents in future. Shipman managed to avoid referrals to the coroner, and thus investigations, in all but a few of the cases in which his patients died.<sup>21</sup> Phase 1 of the inquiry examined the individual deaths and reported on 19

<sup>13</sup> For more detail, see Harrison and Cunneen, *An Independent Police Complaints Commission*, Liberty Report, 2000.

<sup>14</sup> Article 20 of the Articles of Eyre.

<sup>15</sup> For more detail see Matthews, Foreman, *Jervis on Coroners*, pp.3-9.

<sup>16</sup> Section 4 of the Coroners Act 1887, as amended by the Coroners (Amendment) Act of 1926.

<sup>17</sup> Committee on Death Certification and Coroners, 22 September 1971, see note 5.

<sup>18</sup> Apportioning guilt at inquests was finally outlawed after the inquest into the death of Lord Lucan's nanny in 1975, by the Criminal Law Act 1977. See also *R. v South London Coroner, ex p. Thompson* (1982) 126 S.F. 625, D.C.

<sup>19</sup> The coroner Knapman supported the view that the preceding government inquiry had established all the facts and that not much purpose would be served by continuing with the inquest. The Court of Appeal ruled that this decision had been influenced by prejudice, and that the inquest should be resumed with another coroner; for more detail, see M. Ryan, *op. cit.* at p. 116.

<sup>20</sup> The Shipman Inquiry was established under the Tribunals of Inquiry (Evidence) Act 1921. Its Terms of Reference are:

- a. After receiving the existing evidence and hearing such further evidence as necessary, to consider the extent of Harold Shipman's unlawful activities.
- b. To enquire into the actions of the statutory bodies, authorities, other organisations and responsible individuals concerned in the procedures and investigations which followed the deaths of those of Harold Shipman's patients who died in unlawful or suspicious circumstances.
- c. By reference to the case of Harold Shipman to enquire into the performance of the functions of those statutory bodies, authorities, other organisations and individuals with responsibility for monitoring primary care provision and the use of controlled drugs; and

following those enquiries, to recommend what steps, if any, should be taken to protect patients in the future, and to report its findings to the Secretary of State for the Home Department and to the Secretary of State for Health.

The inquiry team is: Dame Janet Smith DBE (chairman), Caroline Swift QC, Christopher Melton QC, Anthony Mazzag, Michael Jones, Henry Palin, Ita Langan, Julie Denham.

<sup>21</sup> He did this by claiming to be able to diagnose and therefore certify the cause of death and persuaded the relatives that there was no need for a post-mortem. For more detail, see Dame Janet Smith, Summary of the first report, phase 1, at para. 27, 19 July 2002.

July 2002. A report is expected to be published in spring/summer 2003 on the first stages of phase 2, with a final report in 2004.

Also in 2001, the Home Office established a team to conduct a Fundamental Review of coroners' services.<sup>22</sup> The Home Office noted that the inquest system is out of date. Recent public inquiries such as Bristol, Alder Hey, Shipman and Marchioness have exposed the shortcomings of the system. Public expectations, both in terms of public service and the product of inquiries by coroners, have run well ahead of what coroners can currently deliver. The Home Office sees an overhaul to modernise the coroner system as essential, in line with plans to reform the criminal justice system.<sup>23</sup> The Coroners Review is expected to report in spring 2003.<sup>24</sup>

The Attorney General and the Director of Public Prosecutions have initiated a separate review of the role of the Crown Prosecution Service (CPS) in prosecuting cases relating to the death of an individual in prison or police custody.<sup>25</sup> However, the review has a limited remit, focusing only on key aspects of the CPS' role. It will not reopen or reconsider individual cases.<sup>26</sup> This is a matter of concern to bereaved families.<sup>27</sup>

The government has now established a new mechanism for investigating complaints against the police – the Independent Police Complaints Commission (IPCC) –

through the Police Reform Act 2002.<sup>28</sup> The IPCC will replace the existing Police Complaints Authority: from April 2004, it will investigate deaths in police custody. The context for its establishment is in the government framework document in December 2000.<sup>29</sup> The IPCC is expected to conduct independent investigation into most deaths in custody, but it is not a requirement that independent investigators are used in every death in custody case. The IPCC will also be able to make recommendations and give advice in relation to general police practices that it considers could be improved.<sup>30</sup> The main focus must now be on ensuring sufficiently independent and expert staffing of the IPCC and the creation of public confidence in its work.

### 3. Obligations under European Law<sup>31</sup>

In line with Article 2 of the European Convention on Human Rights, the Court must, in making its assessment, subject deprivations of life to the most careful scrutiny.<sup>32</sup> Article 2 prohibits the State from taking life and places on it a positive duty to protect life.<sup>33</sup> This right has been extended to include the prevention of suicides by persons in State custody.<sup>34</sup>

The Article 2 duty to protect life also requires the proper investigation of all suspicious deaths.<sup>35</sup> The investigation must be independent, prompt, contain a sufficient element of public scrutiny, and be capable of

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<sup>22</sup> The Coroners Review Team. Its terms of reference included: to consider, in respect of England, Wales, and Northern Ireland, the most effective arrangements for identifying the deceased and for ascertaining and certifying the medical cause of death for public health and public record purposes, having regard to proposals for a system of medical examiners. The team is made up of: Tom Luce, former Head of Social Care Policy at the Department of Health (chair), Elizabeth Hodder, former Deputy Chair Equal Opportunities Commission, Deirdre McAuley LLB, Citizens Advice Bureau Advisor, Sir Colin Berry, former Professor of Morbid Anatomy University of London, Anthony Heaton-Armstrong, Barrister-at-Law, Iqbal A K M Sacranie OBE, Secretary of the Muslim Council of Britain, Mike Gallagher, Secretary, Sophy Osborn, Secretariat.

<sup>23</sup> Announcement upon the appointment of Home Office Minister Beverley Hughes, on 26 July 2001.

<sup>24</sup> See also the consultation paper.

<sup>25</sup> The review process was initiated in spring 2002 and consisted of three stages: the publication of a consultation paper (April 2002), a consultative workshop which took place on 24 April 2002, and finally a seminar which took place on 21 May 2002. In the light of issues raised at the seminar, the Review's report was postponed and is now expected in spring 2003.

<sup>26</sup> Nor does it examine related issues such as prevention, training or other non-procedural questions Answering the Parliamentary Question about the review by the Attorney General, *Written Answers*, [13 December 2001], 237.

<sup>27</sup> See also UFFC submission to Attorney General Review.

<sup>28</sup> A new police complaints procedure was originally envisaged when the government issued a consultation in May 2000 called *Complaints against the Police: A consultation document*. This paper was based on a KPMG study commissioned by the Home Office – *Feasibility of an independent system for complaints against the police* – and the Liberty publication *An Independent Police Complaints Commission*. The consultation was followed by a framework document called *Complaints against the police: Framework for a new system*, which was then incorporated into part 2 of the Police Reform Act.

<sup>29</sup> For more detail, see Home Office, *Complaints against the Police – Framework for a New System*, London 2000.

<sup>30</sup> Section 10(1)(e) of the Police Reform Act.

<sup>31</sup> Article 6 (right to a fair trial) does not apply directly to the coroner's courts because the inquest procedure does not involve the determination of a person's civil rights obligations. However, it may help to determine basic standards of justice and fair procedure, and as such would require more attention (especially its elements of the rights to a fair hearing, public hearings, trial within a reasonable time, access to justice, and disclosure). However, the limited ambit of this paper does not allow for a detailed discussion of this.

<sup>32</sup> *McCann v United Kingdom* [1995] 21 EHRR 97 at para 150.

<sup>33</sup> *X v United Kingdom* [1978] No. 7154/75, 7 Dec 1978 DR14 p31.

<sup>34</sup> For more detail, see *Keenan v United Kingdom* [2001] 33 EHRR 38, subsequently applied in *R (Amin and Middleton) v Secretary of State for the Home Department* [2002] 3 WLR 505.

<sup>35</sup> The Commission in *McCann v United Kingdom* described this procedural aspect as the minimum requirement of a mechanism whereby the circumstances of a deprivation of life by the agents of a state may receive public and independent scrutiny.



leading to a determination of whether State agents are liable.<sup>36</sup> Convention issues that have arisen include the absence of a duty on the authorities to disclose material, the lack of independence in police investigations, delays to the inquest and the criminal investigation, the lack of public scrutiny, and procedural hurdles in the system.

#### 4. Focus of this report

We examine the current system, specifically the investigation, the inquest, and the criminal prosecution, and make recommendations for improvement. It is our intention to use the data collected and the analysis undertaken, to inform the current debate on deaths in custody. We have also drawn international comparisons and established international links with Canada and Australia, with an aim to share experiences and learn from each other.

As outlined earlier in this chapter, it was not an easy task to define ‘death in custody’ in the context of the issues we examine. The term has recently been re-defined by the Home Office; however, we have not employed the same definition.<sup>37</sup> In the context of this report – the investigation process into deaths in which the police were involved – we believe it essential to adopt a broad definition. We therefore take deaths in custody to involve all those where the deceased was arrested or detained in the charge of a constable, or where the deceased was otherwise in the hands of the police. This must include fatal shooting incidents involving the police and deaths following any type of contact with the police.<sup>38</sup> During this research, we took the advice of our Advisory Committee and extended our remit so that we could consider deaths in prison custody and to a more limited extent deaths in mental health institutions.<sup>39</sup>

However the main focus of this report remains on deaths in police custody – because such incidents illustrate the problems involved very clearly. We felt that more depth could be attained if one form of custody was analysed in detail. We hope that the issues raised, conclusions found, and recommendations made will be relevant in addressing deaths in prison custody and under detention in mental

health institutions. Clearly, this is only possible where the situations are similar enough to justify such analogy. Where there are differences, we point them out.

We have not examined cases where the action (or inaction) of state agents has not resulted in a death. This was simply due to time and space constraints. We believe this area should be examined: the issues are pressing as they highlight other violations of rights of detainees, ones that may otherwise lead to fatalities in future.

We have concentrated on institutional and procedural issues, not on the issues facing individual police officers, prison officers or doctors. We intend to highlight shortcomings in the system and not individual liability (and we do not comment in detail on individual cases). We have not made substantive recommendations on how to prevent deaths in custody. More research on how to prevent further deaths is undoubtedly needed; but the remit of this research is restricted to procedural considerations after a death has occurred.

#### 5. Methodology

This report is based on a detailed examination of the process following a death in police custody. The source of information was primarily secondary literature, and cases in recent years. Additional information was gathered through attending inquests and judicial reviews; and conducting interviews with key players in the field. This research involved interviews in the UK, Canada and Australia. The court attendances and interviews contributed to the project not as a means of empirical research but rather as an additional resource to provide up-to-date background information and inform a deeper analysis. INQUEST gave the researcher access to its considerable information and resources. She also met with the staff team who have extensive experience of working with bereaved people, monitoring the investigation and inquest process following such deaths and an understanding of the legal and political history of deaths in custody.

An independent Advisory Committee has overseen the

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<sup>36</sup> For more detail, see *Jordan v United Kingdom* 11 BHRC 1 and *Edwards v United Kingdom*, [2002] 35 EHRR 19. However, in *R (Amin v Middleton) v the Secretary of State for the Home Department* [2002] 3 WLR 505, the Court of Appeal seemed to move away from these criteria and argued that it must be up to the domestic courts to decide what the criteria must be on a case-by-case basis.

<sup>37</sup> See appendix 5.

<sup>38</sup> See section 118(2) of the Police and Criminal Evidence Act 1984.

<sup>39</sup> We are aware that custody should also include detention by immigration services, however this would be more appropriately addressed by a separate, in-depth study.

project.<sup>40</sup> Its role was invaluable, both in informing and guiding the direction for the project, and in providing a forum in which issues could be raised and potential solutions discussed. The committee met regularly to discuss papers prepared by the senior researcher, which outlined the concerns, problems and possible solutions.

## **6. Structure**

The structure of the report was led by the issues that we feel need to be tackled. Thus, the first of the following sections outlines the international obligation derived from the European Convention on Human Rights following a death in custody. This section was written by Danny Friedman, an expert in this area and a barrister at Matrix Chambers.

Thereafter, we have sections focusing on the police investigation, the inquest procedure, and the Crown Prosecution Service. In each of these sections we outline what the current procedures are, what the problems are with these procedures, and what options we see for improvement.

In the final section, we make recommendations for the overall improvement of the system. We have taken these recommendations from the options set out earlier and set up a coherent map for an improved procedure following a death in custody. This map is targeted principally at police custody deaths. However, the reforms suggested should also be considered for deaths in prison and in mental health institutions.

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<sup>40</sup> For the members of this Advisory Committee, please see the Acknowledgements at the beginning of this report.

## 2. DEATHS IN CUSTODY AND THE EUROPEAN CONVENTION ON HUMAN RIGHTS<sup>1</sup>

### 1. Context<sup>2</sup>

According to the South African Constitutional Court, “Those who are entitled to claim [protection under the right to life must most notably] include the social outcasts and the marginalised people of our society”.<sup>3</sup> In this respect the quality of any human rights culture can be especially judged by the manner in which it treats deaths in custody. One of the key premises of the Liberty project is that the fundamental rights of those who die in custodial situations and of their families are not properly respected by the inquest system. Moreover, the current system enables institutions of the state to be insufficiently scrutinised when people die as a consequence of acts and omissions by its agents. In such circumstances, the provision of an inadequate inquiry damages the bereaved and undermines the quality and legitimacy of the public authorities whose conduct has gone without scrutiny. This adversely affects us all.

Within our jurisprudence, the coroner’s court is a fossil-like entity.<sup>4</sup> It bears the layers of almost every era of legal history from feudal policing, to 19th century statehood construction and 21st century human rights culture. The idea that the law must take positive steps to protect life can be found in Blackstone’s Commentaries: ‘The law not only regards life and member, and protects every man in the enjoyment of them, but also furnishes him with everything necessary for their support’.<sup>5</sup> During the 19th century, local coroners like Thomas Wakeley rose to public prominence by attacking the inhuman conditions of Victorian prisons and factories. In the last twenty years the organisation INQUEST has been central to developing an indigenous human rights consciousness in relation to deaths in custody. There are thus a number of pre-Human Rights Act domestic cases that have laid particular emphasis upon the need for full and fearless inquiries, especially in relation to custodial deaths.<sup>6</sup>

The requirements of the European Convention on

Human Rights (ECHR) are, however, far more exacting than under domestic law and at time of writing have already been the source of fundamental review of inquest law in this country.<sup>7</sup> In this introductory chapter, we focus on three aspects of Article 2 in particular:

- the state’s positive obligation to prevent a real and immediate risk to life
- the free-standing obligation of the State to carry out an effective investigation
- the obligation of the State to make public findings about the cause and responsibility for a death, where it involves the direct or indirect conduct of State agents.

### 2. Core Principles

The text of Article 2 of the Convention reads as follows:

1. Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than is absolutely necessary:
  - a. in defence of any person from unlawful violence;
  - b. in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
  - c. in action lawfully taken for the purpose of quelling a riot or insurrection.

#### 2.1 Application of Article 2: General Principles

The right to life is often said to be the most fundamental of all human rights, the basic pre-condition of

<sup>1</sup> We are indebted to Danny Friedman, Barrister, Matrix Chambers, for providing this introductory chapter.

<sup>2</sup> This report examines issues arising in relation to Article 2. The scope does not allow a focus on Article 14 in relation to which further issues arise.

<sup>3</sup> *State v Makwanyane* [1995] 1 LRC 269, 313.

<sup>4</sup> L. Thomas, D. Friedman and L. Christian, *Inquest: A Practitioner’s Guide* (Legal Action, 2002), chapter 2.

<sup>5</sup> *Blackstone’s Commentaries on the Laws of England*, 4th ed, 1876, vol 1, p101

<sup>6</sup> In *re Rapiet* [1988] QB 26; *R v Southwark Coroner ex p Hicks* [1987] 1 WLR 1624; *R v Coroner for North Humberside and Souththorpe ex p Jamieson* [1995] QB 1, 18-18 and 26; *R v HM Coroner for Wiltshire ex p Clegg* [1997] 161 JP 521 at 531; *R v HM Coroner for Western District of East Sussex ex p Homber* [1994] 158 JP 357, 379H; *R v HM Coroner ex p Lisa Douglas-Williams* [1999] 1 All ER 344 at 347-348; *R v DPP ex p Manning and Melbourne* [2001] QB 330, paragraph 33 and *R (Wright and Bennett) v SSHD* [2002] HRLR 1, paragraph 63

<sup>7</sup> See in particular *R (Wright and Bennett) v SSHD* [2002] HRLR 1; *R (Amin and Middleton) v SSHD* [2002] 3 WLR 505



the enjoyment of other rights.<sup>8</sup> Variants of the ECHR right to life are given equivalent prominent protection in other human rights instruments.<sup>9</sup> It is perhaps obvious that any constitutional bill of rights dedicated to the protection of individual human beings should have the right to life and the prohibition on torture and inhuman and degrading treatment as its most fundamental provisions. The ECHR deals with these rights in Articles 2 and 3 respectively. These articles are said to encompass the basic values of democratic societies.<sup>10</sup> In any consideration of cases involving either loss of life and/or torture and inhuman and degrading treatment in custody three overriding considerations must be borne in mind:

- The relevant provisions of Articles 2 and 3 should be applied so as to make their safeguards practical and effective<sup>11</sup>
- Articles 2 and 3 admit no peacetime derogation under Article 15, therefore the level of a discretion afforded to a decision-maker is far less than in other Articles in the Convention<sup>12</sup>
- Deprivations of life must be subject to the most careful scrutiny. Such scrutiny must focus upon not only those who were allegedly directly responsible for the death, but the State organisation or operation that provided the context in which the death took place.<sup>13</sup>

### 3. The State's positive obligation to prevent a real and immediate risk to life

The first sentence of Article 2(1) emphasises that a

person's right to life "*shall be protected by law.*" It has been held that this requirement enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take steps to safeguard the lives of those within its jurisdiction.<sup>14</sup> The use of the word 'protection' indicates a level of effective security that goes beyond the word 'respect' used elsewhere in the Convention. In addition the State is required to give appropriate training, instructions and briefing to its agents who are faced with situations where the deprivation of life may take place under their control or field of responsibility.<sup>15</sup>

The fact that a State is subject to a positive obligation to protect life has been recognised in a number of European Court cases, most notably *Osman v United Kingdom*.<sup>16</sup> In that case the Court was considering a situation in which the police had been alerted to the potential risk of violence to a father and son posed by an apparently deranged and obsessive teacher. The critical reasoning of the Court is set out in paragraph 116 of the judgment:

"In the opinion of the Court where there is an allegation that the authorities have violated their positive obligation to protect the right to life..., it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals ... and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. The Court does not accept the Government's view that the failure to perceive the risk to life in the circumstances known at the time or to take

<sup>8</sup> *R v Secretary of State for the Home Department, ex p Bugdaycay* [1987] AC 514 at 53 and, more recently, *R v Lord Saville of Newdigate & ors ex parte A and ors* [2000] 1 WLR 1855 at 1877. In *Jordan v United Kingdom* 11 BHRC 1, the European Court of Human Rights emphasised the importance of Article 2, stating that it "ranks as one of the most fundamental provisions in the Convention, to which in peacetime no derogation is permitted under Article 15. Together with Article 3, it also enshrines one of the basic values of the democratic societies making up the Council of Europe. The circumstances in which deprivation of life may be justified must therefore be strictly construed. The object and purpose of the Convention as an instrument for the protection of individual human beings also requires that Article 2 be interpreted and applied so as to make its safeguards practical and effective." See also *State v Makwanyane* [1995] 1 LRC 269 at 313 in which the South African Constitutional Court recognised the right to life in the following statement of principle: "The rights to life and dignity are the most important of all human rights, and the source of all personal rights ... By committing ourselves to a society founded on the recognition of human rights we are required to value these two rights above all others. And this must be demonstrated by the state in everything that it does ..."

<sup>9</sup> For example a decision under Article 21 of the Indian Constitution has particularly emphasised that '[c]ustodial death is perhaps one of the worst crimes in a civilised society governed by the rule of law' – see *Basu v State of West Bengal* [1997] 2 LRC 1 at 12.

<sup>10</sup> *McCann v United Kingdom* (1996) 21 EHRR 97, 161-162, paragraphs 146-150; *Andronicou and Constantiou v Cyprus* (1997) 25 EHRR 491, paragraph 171. For similar considerations in relation to Article 3 see *Chahal v United Kingdom* (1997) 23 EHRR 413 and *Assenov v Bulgaria* (1998) 28 EHRR 652, paragraph 93.

<sup>11</sup> *McCann*, paras 146-147; *Osman v United Kingdom* [1999] 29 EHRR 245, paragraph 116

<sup>12</sup> *Bugdaycay v Secretary of State for the Home Department* [1987] AC 514; *R v Lord Saville of Newdigate ex parte A* [2000] 1 WLR 1855.

<sup>13</sup> *McCann v United Kingdom*, paragraphs 181 and 201; *Tomasi v France* (1992) 15 EHRR 1; *Ribitsch v Austria* (1995) 21 EHRR 573, *Andronicou and Constantiou v Cyprus* (1997) 25 EHRR 491, paragraph 186; *Edwards v United Kingdom*, [2002] 35 EHRR 19, para 61

<sup>14</sup> *Osman v United Kingdom*, paragraph 115; *LCB v United Kingdom* (1998) 27 EHRR 212, paragraph 36. See also *X v UK* 14 DR 31 (vaccine damages). In *R (Amin and Middleton) v Secretary of State for the Home Department* [2002] 3 WLR 505, the Court of Appeal summarised the requirements of Article 2 in the following way: "Article 2 imposes two distinct but complementary obligations on the State. Putting the matter very shortly, the first is a substantive obligation not intentionally to take life and also to take reasonable preventative measures to protect an individual whose life is at risk whether from the criminal acts of others or suicide. The second is an adjectival, procedural obligation to investigate deaths where arguably there has been a breach of the substantive obligation."

<sup>15</sup> *McCann v United Kingdom*, paragraph 201; *Andronicou and Constantiou v Cyprus*, paragraph 186

<sup>16</sup> 5 BHRC 293

preventive measures to avoid that risk must be tantamount to gross negligence or wilful disregard of the duty to protect life. Such a rigid standard must be considered to be incompatible with the requirements of Article 1 of the Convention and the obligations of Contracting States under that Article to secure the practical and effective protection of the rights and freedoms laid down therein, including Article 2. For the Court, and having regard to the nature of the right protected by Article 2, a right fundamental in the scheme of the Convention, it is sufficient for an applicant to show that the authorities did not do all that could be reasonably expected of them to avoid a real and immediate risk to life of which they have or ought to have knowledge. This is a question which can only be answered in the light of all the circumstances of any particular case”.

The obligation to take positive steps to protect life is not limited to the taking of steps to prevent unlawful violence (whether by agents of the state or by private individuals against one another). The right has also been identified as extending to the taking of positive steps to prevent environmental disasters<sup>17</sup> as well as suicides by persons in State custody.<sup>18</sup> Thus, in *Keenan v United Kingdom*<sup>19</sup>, the Court acknowledged that the obligation under Article 2 extended to a duty to prevent self-inflicted deaths in custody when the authorities were on notice of a ‘real and immediate risk’ to life.<sup>20</sup> A lack of proper medical treatment in a case where a prisoner is suffering from an illness could in certain circumstances amount to a violation of Articles 2 and 3.<sup>21</sup> Finally, the failures of the authorities to communicate relevant and reasonably obtainable information will give rise to a violation of Article 2 if the subsequent information deficit leads to a person not being adequately cared for when they could have been.<sup>22</sup>

#### 4. A free-standing right to an effective investigation

The obligation to take positive steps to protect life also requires some form of effective investigation where death has occurred in circumstances which engage either Articles 2 or 3 of the Convention.<sup>23</sup> The principle that a procedural right to an investigation into a death could be taken as a free-standing right under Article 2 was first identified in the case of *McCann v United Kingdom*. Thereafter a number of cases involving the lack of effective investigations into deaths in custody and missing persons in Turkey resulted in the Court applying greater emphasis to the principle.<sup>24</sup>

In relation to deaths that result from State-sponsored violence there is a far-reaching requirement to consider the propriety of the activity.<sup>25</sup> Thus in *McCann* and *Andronicou* the inquiry deemed necessary by the Court went significantly beyond an investigation of the means by which the victims came by their deaths and extended to the operational contexts in which the deaths took place. In *McCann* the inquest itself was held to be a sufficiently effective inquiry; not surprisingly so given that there was major international interest in the inquest and its subsequent aftermath and what resulted was clearly not an average coroner’s inquest. The question of whether the inquest system in the UK amounted to an effective remedy in and of itself was left unconsidered. However, the Court emphasised in *McCann* that the protection conferred by Article 2(1)

“...would be ineffective, in practice, if there existed no procedure for reviewing the lawfulness of the use of force by State authorities. The obligation to protect the right to life under this provision read in conjunction with the

<sup>17</sup> *LCB v United Kingdom* (1998) 27 EHR 122

<sup>18</sup> *Keenan v United Kingdom* [2001] 33 EHR 38 (subsequently applied in *R (Middleton) v HM Coroner for Liverpool and SSHD*, [2001] EWHC 1043, paragraph 49

<sup>19</sup> 33 EHR 38.

<sup>20</sup> In *R (DF) v Chief Constable of Norfolk Police* [2002] EWHC 1738 (Admin) Crane J. considered the application of the *Osman/Keenan* threshold test of a real and immediate risk to life in the context of a refusal by the Prison Service to admit a life sentence prisoner to a Protected Witness Unit. He commented “it does not make it easy for those who have to take decisions, or for courts reviewing those decisions, if the search for a phrase encapsulating the threshold of risk is a chimera” (para 33). He pointed to the difference between the situation in a prison as compared with the difficulties facing the police in terms of protecting an individual at large in the community in that the prison authorities will generally be aware that a prisoner who has helped the authorities is at risk, they are in a ready position to take steps to avoid any risk and they are less likely to be inhibited by restraints imposed on the scope of their actions by the need to respect the human rights of others since providing a protective regime is unlikely to affect the rights of others. On the issue of the “immediacy” of the risk, he held that it should not be understood, in the context of admission to a protective regime, to mean that the threat will necessarily materialise in the very near future, rather “the question to be asked is whether there is a real risk to the life of a prisoner if he is not admitted to a PWU, rather than some alternative regime, for whatever period is being considered. However immediacy requires that the risk must be present and continuing” (para 38).

<sup>21</sup> *McFeeley v UK* (1981) 3 EHR 161; *Keenan* (op cit) at paragraph 110 and *R (Wright and Bennett) v SSHD*, [2002] HRLR 1, paragraph 54-57;

<sup>22</sup> *Edwards v UK*, 14th March 2002, para 61. In relation to the same principle in domestic law see *R v HM Coroner for Swansea and Gower ex p Chief Constable of Wales* [2000] 164 JP 191; *R v HM Coroner for Coventry ex p O’Reilly* [1996] 160 JP 749

<sup>23</sup> *McCann v United Kingdom*, paragraph 161

<sup>24</sup> *Kaya v Turkey* [1998] 28 EHR 1, paragraph 86

<sup>25</sup> The mere knowledge of the killing on the part of the authorities can give rise to an obligation under Article 2 to carry out an effective investigation into circumstances surrounding the death: *Ergi v Turkey* [2001] 32 EHR 18.

State's general duty under Article 1 of the Convention to 'secure to everyone within their jurisdiction the rights and freedoms defined in [the] Convention' requires by implication that there should be some form of effective official investigation when individuals have been killed as a result of the use of force by, inter alia, agents of the State."

It has become clear beyond peradventure that the right to an effective investigation into an arguable violation of the right to life is a substantive entitlement under the ECHR. In other words, the lack of an effective investigation will in and of itself constitute a violation of Article 2. Moreover, the entitlement is not limited to death that occurs as a result of the use of force by agents of the state. Similar procedural expectations have now been applied to self-inflicted deaths in prison<sup>26</sup> and to circumstances that led to an inmate being placed in a cell with a dangerous person.<sup>27</sup>

The Strasbourg and post-HRA case law make clear that it is necessary to maintain a distinction between the free-standing Article 2 right to an effective investigation and the Article 13 right to an effective domestic law remedy, which is capable of determining the liability of the State for a particular death and, if appropriate, awarding compensation or just satisfaction. In *Keenan v United Kingdom* it was accepted by all parties that the inquest into Mark Keenan's death could not in law determine issues of civil or criminal liability and thus did not furnish the applicant with the possibility of establishing the responsibility of the prison authorities or obtaining damages.<sup>28</sup> Moreover, as Mark

Keenan had died before the coming into force of the HRA, his mother could not pursue a claim under sections 7(1)(a) and 8 of the 1998 Act in respect of his ill-treatment and death in prison. And as he was over 18 when he died, nor was it practical for her to pursue any claim either under the Law Reform (Miscellaneous Provisions) Act 1934 or the Fatal Accidents Act 1976.<sup>29</sup> In these circumstances, the Court found, in addition to the breach of Article 3, that Article 13 had also been violated, stating that it considered that "in cases of a breach of Articles 2 and 3 of the Convention, which rank as the most fundamental provisions of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be available as part of the range of possible remedies."<sup>30</sup> The fact that an individual is potentially able to pursue a civil claim in relation to a death that engages Article 2/3 will not of itself discharge the Article 2 investigative obligation. As the European Court commented in *Jordan v UK*:

"Civil proceedings would provide a judicial fact-finding forum, with the attendant safeguards and the ability to reach findings of unlawfulness, with the possibility of damages. It is however a procedure undertaken on the initiative of the applicant, not the authorities and it does not involve the identification or punishment of any alleged perpetrator. As such, it cannot be taken into account in the assessment of the State's compliance with its procedural obligations under Article 2 of the Convention."<sup>31</sup>

In both *Jordan v United Kingdom* and *Edwards v United*

<sup>26</sup> *Keenan v UK* [2001] 33 EHRR 38. For a domestic recognition of the same principle see *R (Middleton) v HM Coroner for Western Somerset and SSHD*, 14th December 2001, per Stanley Burnton J approved by the Court of Appeal in *R (Amin and Middleton) v SSHD* [2002] 3 WLR 505 (a case which specifically finds that the limitation upon negligence verdicts imposed by *R v Coroner for North Humberside and Scunthorpe ex p Jamieson* [1995] QB 1 violates the procedural obligation under Article 2 to sufficiently investigate the responsibility of the prison service in causing death).

<sup>27</sup> See *Edwards v United Kingdom*, EctHR, 14th March 2002, paras 69-73. In *R (Amin and Middleton) v SSHD* [2002] 3 WLR 2002, the Home Secretary had originally sought to argue that the procedural obligation to investigate only arose if the relevant death occurred or is alleged to have occurred as a result of the use of force by State agents. Where a death resulted from a failure by the State to fulfil its positive duty to take steps to protect the life of someone in its care against a perceived risk – or a risk that should have been perceived – of death or serious injury at the hands of another, then the availability of the ordinary civil remedies in the domestic courts was said to suffice for Article 2 purposes. In the light of *Edwards*, however, the Government accepted that this distinction was unarguable and the Court of Appeal held at para 44 that "we should without hesitation have concluded that the procedural duty was engaged [on the facts of *Amin*] without the assistance of *Edwards*. A death in State custody, at the hands of another prisoner or (as in *Middleton*) at the deceased's own hands, excites very anxious public concern. The State owes a pressing duty to minimise the risk of such a calamity, even if it cannot be altogether extinguished. The common law would impose such a duty, if it could find an appropriate litigious framework within which to make it good. Now however it is enough to say that such a duty lies within the scope of Article 2. When such a death takes place, the procedural duty to investigate is in our judgment undoubtedly engaged."

<sup>28</sup> The Court stated in para 127 that "Turning to the remedies available after Mark Keenan's death, it is common ground that the inquest, however useful a forum for establishing the facts surrounding Mark Keenan's death, did not provide a remedy for determining the liability of the authorities for any alleged mistreatment or for providing compensation." As Jackson J. correctly pointed out in his judgment in *R (Wright and Bennett) v SSHD* [2002] HRLR 1, it was unnecessary in *Keenan* for the applicant to allege a free-standing breach of the Article 2 investigative obligation before the European Court of Human Rights as the substance of the complaint of a lack of an effective remedy in domestic law was addressed under Article 13.

<sup>29</sup> See the concurring opinion of the *ad hoc* UK judge, Sir Stephen Sedley, in which he analyses the potential inadequacy of the HRA 1998 in terms of its ability to convert a coroner's inquest into an effective Article 13 remedy. Insofar as his analysis is focusing on the inability of an inquest to award compensation/just satisfaction in relation to any breach of Articles 2/3 it is plainly correct; but his analysis of the difficulty of deploying s.3 of the HRA to override the content of Rule 42 of the Coroners' Rules 1984 (which forbids the framing of a verdict in such a way as to appear to determine civil liability or a named person's criminal responsibility) must now be read in the light of *R (Middleton) v Home Secretary* [2002] 3 WLR 505 at paras 83-93.

<sup>30</sup> Para 129.

<sup>31</sup> ECHR, 4th May 2001 – [2001] 33 EHRR 38.

*Kingdom* the European Court held that in order to satisfy the requirements of Article 2, any investigation must satisfy the following criteria:

- It must be independent from those implicated in the events<sup>32</sup>
- It must be capable of leading to a determination of whether State agents are liable for the death and/or the identification of those responsible and, if appropriate, their punishment
- It must be prompt
- It must contain a sufficient element of public scrutiny and must involve the next of kin in the investigative procedure to the extent necessary to protect their legitimate interests.

The language of the Court's judgment indicates these criteria are essential requirements of *any* effective investigation where an arguable violation of Article 2 had been made out. Indeed in *Jordan* violations were found because of a failure to disclose witness statements and call various members of the security forces to give live evidence. Likewise, in *Edwards*, the Court found a violation of Article 2 because of a failure to call prison officers who were on duty on the night Christopher Edwards was killed by his cellmate and because the family were not allowed to attend the entire inquiry.

*R (Amin and Middleton) v Secretary of State for the Home Department*,<sup>33</sup> followed the Strasbourg jurisprudence; however, the Court of Appeal seems to have diluted the apparently clear Strasbourg requirements, holding that the investigative duty under Article 2 could not be defined by strict rules and that it was up to the domestic courts to decide what is sensibly required to support and vindicate Convention rights on a case-by-case basis. The *Amin* case arose from the vicious murder of a young Asian prisoner, Zahid Mubarek, in Feltham Young Offenders Institute by his notoriously violent, racist cellmate. Though the cellmate was successfully prosecuted for murder in the criminal courts, no inquest had subsequently take place in which the culpability of the Prison Service for failing to protect the deceased's right to life might be examined. The Director General of the Prison Service had promptly admitted that the Service had been at fault in a private letter to the deceased's family, and an internal Prison Service inquiry had also taken place whose report had

been disclosed to the family and its advisers – but with a requirement that the report not be disclosed to anyone else. In addition, a private investigation into race discrimination in the Prison Service being conducted by the Commission for Racial Equality was specifically focusing on Feltham YOI and the circumstances in which Mr Mubarek was murdered. Faced with a situation in which there had been no public investigation of the acts and/or omissions of Prison Service personnel in which they had been able meaningfully to participate, the family of Mr Mubarek pressed the Home Secretary to hold a public inquiry.

At first instance, the Home Secretary's refusal to accede to this request was quashed by Hooper J who held that public scrutiny and the involvement of the next of kin were separate requirements of the Article 2 investigative duty and that accordingly an independent public investigation must be held to satisfy the requirements of the Convention. But the Home Secretary's appeal was allowed with the Court of Appeal holding that public scrutiny and next of kin involvement are not separate, compulsory requirements of Article 2 and that the investigative duty had already been discharged on the facts of the case.

The judgment in *Amin* recognises that the coroner is the key public authority responsible for fulfilling the adjectival obligation of the State to carry out an effective investigation into a possible violation of the right to life. It also agrees that this obligation is not limited to fatal shootings or to deaths that necessarily involve the direct responsibility of agents of the state. It recognises the so-called *Jordan* criteria as constituting the clear position of the Strasbourg authorities and that ordinarily an inquest would comply with the requirements of this jurisprudence, including in the provision of appropriate verdicts. However, at paragraph 61, the Court emphasises that

“... the task of our courts is to develop a domestic jurisprudence of fundamental rights, drawing on the Strasbourg cases of which by s2 HRA we are enjoined to take account, but by which we are not bound. .... the nature and scope of an adjectival duty... must especially be fashioned by the judgment of the domestic courts as to what in their jurisdiction is sensibly required to support and vindicate substantive Convention rights.”

<sup>32</sup> The failure of inquiries to call 'independent' witnesses in relation to medical treatment in custody was recognised in *R (Wright and Bennett) v SSHD* [2002] HRLR 1 and *N (a child) v HM Coroner for Liverpool* [2001] EWHC Admin 922

<sup>33</sup> [2002] 3 WLR 505.



On this basis, the Court at paragraph 62 noted

“... this part of the case cannot be satisfactorily resolved by a process of reasoning which sticks like glue to the Strasbourg texts..... What is required will vary with the circumstances..... [The Court then contrasts cases of credible allegations of murder or manslaughter against the state, with alleged negligence.] The means of their fulfilment [the interlocking aims of the obligation to investigate] cannot be reduced to a catechism of rules. What is required is a flexible approach, responsive to the dictates of the facts case by case.”

It is submitted that this approach is fairly at odds with House of Lords and Court of Appeal authorities that have indicated the ill-advised path of departing from clear and recent Strasbourg authority given the likelihood that it will be overturned in Europe.<sup>34</sup> The fact that the judgment indicates that ordinarily inquests will be subject to the *Jordan* criteria mitigates some of its potentially adverse consequences (it is to be remembered that the litigation concerned the decision whether to hold some form of public investigation in the wake of criminal trial and an admission by the Prison Service that it had failed to protect Zahid Mubarek’s right to life). However, it is respectfully submitted that there is a critical flaw in the approach, because it fails to distinguish between the mandatory terms of the *Jordan* safeguards (i.e. *Jordan* paras 102 to 109) and the procedural flexibility that is afforded to member states in providing such safeguards (i.e. *Jordan* para 105 and 143).

Liberty considers that the right to an independent, impartial, prompt, effective and public hearing, in which a bereaved family is ensured preferential involvement, must be accorded in all situations where acts or omissions by state agents may have contributed to a death. The European Court has indicated on a number of occasions, that while the procedure by which the due process entitlements are delivered is a matter for the member states, the entitlements themselves are mandatory. Any attempt to deviate from the so-called *Jordan* criteria indicates a retrogressive step in this jurisdiction and is a bad example to other countries, who for various political and economic reasons will be all too keen to follow suit – especially when death occurs because of the negligence of the State as opposed to fatal shootings.

There could not be a better indication than the European Court’s decision to apply the *Jordan* criteria unequivocally to a clear-cut case of negligence in the Edwards case, of the fact that the Court considers these criteria to be absolutely germane to every State’s obligations under Article 2.

## 5. Verdicts

The minimum requirement identified in *Jordan*, that the inquiry must “establish the cause of death or [where relevant] the person or persons responsible” is of critical importance to any family attending an inquest.<sup>35</sup> Wherever possible it is important to the bereaved that the inquiry should come to a coherent and clear conclusion as to what happened. In Northern Ireland there was no facility to bring back any type of unlawful killing verdict (see *Jordan*). In England and Wales, there are unlawful killing and neglect verdicts. However, rule 42 has been interpreted as prohibiting bringing back a negligence/lack of care verdict, because the rule states that “no verdict shall be framed in such a way as to appear to determine any question of civil liability”. In *R v HM Coroner for North Humberside ex p Jamieson*<sup>36</sup> the test for ‘neglect’ was set at an extremely high level:

“Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself. Failure to provide medical attention for a dependent person whose physical condition is such as to show that he obviously needs it may amount to neglect. So it may be if it is the dependent person’s mental condition which obviously calls for medical attention (as it would, for example, if a mental nurse observed that a patient had a propensity to swallow razor blades and failed to report this propensity to a doctor, in a case where the patient had no intention to cause himself injury but did thereafter swallow razor blades with fatal results). In both cases the crucial consideration will be what the dependent person’s condition, whether physical or mental, appeared to be”.

Since *Jamieson*, certain High Court judgments have specifically questioned whether there is a meaningful

<sup>34</sup> *R v Secretary of State for the Environment ex parte Alconbury* [2001] 2 WLR 1389 per Lord Slynn at para. 26. *R (Anderson) v SSHD* [2002] 2 WLR 1143, per Simon Brown LJ at paras. 65– 66 and Buxton LJ at paras. 87– 93

<sup>35</sup> *Jordan v UK* 4th May 2001, paragraph 107. The principle was affirmed in relation to Article 3 in *Z v United Kingdom* 10 BHRC 384, paragraph 109

<sup>36</sup> [1995] QB 1

distinction between the test for neglect and the test for gross negligence manslaughter.<sup>37</sup> Indirectly other judgments have adopted a more liberal approach, including within the *Jamieson* definition of neglect matters which are more akin to negligence.

In *R (Amin and Middleton) v SSHD* [2002] 3 WLR 505 the Court of Appeal held that in a case where:

- a coroner knows that it is the inquest which is in practice the way the state is to fulfil the adjectival obligation under Article 2 of the ECHR and
- a finding of neglect by the jury at the inquest could serve to reduce the risk of repetition of the circumstances giving rise to the death being inquired into

Rule 42 of the Coroner's Rules 1984 can and should be construed as allowing such a finding, providing that no individual is named therein.

While it was thought that such an approach would normally be in keeping with the *Jamieson* approach, it was also emphasised that the dicta in that case could not frustrate the obligation of the coroner to carry out an effective inquiry, including the provision of adequate conclusions concerning the systemic faults of the State.<sup>39</sup> In reaching this conclusion, the Court drew a critical distinction between individual acts of negligence and systemic failings (para 87-89).

Again, it is submitted that this reasoning is at odds with the approach of the Strasbourg courts. A substantive breach of Article 2 will arise where there is evidence that the authorities knew or ought to have known of a real and immediate risk of death and the authorities failed to take measures within the scope of its powers, which judged reasonably, might have been expected to avoid the risk: *Osman v UK* 29 EHRR 245 (para 116); *Keenan v UK* 10 BHRC 319 (para 89). Where an inquest is investigating a death resulting from the negligent failure of State agents to protect the right to life, the rationale for allowing a more relaxed approach to the concept of neglect is essential. It seems extraordinary that an inquest would be bound to engage in an inquiry of the "utmost rigour, conducted

independently for all to see" (*Amin and Middleton* para 62), but be prevented from reaching a conclusion that in effect those who were responsible for the death had acted negligently.

A finding of lack of care/negligence or some such verdict on the facts of *Amin and Middleton* could have had the effect of bringing home to the relevant authority and to the individual armed officers the need for the Article 2 principle of absolute necessity to be observed at all times. Moreover, the orthodox *Jamieson* meaning of neglect means that a jury is incapable of applying a sufficiently sensitive and calibrated approach to the concept of the State's obligation to protect the right to life.

## 6. Conclusion

The modern history of coronial law, since statutory codification in the 19th century Coroners Acts, has principally been about trying to find a system of inquiry capable of dealing with the tensions of a complex industrial urban society. The main political tensions in the 19th century involved dangerous factories. The principal tensions in the late 20th century/early 21st century involve deaths in custody, although other key areas of concern have included major urban disasters, environmental disasters, deaths within a context of domestic violence and others.

While the current promises of the Government to reform the inquest system must be partly prompted by the run of cases that the British Government has lost in Strasbourg (and now in the domestic courts) in relation to Articles 2 and 3, there has also been a profound change of outlook in both political and judicial circles to the treatment of families in relation to controversial deaths. Beneath the short-term changes in political outlook, it is important to appreciate that the broader reasons for the jurisprudence of the European Court of Human Rights and other human rights jurisdictions concern the need to create workable safeguards for individuals in the face of increasing State power in the modern world. It is not entirely coincidence that the change of view in relation to coroners' inquests has taken place at precisely the same time that the blanket policy prohibitions on suing the

<sup>37</sup> *R (Dawson and Others) v HM Coroner for East Riding and Kingston Upon Hull* [2001] EWHC Admin 352 per Jackson J at paragraph 71 and *R (Middleton) v HM Coroner for Liverpool and SSHD*, 14th December 2001, per Stanley Burnton at paragraph 36

<sup>38</sup> *R v HM Coroner for Wiltshire ex p Clegg* 520 JP 521; *R v HM Coroner for Swansea and Gower ex p Chief Constable of Wales* (1999) 164 JP 191; *R v HM Coroner for Coventry ex p Chief Constable of Staffordshire Police* (2000) 164 JP 665, 675-676; *R (Scott) v HM Coroner for Inner West London* [2001] EWHC Admin 105, paragraphs 14-15.

<sup>39</sup> *R (Middleton and Amin) v SSHD* [2002] 3 WLR 505, paragraphs 86-93

police and social services for negligence have been overturned.<sup>40</sup>

The need to find proper procedures for protecting the rights of individuals against the vagaries of modern society was recognised by Lord Denning as long ago as 1949 in his Hamlyn Lectures, “Freedom Under the Law”:

“No one can suppose that the executive will never be guilty of the sins that are common to all of us. You may be sure that they will sometimes do things which they ought not to do: and will not do things that they ought to do. But if and when wrongs are thereby suffered by any of us, what is the remedy? Our procedure for securing our personal freedom is efficient, but our procedure for preventing the abuse of power is not. Just as the pick and the shovel is no longer suitable for the winning of coal, so also procedures of mandamus, certiorari, and actions on the case are not suitable for the winning of freedoms in the new age. They must be replaced by new and up to date machinery, by

declarations, injunctions and actions for negligence... This is not the task of Parliament. The courts must do this. Of all the great tasks that lie ahead, this is the greatest. Properly exercised the new powers of the executive lead to the Welfare State: but abused they lead to a totalitarian State. None such must ever be allowed in this country.”

Although the Human Rights Act would enable the Courts to re-write the Coroners Rules on a case-by-case basis, the creation of a measured and Convention-compatible system by the executive would be a far preferable means of adapting the 19th century coronial system to contemporary requirements. Dostoyevsky argued that the measure of civilisation in a society was the way it treated its prisoners. The Liberty Project on Deaths of Custody has found the system – with regard to police and prison custody – in the United Kingdom to fall short of the mark. The following text seeks to set out a blueprint for change in the investigation of death, the inquest and other remedies.

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<sup>40</sup> *Osman v UK* [1999] 29 EHRR 245; *Barrett v Enfield BC* [1999] 3 WLR 79; *Phelps v Hillingdon BC* [2000] 3 WLR 776; *Kent v Griffiths* (No.3) [2000] 2 WLR 1158

### 3. INVESTIGATION

#### 1. Introduction

Any investigation into a death in custody needs to be compliant with domestic law, natural justice and the obligations of Article 2 of the European Convention on Human Rights. This chapter evaluates whether the current investigation processes are able to fulfil both the needs of the relatives of the deceased, the rights of those responsible for the death and the requirements of Article 2.

This chapter evaluates the current procedure. It looks at the police investigation supervised by the Police Complaints Authority (PCA); the composition and powers of the future Independent Police Complaints Commission (IPCC); the investigation powers of the coroner; and the role of the pathologist. It outlines the existing rules, summarises what happens in practice and ends with some recommendations for change.

#### 2. Current procedure – the police

##### 2.1 The rules after a death has occurred

When a person has died in custody it is common practice for a doctor to be called and asked to confirm death. The doctor, or paramedics, will examine the body and, usually by the use of a flat line heart trace, will confirm the fact of death.

There is no statutory regulation in place prescribing what should be done after a person has died in custody. According to ACPO guidelines, after a death in custody, the Senior Police Officer<sup>1</sup> must secure the scene and contact a coroner.<sup>2</sup> This Senior Officer should then call out the Scenes of Crime Officers (SOCOs) who have the sole

responsibility to investigate and secure the scene. Each force has a Senior Scenes of Crimes Officer. The Complaints and Discipline Department should contact the PCA.<sup>3</sup>

Thereafter, the force in which the incident occurred should appoint a Senior Investigating Officer (SIO).<sup>4</sup> It is part of the duties of this officer to commence a preliminary investigation ensuring the preservation of the scene, exhibits and witness evidence, as well as the initial notes of the officers involved.<sup>5</sup> This officer will also obtain witness statements from the officers involved. Again, there is no specific statutory guideline on how to obtain such a statement in cases of custody deaths. But the ACPO guideline states:

‘...in order to avoid any additional pressure in addition to that already experienced, the officers involved in the incident should not be retained on duty solely for the purpose of a formal interview. However, where the information is clearly insufficient to allow a proper investigation of the incident, it may nevertheless be necessary to interview the officers directly concerned more urgently. Any such interview should be conducted under any relevant statutory provision and subject to medical advice’.

The relevant provisions include the Police and Criminal Evidence Act 1984 Codes of Practice, Code C.<sup>6</sup>

According to sections 71 and 72 of the Police Act 1996 a member of the Police Complaints Authority may then be contacted.<sup>7</sup> There is nothing mandatory about section 71.

<sup>1</sup> A senior member of the police; this officer is often also referred to as the scene manager.

<sup>2</sup> For more detail, see *Association of Chief Police Officers, Investigations and Remedies*, Chapter 6, at 2.14.

<sup>3</sup> Changes to the role of the PCA are taking place: this will be discussed under subsection 2.2 and will focus on the practice of the planned IPCC.

<sup>4</sup> Sometimes this officer is also referred to as the Initial Investigating Officer – IIO.

<sup>5</sup> See also: Association of Chief Police Officers, *Manual of Guidance of Police Use of Firearms*, section 6-20.

<sup>6</sup> Prepared by the Home Office, came into force on January 1, 1986; a second, revised edition came into force on April 1, 1991, the latest edition came into force on April 10, 1995; for more detail, see Zander, *The Police & Criminal Evidence Act 1984*, at pages 173 and 453-486.

<sup>7</sup> The PCA will be replaced by the IPCC in April 2004. Until then, the PCA remains the institution in charge. For more analysis of the IPCC, see section 2.4.

**Section 71.** - (1) The appropriate authority may refer to the Authority any matter to which this section applies, if it appears to the appropriate authority that the matter ought to be referred by reason-

(a) of its gravity, or  
(b) of exceptional circumstances.

(2) This section applies to any matter which-

(a) appears to the appropriate authority to indicate that a member of a police force may have committed a criminal offence or behaved in a manner which would justify disciplinary proceedings, and  
(b) is not the subject of a complaint.

Supervision of investigations by Authority.

**Section 72.** - (1) The Authority shall supervise the investigation of-

(a) any complaint alleging that the conduct of a member of a police force resulted in the death of, or serious injury to, some other person,  
(b) any other description of complaint specified for the purposes of this section in regulations made by the Secretary of State, and

(c) any complaint which is not within paragraph (a) or (b), and any matter referred to the Authority under section 71, if the Authority determine that it is desirable in the public interest that they should do so.



It is entirely within the discretion of the police service as to whether or not they refer a death in custody. However, in practice, invariably they do decide that a death in custody fits within section 71.<sup>8</sup> According to section 72(1)(a) of the Police Act 1996 the PCA may then supervise the investigation after a person has died in custody. Here too, the PCA has discretion to decide whether or not to supervise<sup>9</sup> (although under section 72(1)(a), it must supervise if a complaint is made). Nevertheless, investigations of death in custody are in practice supervised.

The PCA member, as a part of the supervision of the police investigation, has to approve the person chosen as the investigating officer. The PCA has the power to impose requirements regarding the investigating officer,<sup>10</sup> but there is no guidance on how the PCA member should assess whether or not the appointment of the investigating officer is satisfactory. The Senior Investigating Officer must then submit a final report on the investigations to the PCA.<sup>11</sup>

The Home Affairs Committee report on police complaints and discipline procedures recommends investigation by officers from a different force in such circumstances.<sup>12</sup> There is no legal obligation to appoint an independent investigating force. But in practice, again, an outside force is usually appointed. However, the lack of guidelines on when to appoint an outside force to investigate is a matter of concern and has resulted in considerable disquiet.

There are no statutory provisions or formal guidelines on who should contact the relatives of the deceased and how they are to be dealt with.

## 2.2 Practice

Due to the lack of statutory regulation prescribing what should be done after a death has occurred, procedures and guidelines differ from police force to police force. Nevertheless, according to ACPO certain elements should be a fundamental part of the investigation:

- Management of the scene
- The commencement of the investigative stage
- The immediate management of the officers involved in the incident
- Collection of exhibits
- Welfare considerations
- Media

It is general practice that the management of the scene is the responsibility of the Scenes of Crime Unit. While it is the Senior Officer who must secure the scene, he or she has no authority to undertake any investigation. Scenes of Crime staff based within each police force undertake this. They then report to the Senior Investigating Officer who should be on the scene within an hour.<sup>13</sup> This period is often referred to as the Golden Hour, given that it is the most vital time for collecting evidence.

The scene-of-crime preservation involves sealing off the scene. If this is not done carefully evidence will be destroyed at this early stage. Scenes of Crimes Investigators are specialists in crime scene investigations; they are specifically trained (as are their support staff) and are based comparatively locally. The loss of time waiting for investigating staff to arrive is thus cut to a minimum and evidence does not age unnecessarily. These are, under the

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(2) Where the Authority have made a determination under subsection (1)(c), they shall notify it to the appropriate authority.

(3) Where an investigation is to be supervised by the Authority, they may require-

(a) that no appointment is made under section 68(3) or 69(5) unless they have given notice to the appropriate authority that they approve the person whom that authority propose to appoint, or

(b) if such an appointment has already been made and the Authority are not satisfied with the person appointed, that-

(i) the appropriate authority, as soon as is reasonably practicable, select another member of a police force and notify the Authority that it proposes to appoint him, and

(ii) the appointment is not made unless the Authority give notice to the appropriate authority that they approve that person.

(4) The Secretary of State shall by regulations authorise the Authority, subject to any restrictions or conditions specified in the regulations, to impose requirements as to a particular investigation additional to any requirements imposed by virtue of subsection (3).

(5) A member of a police force shall comply with any requirement imposed on him by virtue of regulations under subsection (4).

<sup>8</sup> Many 'proximate' deaths are also referred, such as deaths following road traffic accidents.

<sup>9</sup> Some investigations of 'proximate' deaths (e.g. of a person who is not in custody) may not be supervised. This can be an issue, if the definition of 'in custody' is read too narrowly.

<sup>10</sup> No appointment shall be made unless the PCA is satisfied with an investigating officer.

<sup>11</sup> See section 73(1)(a) of the Police Act.

<sup>12</sup> See Home Affairs Committee Report on Police Complaints and Discipline Procedures, January 1998; this is mentioned expressly in the revised PCA guidelines as well as in the PCA's out-of-hours folder, under B External.

<sup>13</sup> Research interview with the police.

circumstances, valuable characteristics that must remain a priority for the effectiveness of the investigation. However, the major criticism of this process is that the same force that employs officers involved in the incident also employs these investigating officers.

There is no substantive published research to indicate that this potential problem materialises in a less robust investigation. However many of those lawyers who subsequently represent the families of the deceased have raised substantial concerns during this research and have given detailed accounts of what has gone wrong in individual cases. In addition, the existence of such a potential conflict of interest causes fatal damage to the credibility of and public confidence in such an investigation.

Currently, in England and Wales, the members of the Police Complaints Authority (PCA) provide supervision of an investigation. For this to be efficient they should ideally be contacted immediately and appear on the scene to supervise at once. Unfortunately, there is only one central office of the PCA in London for the whole of England and Wales. Even though its members can be contacted around the clock, this inevitably creates problems of delay for those areas further away from London.

Interviews for the purpose of generating witness statements are a sensitive issue. The Senior Investigating Officer needs to balance the interests of the police officers involved (who may be in shock, injured or upset) and the risk of evidence being lost or contaminated (for example through the possible collaboration of witness statements). The ACPO guidelines allow for the release of the police officer involved before obtaining a witness statement.<sup>14</sup> However, the absence of a specific central recommendation has resulted in each individual police force having its own

guidelines on how to deal with a death in custody. Some forces do consider the involved officers' evidence as central to the investigation and aim to obtain the statements early.<sup>15</sup>

In line with the duty to supervise the investigations, the PCA member should be present at the scene at this crucial time. The PCA policy<sup>16</sup> is that when the member of the Authority (usually accompanied by a caseworker) comes to the scene, s/he has to supervise the preservation of the scene,<sup>17</sup> secure evidence,<sup>18</sup> secure witnesses,<sup>19</sup> notify relevant persons<sup>20</sup> and collect the relevant documents.<sup>21</sup>

However, the police will not (nor should they) wait for a PCA person to arrive at the scene before starting the initial investigation. With one central office for the PCA, the time taken by the member to arrive may be problematic as some evidence may be tainted or lost during that time. This may be why, in practice, some forces contact the PCA member by telephone and appraise him or her that way.<sup>22</sup> Whereas this at least secures immediate liaison, it does not secure effective supervision and does not create the perception of accountability, independence or credibility.

The force will suggest an investigating officer, usually from their own Complaints and Discipline Department, but occasionally from a specialist unit if an incident requiring some special expertise has occurred (for instance involving the use of firearms). It is the policy of the PCA that the appointment of an external investigating officer should be seriously considered, and discussed with the force in death in custody cases.<sup>23</sup> Nevertheless, as long as the PCA is not present at the scene this decision is more difficult and may not be based on all the relevant facts. The importance of early PCA presence at the scene cannot be emphasised enough.

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<sup>14</sup> See earlier subsection 2.1 focusing on the rules after a death has occurred.

<sup>15</sup> See Durham Constabulary Policy, *Death in Custody – Aide Memoire*, at 1), which considers custody staff and the arresting officer as part of the immediate investigation, and thus organises for him/her to be escorted to remain on duty.

<sup>16</sup> See the PCA's out-of-hours folder.

<sup>17</sup> Crime scene log, cordons, establishing routes in and out, identifying anything moved and where to, minimising contamination, specialist scene protection – after discussion with the crime scene manager, portable lighting.

<sup>18</sup> Securing of pocket books, crime report entries, communication records, tapes and logs, custody records, MISPER records, ambulance identity, hospital name, other emergency service records, intelligence reports, homicide assessment team, search slips, FME records, victim's medical history, other records, pre-transfusion blood, clothing, first aid equipment used, firearms.

<sup>19</sup> CCTV, House-to-House, cordons, other prisoners, co-arrested, appeals, media, family, friends; identifying which are significant witnesses.

<sup>20</sup> Crime scene manager, photographer, pathologist, PCA, DPS ACPO, territorial ACPO, press bureau, internal investigations superintendent, other specialist, coroner's officer, on-call local superintendent, homicide assessment team, search team, helicopter/traffic car re scene video.

<sup>21</sup> Decision logs, crime scene logs, exhibit books, House-to-House video, briefing sheets (ACPO, PCA, pathologist), etc.

<sup>22</sup> See Durham Constabulary Policy, *Death in Custody – Aide Memoire*, at 8).

<sup>23</sup> This is mentioned expressly in the revised PCA guidelines as well as in the PCA out-of-hours folder, under B b.; see also earlier subsection 2.1 on rules after a death has occurred.

There are no guidelines on the responsibility for dealing with media coverage, however in practice the PCA deals with this aspect.

The current lack of guidelines on who should contact the family of the deceased and who should provide support for them suggests that the interests and welfare of the families are not protected effectively. In some forces there is a policy to try to ensure that the police at least establish initial contact with the family, appoint a family liaison officer, offer victim support etc.<sup>24</sup> This practice, though not an ideal solution (the police are rarely going to be the appropriate body to inform the family of their loss), clearly demonstrates consideration for the interests of the family. However the frequent criticism of a lack of disclosure to the family and friends by the police during investigations after a death in custody suggests early contact by the actual investigators, in a sensitive and careful way, should remain a priority.

There has until very recently been no duty on the police or the PCA to keep the relatives informed nor to provide them with documents as they are discovered or produced (in a welcome change, this duty is now set out in section 21 of the Police Reform Act 2002).

The coroner's pathologist conducts a post-mortem examination to establish the cause of death, whilst the police officer conducts the investigation. The aim is to conclude the investigation phase (police and pathologist) within four months.<sup>25</sup> Once this investigation is completed, the findings are provided as evidence to the coroner and, if appropriate, to the Crown Prosecution Service (CPS). The coroner starts the inquest, however, if the CPS decides to bring criminal charges, the coroner adjourns the inquest until the criminal process is completed. Where the CPS does not bring charges, and the inquest jury returns a verdict suggesting some form of liability – such as 'unlawful killing' – the CPS decision may be reviewed.

### 2.3 Disclosure of documents

There are no statutory guidelines on the pre-inquest

disclosure of documents, although the need for change has already been recognised. The Home Office has encouraged change by providing voluntary guidelines to Chief Police Officers for pre-inquest disclosure by the police:<sup>26</sup>

Chief Officers are advised, therefore, that there should be as great a degree of openness as possible, and that disclosure of documentary material to interested persons before the inquest hearing should be normal practice ... In all cases Chief Officers will want to consider whether there are compelling reasons why certain documents, or parts of documents, may not be disclosed. But there should always be a presumption in favour of openness.

Even though this demonstrates an appreciation of the importance of openness and transparency, the guidelines are voluntary and do not compel the police to disclose documents. In practice therefore, cases of deaths in custody are still, all too often, characterised by secrecy and the lack of disclosure.<sup>27</sup>

## 2.4 Reform

### 2.4.1 An independent police complaints commission

The PCA is an independent organisation created to supervise the investigation of serious cases of police misconduct: the problem is that it does not undertake investigations into deaths in custody itself. It is now generally accepted that an independent organisation is needed to undertake the investigation of police misconduct, in order to create public confidence.<sup>28</sup> Several reports have highlighted this and stressed the inappropriateness of the police investigating the police in serious matters. For many years the investigation of police complaints has been dogged by poor public confidence.<sup>29</sup> Liberty highlighted the fact that public and complainant attitude surveys suggested that more independence is essential if confidence is to increase.<sup>30</sup>

Such independence must be provided through the formal structure of the new body as well as through its substantive work. It is clear that supervision of police

<sup>24</sup> See the Durham Constabulary Policy, *Death in Custody – Aide Memoire*, at 10).

<sup>25</sup> For more detail see Leigh, Johnson, Ingram, *Deaths in Police Custody: Learning the Lessons*.

<sup>26</sup> See Home Office, "Circular Guidance to Chief Police Officers", 20/1999; updated 2002

<sup>27</sup> See for instance the case of Roger Sylvester where the claimant and her family have not had access to a very large proportion of the evidence.

<sup>28</sup> For more detail, see Harrison and Cunneen, *An independent police complaints commission*, Liberty, April 2000.

<sup>29</sup> European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Report to the United Kingdom on the visit to the United Kingdom and the Isle of Man*, 8-17 September 1997, section 48- section 55; see also Sir William MacPherson of Cluny, *The Stephen Lawrence Inquiry Report*, at p. 333; and also: The Home Affairs Committee, *First Report: Police Complaints and Disciplinary Procedures*, vol.1, at p. xxvi.

officers is not enough, and independent investigation must be introduced in order to enhance confidence in the system.<sup>31</sup> Furthermore, there needs to be greater transparency so that the victims – the family and friends – are empowered to participate.

Experience in Canada shows that it is possible to move away from the police investigating themselves. In the Province of Ontario, this has been a two-stage process. First the Office of the Public Complaints Commissioner was created in 1981. While the police retained responsibility for investigating public complaints, the Commissioner monitored progress by evaluating 30-day interim reports on the status of the investigations.<sup>32</sup> In 1990 the Police Services Act created the Special Investigations Unit,<sup>33</sup> an independent investigating body aimed at civilian oversight. It conducts investigations into the circumstances of serious injuries and deaths that may have resulted from criminal offences committed by the police.<sup>34</sup>

The following section will analyse the new Independent Police Complaints Commission (IPCC), now being set up under the Police Reform Act – its composition, its powers, and whether more disclosure can be expected.

#### 2.4.2 Composition of the IPCC

The Independent Police Complaints Commission<sup>35</sup> will consist of a chairman<sup>36</sup> and not less than ten other members.<sup>37</sup> The chairman and members of the Commission must not have been police officers or have “at any time been under the direction and control of a chief officer or any person holding an equivalent office in Scotland or Northern Ireland.”<sup>38</sup> The first chairman of the new IPCC, Nick Hardwick, was appointed in December 2002.

As an illustration of its independence, the Commission

will not be regarded as the servant or agent of the Crown and may not enjoy any status, privilege or immunity of the Crown.<sup>39</sup> This is similar to the regulation of the Canadian Special Investigations Unit,<sup>40</sup> whose Director cannot be a police officer or a former police officer.

But the Canadian system also prohibits police officers being appointed as investigators (though former police officers are not barred). By contrast, under the new system for England and Wales, most complaints will still be investigated by the police themselves. The Act states:<sup>41</sup>

- (1) The Commission may appoint such employees, on such terms and conditions, as appear to it to be appropriate.
- (2) The Commission may make arrangements with –
  - (a) the chief officer of police of any police force maintained for a police area in England and Wales,
  - (b) the chief constable of any police force maintained for a police area in Scotland,or
  - (c) the Chief Constable of the Northern Ireland Police Service, under which members of his force are engaged on temporary service with the Commission.
- (3) The Commission may make such other arrangements for its staffing as it thinks fit.
- (4) A member of a police force on temporary service with the Commission shall be under the direction and control of the Commission.
- (5) The approval of the Secretary of State as to numbers and to the terms and conditions of staff shall be required for the exercise by the Commission of its powers under this paragraph.

As highlighted earlier, the high degree of involvement of the police in the investigation of its own cases is a matter for concern. But it must be borne in mind that members

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<sup>30</sup> Harrison and Cunneen, *An independent police complaints commission*, at p. 5.

<sup>31</sup> See Police Federation, at <http://www.polfed.org.uk/wherewes.html#polview>

<sup>32</sup> Consultation Report of the Honourable George W. Adams QC to the Attorney General and Solicitor General Concerning Police Co-operation with the Special Investigations Unit, Toronto, May 14, 1998.

<sup>33</sup> Police Services Act, R.S.O. 1990, c. P. 15; this followed the Lewis Task Force on Race Relations and Policing, created by the Government after two black men were fatally shot by police in 1988, and chaired by Clare Lewis; for more detail see *Report of the Race Relations and Policing Task Force*, Toronto: Queen's Printer, 1989.

<sup>34</sup> See section 113 of the Police Services Act.

<sup>35</sup> See section 9(1) of the Police Reform Act.

<sup>36</sup> Appointed by Her Majesty.

<sup>37</sup> Appointed by the Secretary of State.

<sup>38</sup> See section 9(3) of the Police Reform Act (the chairman shall also not be appointed if he or she has been a member of the National Criminal Intelligence Service or the National Crime Squad or has been a member of a body of constables).

<sup>39</sup> See section 9(5) of the Police Reform Act.

<sup>40</sup> See section 113 of the Police Services Act.

<sup>41</sup> Schedule 2, para. 6(2) to the Police Reform Act, 2002.

of the police have considerable expertise in conducting investigations and as such would provide a valuable resource. Thus, a constructive compromise must be found to ensure an acceptable degree of independence and at the same time provide the highest standard of investigation.

Liberty suggested a model employing a mix of seconded police officers and non-police investigators – with a ceiling on the number of police investigators allowed (25%).<sup>42</sup> Such staffing of the new Commission, theoretically, would be of some considerable symbolic value regarding independence and would thus enhance public confidence. The Ontario Special Investigations Unit has recruited 50% of its full-time investigators from non-police positions in the law enforcement community.<sup>43</sup>

The lack of experience amongst non-police staff is addressed through training and by working with more experienced staff. The SIU spends 5% of its budget on training its staff. Investigator training for the SIU consists of an Orientation Programme, monthly Case Debriefs, Unit Training Sessions, and annual Investigators’ Seminars. Training is ongoing.<sup>44</sup> Investigations for the Unit differ considerably from police work itself and thus a lack of police experience does not always disadvantage non-police investigators.

The Schedule to the Act provides for the secondment of police officers to IPCC staff, with no upper limit to such appointments. Even though the Commission may make such other arrangements for its staffing as it thinks fit, and appoint such employees as it deems appropriate, Liberty takes the view that this leaves too much discretion to be an effective regulation. The guidelines need to set out a limit for the number of police officers involved. The symbolic value of an IPCC that is staffed by non-police must not be underestimated.

### **2.4.3 Powers of the Independent Police Complaints Commission**

In line with Schedule 3 of the Police Reform Act, the IPCC has the duty to decide whether to investigate a complaint,<sup>45</sup> and the power to determine the form of an investigation:

- (1) This paragraph applies where–
  - (a) a complaint or recordable conduct matter is referred to the Commission; and
  - (b) the Commission determines that it is necessary for the complaint or matter to be investigated.
- (2) It shall be the duty of the Commission to determine the form which the investigation should take.
- (3) In making a determination under sub-paragraph (2) the Commission shall have regard to the following factors–
  - (a) the seriousness of the case; and
  - (b) the public interest.
- (4) The only forms which the investigation may take in accordance with a determination made under this paragraph are–
  - (a) an investigation by the appropriate authority on its own behalf;
  - (b) an investigation by that authority under the supervision of the Commission;
  - (c) an investigation by that authority under the management of the Commission;
  - (d) an investigation by the Commission.

As established, there is a real need for a separate, independent body to investigate deaths in police custody itself. However, the wording of the Act does not guarantee such an independent investigation even in cases of deaths in police custody. It leaves it to the discretion of the Commission to determine the form of investigation, which can take place without the Commission’s involvement, be supervised or managed by it, or be undertaken by it directly. Liberty believes that it would have been better to specifically require that deaths in police custody should always be investigated by the Commission itself.

It is generally understood that such regulation would require additional resources, namely personnel and funding and that in a few cases independent investigation would be unnecessary.<sup>46</sup> Nevertheless, this needs to be weighed against the benefit of enhanced efficiency and public confidence. As the Act itself says of the general duty of the Commission, it must “secure that arrangements ... are efficient and effective and contain and manifest an appropriate degree of independence”.<sup>47</sup>

<sup>42</sup> See the KPMG study for the Home Office on an independent police complaints commission; and Harrison, Cunneen, *An Independent Police Complaints Commission*, at 2.3 on p. 9.

<sup>43</sup> For more detail, see SIU Special Investigations Unit, Annual Report 2001-2002, at p. 20.

<sup>44</sup> SIU Special Investigations Unit, Annual Report 2001-2002, at pp. 23-27.

<sup>45</sup> Schedule 3 para 25 of the Police Reform Act. Note: it does not have the duty to investigate but the duty to decide whether to investigate.

<sup>46</sup> Home Affairs Committee, “First Report, Police Complaints and Disciplinary Procedures”, vol.1, at p. xxvi.



Experience in Ontario shows that the actual investigation of all deaths in custody by an independent unit is possible. This Unit employs 10 full-time investigators, several regional investigators as needed, and eight Forensic Identification Technicians as needed.<sup>48</sup> Furthermore, this team of investigators not only investigates deaths in police custody but also serious injuries where the police were involved.<sup>49</sup> This may be a useful model for the forthcoming IPCC as well, given that systemic faults may be revealed and recurrence be prevented more readily.

As regards the investigation powers of the members of the IPCC, the Act provides that a member shall, for the purposes of carrying out the investigation and all purposes connected with it, have all those powers and privileges of Constable throughout England and Wales and the adjacent United Kingdom waters.<sup>50</sup> Such powers are welcome and essential.

Following the frequent criticism of a lack of disclosure to the family and friends during investigations after deaths in custody there will be a new regime for the IPCC, which will be reinforced by regulations and guidance. The Government has accepted that the restrictions on the disclosure of information by the Police Complaints Authority<sup>51</sup> have inhibited the PCA in explaining its work and it has set out to relax this restriction.<sup>52</sup> The Police Reform Act (at s20) places a duty on the Commission to keep the complainant (and the relatives of those who have died in police custody) informed:

- (1) In any case in which there is an investigation of a complaint in accordance with the provisions of Schedule 3–
- (a) by the Commission, or
- (b) under its management,

it shall be the duty of the Commission to provide the complainant with all such information as will keep him properly informed, while the investigation is being carried out and subsequently, of all the matters mentioned in subsection (4).

- (2) In any case in which there is an investigation of a complaint in accordance with the provisions of Schedule 3–

- (a) by the appropriate authority on its own behalf, or
- (b) under the supervision of the Commission,

it shall be the duty of the appropriate authority to provide the complainant with all such information as will keep him properly informed, while the investigation is being carried out and subsequently, of all the matters mentioned in subsection (4).

...

- (4) The matters of which the complainant must be kept properly informed are–

- (a) the progress of the investigation;
- (b) any provisional findings of the person carrying out the investigation;
- (c) whether any report has been submitted under paragraph 22 or Schedule 3;
- (d) the action (if any) that is taken in respect of the matters dealt with in any such report; and
- (e) the outcome of any such action.

Thus, the IPCC will have a far greater duty to disclose than does the Police Complaints Authority. However, the Act does allow some exceptions from the duty of disclosure. For instance, disclosure of information that is relevant to, or may be used in, any actual or prospective criminal proceedings is exempt. Furthermore, the Commission does not have to disclose information:

- if it is in the interests of national security;
- if it is for the purposes of the prevention or detection of crime, or the apprehension or prosecution of offenders;
- if it is required on proportionality grounds; or
- if it is otherwise necessary in the public interest.<sup>53</sup>

Thus, this commendable duty could, Liberty believes, be curtailed unnecessarily. It would have been better to have a stronger duty imposed in such cases and this way ensure more openness, transparency and confidence in the

<sup>47</sup> Part 2 section 10(1)(c) of the Police Reform Act.

<sup>48</sup> For more detail see SIU Special Investigations Unit Annual Report 2001-2002, at p. 21.

<sup>49</sup> See section 113(5) of the Police Services Act.

<sup>50</sup> See Schedule 3, Part 3, clause 19(4)(a) and (b) of the Police Reform Act.

<sup>51</sup> See section 80 of the Police Act.

<sup>52</sup> See Home Office, *Complaints against the Police – A Consultation Paper*, May 2000, at Q15, p. 7.

<sup>53</sup> clause 20(6)(a) and (b) (i)–(iv).

procedures. The consultation on ways to improve the relationship between the Special Investigations Unit (SIU) and the police also emphasised that the investigation must be carried out in a transparent manner to secure public confidence.<sup>54</sup>

In Ontario it was thus recommended, among other things, that the written report of the SIU should be made public where no charges are laid. It was also stressed that the Police Services Act should be amended to provide for its release notwithstanding the Freedom of Information and Protection of Privacy Act.<sup>55</sup> Despite these recommendations, in practice the SIU releases only an oral summary of its report to affected families and officers.

In the Australian state of New South Wales, the coroner reveals all documents to the family. A copy of all the material used in the coroner's investigation is sent to the family well before the inquest commences.<sup>56</sup>

#### 2.4.4 Conclusion

Even though the IPCC is not yet operational, it is important to analyse its provisions in the light of the problems of its predecessor and of international experience. The commitment to provide a new institutional body governed by new legislation is very positive. The new body comes with both considerable symbolic value and, potentially, full investigating powers. However, at the time of writing there was a distinct lack of guidance as to how these powers will be used, in particular for deaths in custody.

Furthermore, it is recommended that the IPCC should take on board the 12 years of experience of the Canadian Ontario SIU. The review of the SIU has revealed that there are insufficient legal references in the Police Services Act or in the regulations to the conduct of SIU investigations. The generality of the statute and its potential relationship with the Canadian Charter of Rights and Freedoms,<sup>57</sup> have proven fertile ground for dispute and

confusion over what precisely is expected of police officers.<sup>58</sup>

It is therefore vital for the IPCC to be regulated by a clear set of regulations and guidelines to ensure clarity and consistency from the start. If this is not the case, then any public confidence initially created by the establishment of the new body may quickly ebb away.

Finally, the IPCC's duties remain limited: there is no obligation to investigate deaths in custody or serious injuries. The mandatory referral of death in custody cases does not automatically result in an investigation by the IPCC, whose staff still have discretion as to whether it will investigate or supervise an investigation. This appears weak when compared to the Canadian practice, where it is mandatory that all cases of death and serious injury at the hands of the police are investigated by the independent body.

#### 2.5 Investigations in prisons and mental health institutions

The investigations following prison deaths and deaths under compulsory Mental Health Act detention are characterised by an even greater lack of independence. Following a death in prison custody, an internal investigation takes place, led by a senior investigating officer from the Prison Service. Senior investigating officers are Governors from establishments other than the one under investigation. In line with their terms of reference, they investigate the facts pertaining to the apparent cause of death, and determine whether a separate investigation under the Code of Discipline is required.<sup>59</sup> The death must be reported by the Prison Governor to the coroner.

Deaths of psychiatric patients who are compulsorily detained are also investigated internally. It is the management of the hospital that sets up an inquiry. What form the inquiry takes depends on the circumstances leading up to the death. If a patient is believed to be a

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<sup>54</sup> Consultation Report of the Honourable George W. Adams, QC to the Attorney General and Solicitor General Concerning Police Co-operation with the Special Investigations Unit, 14 May 1998, at p. 4.

<sup>55</sup> Consultation Report of the Honourable George W. Adams QC to the Attorney General and the Solicitor General Concerning Police Co-operation with the Special Investigations Unit, 14 May 1998, at p. 96, recommendation 16.

<sup>56</sup> Research interview with the Deputy Chief Coroner for New South Wales.

<sup>57</sup> Part I of the Constitution Act, 1882, being Schedule B of the Canada Act of 1982, c.11.

<sup>58</sup> Consultation Report of the Honourable George W. Adams, QC to the Attorney General and Solicitor General Concerning Police Co-operation with the Special Investigations Unit, 14 May 1998, at p. 13

<sup>59</sup> For more detail, see Safer Custody Group Report for 2001, *Self-inflicted deaths in Prison Service Custody*, p. 10.

victim of a homicide, the police must be informed.<sup>60</sup> Since the Mental Health Act 1959, it is not considered necessary that the death of all patients in a mental health institution should be reported to the coroner.<sup>61</sup> This matter was fully re-considered by the Brodrick Committee in 1971,<sup>62</sup> but resulted in no change on this issue. It is still the case that the Mental Health Act Commission should be informed of the death of any detained patient. This, however, only partly compensates for the absence of an inquiry by a coroner. This issue is being considered again by the Shipman Inquiry, chaired by Dame Janet Smith.<sup>63</sup>

So lack of independence in the investigation of these types of custody death is an issue quite as serious as with deaths in police custody. This examination focuses on police custody; however, we hope that the analysis is equally applicable to the procedures following deaths in prison and under compulsory mental health detention.

## 2.6 Conclusions

What is needed to restore lost public confidence is an effective and transparent system of investigation that shows real consideration for the family of the deceased.

The early stages of the investigation are crucial. To improve effectiveness, there is a need for:

- uniform guidelines and procedures
- specifically trained independent investigators
- an investigator from the independent body to be at the scene as soon as possible
- mandatory investigation by the IPCC of all deaths and serious injuries at the hands of the police.

On transparency, a change of policy is needed to ensure more openness, through compulsory disclosure of evidence and other documents before an inquest.

Finally, greater consideration for the family perspective entails a need to:

- ensure the family is informed of the death by an independent body (e.g. the IPCC or equivalent)
- ensure the family is provided with support
- ensure the family is informed of the process, their rights, the findings etc.

Above all, the IPCC must have sufficient resources to fulfil its mandate. Experience in Ontario has shown, that limited resources inhibit the effective investigation of deaths in custody, damage relations with other institutions, restrict the ability to be at the scene promptly, and make the independent body's performance ineffective. The Ontario SIU, in its early years, had to struggle to secure public confidence as a result of the inadequacy of its resources.<sup>64</sup> Increased resources resulted in a boost to the SIU's capabilities and competence – through hiring staff, putting in place a training programme, and acquiring new equipment to support investigators and forensic technicians. For example, the Unit now has at its disposal vans that have been set up as computer-equipped offices in which investigators can conduct interviews wherever a witness is located.<sup>65</sup> The success of the IPCC depends on adequate resources: every effort must be made to provide the new institution with a reasonable budget.<sup>66</sup>

## 3. Current procedure – the coroners<sup>67</sup>

### 3.1 The rules after a death is reported

The coroner, when informed of the presence of a body within his/her area, must consider the circumstances of the death:<sup>68</sup>

- (1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters,

<sup>60</sup> See Louis Blom-Cooper, 'Deaths of detained mental patients', in A. Liebling, *Deaths in Custody – caring for people at risk*.

<sup>61</sup> Compare with sections 20 and 21a of the Lunacy Act 1890, where it was enacted that every such death must be reported.

<sup>62</sup> which recommended that the deaths of all compulsorily detained psychiatric patients should be referred to the coroner (at para 12.09). *Report of the Committee on Death Certification and Coroners*, 22 September 1971, Cmnd. 4810, chaired by Norman Brodrick QC

<sup>63</sup> Phase two will look into systemic failures in relation to the patients killed by Dr Shipman.

<sup>64</sup> For more detail, see Consultation Report of the Honourable George W. Adams, QC to the Attorney General and Solicitor General Concerning Police Co-operation with the Special Investigations Unit, 14 May 1998, at pp. 82-84.

<sup>65</sup> Special Investigations Unit Annual Report, 2000-2001, at p. 10.

<sup>66</sup> The SIU for the Province of Ontario in Canada has an annual financial expenditure of just over \$(Ca)5 million (this is just over £2 million); 70% of that is spent on investigative services. For more detail, see Special Investigations Unit Annual Report 2000-2001, at p. 26 and Special Investigations Unit Annual Report 2002-2002, at p. 29; it would be useful if the IPCC had access to helicopters.

<sup>67</sup> This sub-section only deals with issues regarding the investigation of the coroner; a more detailed examination of the whole inquest system can be found in the next chapter

<sup>68</sup> Rule 36 of the Coroners Rules.



namely-

- (a) who the deceased was;
  - (b) how, when and where the deceased came by his death;
  - (c) the particulars for the time being required by the Registration Acts to be registered concerning the death.
- (2) Neither the coroner nor the jury shall express any opinion on any other matters.

According to the Coroners Act and the Coroners Rules, the coroner's inquest is inquisitorial: its sole purpose is to find the true answer to the questions set out in rule 36.<sup>69</sup> According to the Coroners Act, the coroner's jurisdiction arises where there is reasonable cause to suspect that the deceased is a person who has died in prison.<sup>70</sup> This reference to "prison" would not include an obligation to hold an inquest following a death in any other form of legal custody.<sup>71</sup> The Home Office recommends that coroners should hold an inquest on the death of any person in any kind of legal custody, even if the person concerned died in hospital after having been held in such custody.<sup>72</sup> Jervis, in line with the Brodrick Report recommendations, points out that it is curious that there should be no obligation to hold an inquest merely because the deceased died in police custody, yet any inquest that is held must be a jury inquest.<sup>73</sup>

The coroner has the common law right to possession of the body.<sup>74</sup> The coroner can give authority for the examination or removal<sup>75</sup> of the body from the place where it was found. The coroner alone has the legal power to order an examination of the body but this is often carried out in agreement with the police.<sup>76</sup> In line with this the coroner has the power to instruct a pathologist.<sup>77</sup> Which pathologist to instruct is at the discretion of the coroner, within the constraints of the Coroners Rules.

The coroner's power in respect of the post-mortem or special examinations begins and ends with the question of "how" the deceased came by their death. He or she cannot authorise examination beyond that as a matter of interest nor, for example, as research into an area of public importance. The pathologist instructed has to provide the coroner with a post-mortem report (for the pathologist's remit, see the next subsection).<sup>78</sup> The coroner has the power to decide which witnesses to call. If witnesses do not attend, the coroner has the power to order a witness summons requiring the attendance of a witness and s/he can enforce this by a fine.<sup>79</sup>

Any disclosure of documents is very much at the discretion of the coroner and the legislative framework does not provide much help. According to the Coroners Rules a coroner shall, on application and on payment of the prescribed fee (if any), supply to any person who, in the opinion of the coroner, is a properly interested person a copy of any report of the post-mortem examination or special examination.<sup>80</sup> The same applies to any notes of evidence, or of any document put in evidence at the inquest (but only after the inquest).

### 3.2 Practice

Despite the lack of an express obligation, coroners do assume they have a duty to hold an inquest in all cases of death in custody and do not restrict this duty to deaths in prison. As has been established, it is the coroner's responsibility to ensure that a fair and balanced account of the death is presented at the inquest. This means that the circumstances must be properly investigated (by the coroner or the coroner's officer on behalf of the coroner) and that relevant witnesses must be called to the hearing. Thus the coroner is the arbiter as to what evidence will be

<sup>69</sup> Dorries, *Coroners' Courts – a guide to law and practice*, 7.04, at p. 141.

<sup>70</sup> See section 8(1)(c) of the Coroners Act.

<sup>71</sup> For more detail, see *Nicoll v Catron* (1985) 149 J.P. 424, D.C. In this case there is not even a specific duty to report the death to the coroner at all, although the then Home Secretary thought that all the deaths in custody should be reported to the coroner, see House of Commons Official Report, 11 November 1980, col. 151.

<sup>72</sup> See Home Office Circular No.35, 1969, and also: *cf R v Inner London Coroner ex Limane* [1989], W.L.R. 395, D.C.

<sup>73</sup> See the Brodrick Report at paras 12-07 and 14-10, which also recommends that there should be both a duty to report a death in police custody and a duty to hold an inquest.

<sup>74</sup> *R v Bristol Coroner ex parte Kerr* [1974] 2 All ER 719: the coroner's authority over the physical control of the body arises as soon as he decides to hold an inquest and lasts at common law until the inquest itself is determined.

<sup>75</sup> See section 22(1) and (2) of the Coroners Act 1988, which make discretionary provisions for a coroner to remove a body for examination.

<sup>76</sup> See Jervis, *On Coroners' Law*, 14-07, at p. 262; see also rule 6(1)(a) of the Coroners Rules; see also the earlier subsection.

<sup>77</sup> See rule 6(1)(a) of the Coroners Rules which requires the coroner to instruct, whenever practicable, a pathologist with suitable qualifications and experience and who has access to laboratory facilities.

<sup>78</sup> See rule 10(1) of the Coroners Rules.

<sup>79</sup> See section 10(2) of the Coroners Act.

<sup>80</sup> See rule 57(1) of the Coroners Rules.

heard before the inquest and he or she alone can regulate the conduct of the proceedings.<sup>81</sup> However the investigation and, to some extent, the collection of the evidence is not in the coroner's control.

In order to investigate the circumstances properly, the coroner needs to be fully informed of the details surrounding the death, especially of the evidence found at the scene and during the 'Golden Hour'. But the coroner is dependent on the expertise, efficiency and effectiveness of the police at the scene and on the chief investigating officer (supervised by the PCA member).<sup>81</sup> Clearly, any shortcomings in this initial phase will hamper the coroner's investigation severely.

The coroner must become conversant with the inquiries made by the police – including documents the police have acquired and statements they have taken. There is no express statutory power for the coroner to require the police to co-operate.<sup>83</sup> The evidence collected by the police is, as a matter of practice and goodwill, given to the coroner to avoid his or her having to make similar and parallel investigations.<sup>84</sup> So the coroner (or the coroner's officer) has no trouble obtaining the evidence that has been collected and in practice, the production of necessary documents does not really cause difficulties. The coroner is not, however, in control of the investigation.

Once all the necessary information is to hand, the coroner will decide which witnesses to call. The coroner is under a duty to ensure that a balanced and representative picture of evidence is available in court.<sup>85</sup> However, the choice of witnesses too – and thus the coroner's further investigation – is likely to be based on the police's collection of evidence (particularly if no other agency has investigated). Thus, again, the coroner is largely dependent on the expertise, efficiency, and effectiveness of the police.

Effectively the law gives the coroner a dual role – as the investigator and as the adjudicator after a death in custody

has occurred. This confusing mix of roles could undermine public confidence – even though in practice, it is not the coroner who investigates but rather the police who provide the coroner with the evidence gathered (if only on the basis of goodwill).

In France, the inquiry into a death truly combines investigation and adjudication. There the investigating magistrate investigates the death and delivers a criminal verdict upon completion. This system may not be appropriate for England and Wales because this combination of roles would conflict with the adversarial system in our courts.

It may be better if the coroner in England and Wales retains the judicial role and the fiction of responsibility for the investigation is ended. The benefit of such a system is illustrated by the Canadian (Ontario) and Australian (New South Wales and Victoria) procedures where the coroners obtain the evidence collected by the police. In Australia, independence is secured through the establishment of a unit overseeing the police investigation: the ethical standards department (Victoria) and the police integrity unit (New South Wales).

Even though there is a lack of clear guidelines regarding the disclosure of information, evidence and other documents, some coroners are now seeking to provide such documents to the family or other interested parties. Problems occur, mainly due to the lack of clear rules with regard to evidence collected by others, particularly by those outside the remit of the coroner's investigation. Statements and documents collected by the police during their investigation, and supplied to the coroner, start as police property and, it is claimed, remain police property.<sup>86</sup> As such, the coroner is only the custodian of the documents, and could not without breach of confidence or trust show them to the applicant. Although any interested person is entitled to examine any witness at an inquest either in person or by counsel or solicitor,<sup>87</sup> this is interpreted as applying only to examination of a witness at the inquest

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<sup>81</sup> For more detail see Dorries, *Coroners' Courts*, at p. 118.

<sup>82</sup> See section 2 of this chapter, on the current procedure for investigation.

<sup>83</sup> In the 1983 case of *R v Southwark Coroner ex parte Hicks* [1987] 2 All E.R. 140 it was said that the coroner has himself no power to order the production of documents although he may apply to the High Court for a subpoena duces tecum compelling production. Dorries, *Coroners' Courts*, argues on p. 123 that this subpoena is an administrative function of the High Court rather than a judicial order made in court, and it is difficult to see why it should be felt this cannot be undertaken by a coroner, indeed, no reason was given for this view in *Hicks*.

<sup>84</sup> See *R v H.M. Coroner for Hammersmith ex parte Peach* No. 2

<sup>85</sup> See Dorries, *Coroners' Courts*, at 6.02 and 6.03, p. 118.

<sup>86</sup> See *R v H.M. Coroner for Hammersmith*, ex parte Peach [No.2]

<sup>87</sup> See rule 16 of the Coroners Rules.

hearing itself. It does not affect the fact that the documents are still the property of the police, are not within the coroner's disposition, and cannot be disclosed before the inquest.<sup>88</sup>

This situation has been partly resolved by the current trend towards more – albeit voluntary – pre-inquest disclosure. In preparation for the Roger Sylvester inquest, a special one-day pre-inquest hearing took place before the coroner to arrange for the disclosure of all documents.<sup>89</sup> Such hearings are not entirely new, but the trend towards holding pre-inquest hearings in most controversial inquests should be welcomed.

Again, however, the Canadian and Australian systems examined highlight a much greater degree of disclosure in these countries. The system in the Province of Ontario ensures the disclosure of the complete coroner's brief before the inquest. This does not include the police report, but much of the police report is covered in the brief. Furthermore, the Adams review recommended that the SIU report should be made public where no charges are laid.<sup>90</sup> This recommendation has not been implemented so far,<sup>91</sup> but a follow-up review by George Adams towards the end of 2002 was due to revisit this issue.

Apart from the police report, the coroner does – voluntarily – provide most of the information to interested parties. Nevertheless, there are still problems involving lack of disclosure. This, once again, can only be overcome if clear statutory guidelines are set up and their implementation is monitored. The jurisdictions examined in Canada and Australia do not face this problem because the coroner collects all the material beforehand and this file (apart from the police report in Ontario) is disclosed to the family and interested parties at least four weeks before the inquest.

### 3.3 Conclusions

Five key improvements are needed to ensure an effective investigation through the inquest system:

- Clear statutory guidelines regulating the remit of the coroner
- Coherent and uniform guidelines for all coroners' courts
- Regulations providing the coroner with the powers to obtain necessary information for the investigation (i.e. regulating the relationship between police and coroner)
- Regulations for pre-inquest disclosure, making disclosure obligatory
- Streamlining of the process.

## 4. The pathologist

### 4.1 The rules after a death has occurred

There are no statutory guidelines directing pathologists on what they need to do after a death in custody has occurred. There is also no structure or central control.<sup>92</sup> The profession has recently produced a document, *Good Medical Practice in Pathology*, with the aim of providing a code of practice by which pathologists will eventually be judged in terms of annual appraisal and revalidation.<sup>93</sup> But this code of practice offers no guidelines to forensic pathologists.<sup>94</sup>

### 4.2 Practice

The pathologist plays a substantial role in the investigation of the coroner. Although the pathologist may sometimes visit the scene of a suspicious death, in the vast majority of cases the pathologist will see the body of the deceased for the first time in the mortuary. The pathologist is entirely reliant on the information gathered by those who have attended the scene, the coroner's officer or the local police force, although he should also be given access to any hospital records in appropriate cases.<sup>95</sup>

Even though the coroner is in charge of appointing the pathologist, in practice it is the police, or sometimes the coroner's officer, who call the pathologist following an incident. The Metropolitan Police, for example, have a

<sup>88</sup> See *R v H.M. Coroner for Hammersmith, ex parte Peach* [No.2]

<sup>89</sup> Friday 25 January 2002 at St Pancras Coroners' Court. This hearing was in confidence and thus no documents are available.

<sup>90</sup> Consultation Report of the Honourable George W. Adams, QC to the Attorney General and Solicitor General Concerning Police Cooperation with the Special Investigations Unit, 14 May 1998, at p. 95-96, recommended that the SIU report should be made public where no charges are laid.

<sup>91</sup> See Special Investigations Unit Annual Report, 2001-2002, at p. 10.

<sup>92</sup> See Pounder in INQUEST and The Law Society report – *Inquests: are they delivering truth and justice?*, Seminar, 20th November 2001, The Law Society, London, at 11.

<sup>93</sup> The Royal College of Pathologists, *Good Medical Practice in Pathology*, January 2001.

<sup>94</sup> It is addressed to doctors practising chemical pathology, medical microbiology, haematology, histopathology and cytopathology. But a forensic pathologist usually attends after a death in police custody.

<sup>95</sup> Dorries, *Coroners' Courts*, at 5.10, p. 96.

number of pathologists under contract and working on a duty rota for call-outs.

This is an obvious departure from the regulations of the Coroners Act by which the coroner has the authority to order a post-mortem,<sup>96</sup> and the rule according to which someone independent of the police has the right to choose a pathologist.<sup>97 98</sup> It is a departure designed to speed up the investigation and to secure evidence at an early stage; but it nevertheless deprives the process of an element of independence from the police investigation.

In Ontario, this problem is avoided by completely excluding the police after a death in police custody. The coroner in Ontario is a fully-qualified doctor and always attends the scene after a death in custody.<sup>99</sup> The coroner reports this case to a group of seniors (coroners and lawyers) at the head office and this meeting decides whether an autopsy is necessary. An autopsy will generally be held after a death in custody – undertaken by a pathologist employed by the state's chief coroner. The police are not involved in the process at all.

In England and Wales, once the pathologist has been contacted s/he should go to the scene or the hospital.<sup>100</sup> In practice, it may take a pathologist four hours to arrive. This should be co-ordinated with the member of the PCA. The pathologist then undertakes an investigation at the scene and a preliminary investigation of the body. A thorough autopsy will follow. In England and Wales there is at least one autopsy following almost every death in custody. This puts enormous strain on the system and makes the inquest procedure a costly process.

The number of autopsies undertaken in Ontario is far lower than in England and Wales. This keeps costs down and places less demand on forensic pathologists. The reason for this is that the coroners in Ontario are qualified physicians and do not need medical advice during the investigation. Second autopsies are unusual: there is sufficient confidence in the system and families and friends

are usually satisfied with the procedure and results obtained. This may be because the system is coherent and uniform, there are strict guidelines, and strict quality controls. In Victoria/Australia, the autopsy is carried out with the family and the police as observers, able to ask questions during the process.<sup>101</sup> In these jurisdictions, the family is sent the coroner's brief before the inquest, including the full report by the pathologist.

In any jurisdiction, the pathologist faces several problems when undertaking the autopsy. Firstly, resuscitation attempts often destroy relevant evidence in the body. First-aiders and paramedics have to do everything to save the victim's life, but these efforts cause severe bruises and some fractures that may cover up or cause confusion with other injuries obtained separately. Secondly, the pathologist needs as many witness accounts as possible to be able to provide definitive conclusions. For instance, bruises alone are not sufficient to prove restraint-related death/positional asphyxia. However, if a witness can state with certainty that the victim was lying face-down and officers kneeled on his back, then the autopsy in combination with this statement would allow for such a conclusion.

But in England and Wales, the pathologist will usually not hear about witness accounts until the inquest. Given that there is no regulation on the order of witnesses, the pathologist may even hear about these statements only after s/he has given evidence. By contrast, in Ontario and the Australian states of Victoria and New South Wales, all parties receive the complete set of evidence before the inquest. This speeds up the process and provides the pathologist with a full account of the circumstances.

In contrast to ordinary homicide investigations however, there may be more than one pathologist present at a custody death autopsy in England and Wales. It has become more common for the Police Federation to instruct their own pathologist and sometimes, the family will do so as well. Thus, there may be at least three pathologists present.

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<sup>96</sup> See sections 19 and 20 of the Coroners Act.

<sup>97</sup> See rule 6 of the Coroners Rules.

<sup>98</sup> For more detail see the first section of this chapter.

<sup>99</sup> In non-controversial cases the coroner may give instructions over the phone and the body is brought to Toronto for physical examination. However, by definition deaths in custody are always seen as controversial and there will always be a coroner attending at the scene.

<sup>100</sup> The body will usually be removed to the hospital and transferred to a mortuary in that hospital.

<sup>101</sup> In Melbourne (Victoria, Australia) the police and the family can be present at post-mortem, can observe through a glass window from a seated viewing room and can ask questions through a microphone linked with the pathologist.

Upon conclusion of the autopsy, the (lead) pathologist has to submit a report. This is usually a very long document that goes to the coroner and the police. The document is written in two versions: report format and statement format. The report is for the coroner, the statement may form the basis for a criminal prosecution or a disciplinary procedure. These reports may take up to six weeks to produce.<sup>102</sup> There is always a danger in reporting prematurely without having considered all the relevant facts.<sup>103</sup> Full disclosure before the inquest would not only provide more transparency but also support the pathologist in their examination.

### 4.3 Conclusions

For the pathologist's investigation to be effective, there is a need for:

- Clear guidelines
- Existing guidelines to be updated
- Increased disclosure to ensure transparency
- Promptness – including the investigator reaching the scene quicker and the pathologist conducting the post-mortem and writing the report quicker.

## 5. Conclusion

Overall the current system is characterised by a lack of guidelines and regulation, and a damaging lack of disclosure. Too much depends on the police – and they cannot be expected to provide the entire basis for the investigation into the actions of their colleagues and provide support and welfare services to the family.

The current system does not contribute to greater public confidence. The lack of disclosure, the lack of independence, and the lack of promptness do not provide the police with the opportunity to prove they have undertaken a thorough and effective investigation. At the same time, where the police investigation involves mistakes there is little opportunity to pinpoint and remedy these mistakes, and learn lessons for the future. Recommendations for change should consider the imposition of clear regulations and guidelines, a greater degree of disclosure, improved public scrutiny and independence. The need for greater promptness and independence may in turn require greater decentralisation of the IPCC, so its staff can attend a death as soon as possible.

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<sup>102</sup> The toxicology examination takes considerable time: pathologists would not like to draw conclusions without considering all the relevant facts.

<sup>103</sup> See the case of Wayne Douglas, who died in contact with the Metropolitan Police, where the report prematurely concluded natural causes of death.

## 4. PUBLIC SCRUTINY: THE INQUEST SYSTEM

### 1. Introduction

Even though inquests into custody deaths form only 12% of the coroner's caseload,<sup>1</sup> they will be the main focus of this section. Inquest proceedings are almost unique to the English legal system; they have only now begun to be scrutinised more thoroughly by the European Court of Human Rights in Strasbourg.<sup>2</sup> As Jervis states, the coroner's court is peculiar in being inquisitorial in nature rather than accusatorial.<sup>3</sup> This gives rise to fundamental differences, both in procedure – compared to ordinary civil and criminal courts – and in comparison to other European and international experiences. It is also characterised by some practical problems, especially from the perspective of the relatives of the deceased, as regards its function, its structure, its transparency, and its effectiveness. This section describes a typical inquest and analyses the issues that arise.

### 2. The inquest system

The inquest is formally inquisitorial rather than adversarial: technically there are no parties to it, and there are no formal allegations or pleadings.<sup>4</sup> In line with this, the Coroners Rules proclaim:<sup>5</sup>

- (1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely–
  - (a) who the deceased was;
  - (b) how, when and where the deceased came by his death;
  - (c) the particulars for the time being required by the Registration Acts to be registered concerning the death.

- (2) Neither the coroner nor the jury shall express any opinion on any other matters.

No verdict shall be framed in such a way as to appear to determine any question of –

- (a) criminal liability on the part of a named person, or
- (b) civil liability.

So the key function of the coroner is to determine when, where and how the deceased came by their death. In cases inquiring into police deaths or prison deaths the coroner has to sit with a jury.<sup>6</sup> There is no such provision for the death of persons detained under the Mental Health Act.<sup>7</sup> The inquest, as a fact-finding exercise, involves the examination of witnesses by the coroner and interested persons. Individuals such as the spouse, parent, child or other relative are likely to be considered an interested person by the coroner.<sup>8</sup>

The jury will listen to the evidence and may ask questions.<sup>9</sup> The coroner may assist the jury by asking questions him or herself. After the evidence has been given no person other than the coroner is entitled to address the jury as to the facts of the case.<sup>10</sup> Legal representatives will not be given the chance to make a closing statement putting forward their view of the case, as would happen in a criminal court. If any person wishes to address the coroner on a point of law,<sup>11</sup> this must be done in the absence of the jury so that they are not influenced by whatever may be said.<sup>12</sup>

The coroner sums up the evidence for the jury and directs them as to the relevant law.<sup>13</sup> Thereafter, the coroner sets down for the jury those verdicts s/he considers

<sup>1</sup> Home Office Statistical Bulletin, issue 11/98.

<sup>2</sup> *Jordan v United Kingdom* (dealing with the Coroners Act (Northern Ireland) 1959, and the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963); *McKerr v United Kingdom*; *Kelly and others v United Kingdom*; *Shanaghan v United Kingdom*.

<sup>3</sup> Matthews and Foreman, *Jervis on Coroners*, p. 186 at 11–01.

<sup>4</sup> For more detail, see: Dorries, *Coroners' Courts – a guide to law and practice*, p. 137.

<sup>5</sup> See sections 36 and 42 of the Coroners Rules.

<sup>6</sup> Section 8(3)(a) and (b). Only about 4% of inquests each year are held before a jury, see Dorries, *Coroners' Courts – a guide to law and practice*, 8.01.

<sup>7</sup> Nevertheless, some patients in a mental hospital are held by order of the court under section 42 of the Mental Health Act, 1983, and that is often considered as a case under section 8(3)(a) of the Coroners Act, thus as a police death.

<sup>8</sup> See Rule 20 of the Coroners Rules.

<sup>9</sup> But rarely does so and may not even be told that it has the right to do so. For more detail, see later sections.

<sup>10</sup> Rule 40 of the Coroners Rules. This is unlike criminal or civil cases where both parties can address the issues of fact in their final submissions.

<sup>11</sup> Before s/he sums up to the jury.

<sup>12</sup> For more detail, see Dorries, *Coroners' Courts – a guide to law and practice*, at 8.24.

<sup>13</sup> See rule 41 of the Coroners Rules. For more detail, see Dorries, *Coroners' Courts – a guide to law and practice*, chapter 8.



available to them as a matter of law and as justified by the evidence. Some describe the duty of the coroner in this regard as acting as a filter to avoid injustice.<sup>14</sup> There is no definitive list of verdicts. There is, however, a suggested list which is contained in the notes to the prescribed form of inquisition set down under the Coroners Rules.<sup>15</sup> The notes do not form part of the Rules and are not binding.<sup>16</sup>

Before reaching a particular verdict, the coroner or jury must be satisfied on the necessary facts to the required standard of proof. For a verdict of suicide or unlawful killing the standard of proof is at the same level set in a criminal court – beyond reasonable doubt.<sup>17</sup> For all other verdicts the lesser (civil) standard of proof applies – on the balance of probabilities. No verdict may determine any form of criminal or civil liability, although prior to 1977 it was a function of the coroner’s court, in cases involving murder, manslaughter or infanticide, to name the alleged perpetrator. This had the effect of committing the named person for trial at the Crown Court.<sup>18</sup> Verdicts today include: death by natural causes,<sup>19</sup> suicide,<sup>20</sup> accidental death,<sup>21</sup> misadventure,<sup>22</sup> open verdict,<sup>23</sup> drugs death,<sup>24</sup> lawful killing,<sup>25</sup> neglect,<sup>26</sup> unlawful killing.<sup>27</sup>

The jury retire to consider their verdict, and they will stay in seclusion until such time as they have reached a verdict.<sup>28</sup> The formal record of the inquest, containing the verdict, is called the inquisition.<sup>29</sup> The form of inquisition is prescribed by the Coroners Rules and consists of three parts: the caption, the facts found (the verdict in a strict sense), and the attestation by the coroner and the jury.<sup>30</sup> The so-called rider to a verdict has been abolished,<sup>31</sup> and the coroner cannot pass an opinion on matters outside the questions of who, when, where, how, although the prevention of future fatalities is still included in the remit of the coroner.<sup>32</sup> The coroner, rather than the jury, has the power to report the circumstances of the case to an appropriate authority with a view to remedial action being taken.<sup>33</sup> This recommendation does not have to be made public nor do the ‘parties’ have a right to be consulted about it or see it themselves.

### 3. International soft law standards<sup>34</sup>

The relevant ‘soft law’ standards applicable to the area of inquest systems are contained in the *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*,<sup>35</sup> and

<sup>14</sup> See: Woolf MR, in *R v HM Coroner for Exeter & East Devon ex parte Palmer*, unreported, Court of Appeal, 10 December 1997.

<sup>15</sup> See Form 22, of Schedule 4 of the Coroners Rules.

<sup>16</sup> *R v Poplar Coroner ex p. Thomas*, [1993] QB 610.

<sup>17</sup> *R v Wolverhampton Coroner ex parte McCurbin* (1990) 1 WLR 719.

<sup>18</sup> This power was specifically abolished by the Criminal Law Act, 1977.

<sup>19</sup> There is no statutory definition but it is understood as the normal progression of a natural illness, without any significant element of human intervention, see Dorries, *Coroners Courts – a guide to law and practice*, at 9.13.

<sup>20</sup> Voluntarily doing an act for the purpose of destroying one’s life while one is conscious of what one is doing. There must be evidence that the deceased intended the consequence of his act. See: *R v Cardiff Coroner ex parte Thomas* (1970) 3 All ER 469. The Government has announced that it is considering abolishing the verdict of suicide because of its connotations. The exact wording of what will take its place has not yet been decided.

<sup>21</sup> The unexpected result of a deliberate act, see *Jervis, Jervis on Coroners*, at paras. 13–24.

<sup>22</sup> There remains uncertainty on the definition of misadventure. It is applied by some when a person deliberately undertakes a task which then goes wrong, causing death, see Dorries, *Coroners’ Courts – a guide to law and practice*, at 9.16; also *R v Portsmouth Coroner ex parte Anderson*. For statistical purposes, accidental death and misadventure are treated as one.

<sup>23</sup> This is an acceptance that the evidence does not fully disclose the means whereby the cause of death arose, for more detail see Form 22 in Schedule 4 to the Coroners Rules 1984.

<sup>24</sup> The suggested list includes “dependence on drugs” and “non-dependent abuse of drugs”. There is however, no statutory or recognised definition of these conclusions.

<sup>25</sup> The death was the result of an action justified in law, such as self-defence. It is seen to relate to the shooting of an armed person by the police during a robbery or siege to save the life of another.

<sup>26</sup> “Neglect” is seen to be more limited than “negligence”. It is taken to mean: a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself. Failure to provide medical attention for a dependent person whose physical condition is such as to show that he obviously needs it may amount to neglect. So it may also if it is the dependent person’s mental condition which obviously calls for medical attention. For more detail, see: *R v HM Coroner for North Humberside ex parte Jamieson* [1995] QB 1; (1994) 3 All ER 972 and (1994) 3 WLR 82.

<sup>27</sup> This is a very rare conclusion of the court (although lawful killing verdicts are even rarer). The coroner is not allowed to give a verdict that accuses a named person of criminal liability, but he is allowed to return a verdict stating that the deceased was unlawfully killed, without making reference to the culprit.

<sup>28</sup> See Dorries, *Coroners’ Courts – a guide to law and practice*, at 8.25.

<sup>29</sup> See Annex.

<sup>30</sup> Matthews, Foreman, *Jervis on Coroners*, 245 at 13–10; see also: Schedule 4, form 22 of the Coroners Rules.

<sup>31</sup> See Coroners Amendment Rules 1980.

<sup>32</sup> See section 43 of the Coroners Rules.

<sup>33</sup> See Rule 43 of the Coroners Rules; the application of this rule varies, see e.g.: the purpose of such a jury inquest is seen to be that lessons are learnt from the circumstances of the death so that in future the risk of injuries to health or safety arising from similar circumstances should be prevented or reduced, see: *R v HM Coroner for Western District of East Sussex ex parte Homberg* (1994) 158 JP 357.

<sup>34</sup> This is taken from CAJ, *Response from the Committee on the Administration of Justice (CAJ) to the Consultation Document Issued by the Coroners Review Team*, December 2002, pp. 24–26.

<sup>35</sup> Adopted on 7 September 1990 by the eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders.

the *United Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions*,<sup>36</sup> and the *UN Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions*.<sup>37</sup> These standards are not strictly legally binding; however, they do represent an important yardstick by which a State may judge its adherence to the generally recognised principles applicable in the conduct of an investigation into a suspicious death. Furthermore, these principles are referred to and given credence by the European Court of Human Rights in the recent cases of *Jordan*,<sup>38</sup> *McKerr*,<sup>39</sup> *Kelly*,<sup>40</sup> and *Shanaghan*.<sup>41</sup>

These principles proclaim that an investigation shall be adequate,<sup>42</sup> thorough, prompt and impartial.<sup>43</sup> The investigation must be independent,<sup>44</sup> and families of the victims must have access to the legal process.<sup>45</sup> One of its aims should be to bring the suspected perpetrator before a competent court established by law.<sup>46</sup> The investigation should lead to more than mere ‘findings’ but should also include recommendations.<sup>47</sup> The Report must be published and the government must formulate a response to it.

## 4. Issues arising in practice

### 4.1 Introduction

The following sub-section will examine the remit of the coroner, the structure of the courts, issues of disclosure,

delays, the lack of public funding, and the scrutiny of the inquest courts.

## 4.2 The remit (and the verdict)

### 4.2.1 Rule 42 of the Coroners Rules

As has been established earlier, the coroner and the jury in their inquisition must only focus on the questions of who the deceased was, and when, where, and how death occurred. As regards the caption, this usually does not involve any difficulty. However, the section on the facts found includes paragraph 4, which deals with the conclusions of the jury and the coroner as to death. Note 4 to the prescribed form of inquisition gives a comprehensive list of suggested conclusions.<sup>48</sup> The object of this list is to standardise conclusions over the whole country and to make the statistics based on the Annual Return more reliable by avoiding as far as possible any overlap or gaps between the different conclusions.<sup>49</sup> ‘Self-neglect’ or ‘neglect’ may be used as a qualification or as a free-standing conclusion if the circumstances warrant.<sup>50</sup>

This latter conclusion seems to be in conflict with rule 42 of the Coroners Rules, which forbids any verdict that appears to be determining a question of civil or criminal liability. However, the courts have established that the concept of ‘lack of care’ has nothing to do with the concept of civil negligence, and therefore cannot, and does not, indicate a breach of duty of anyone.<sup>51</sup> Thus, ‘lack of care’ is

<sup>36</sup> Adopted on 24 May 1989 by the Economic and Social Council Resolution 1989/65.

<sup>37</sup> *United Nations Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions*, U.N. Doc. ST/CSDHA/12. The manual provides model methods of investigation, purposes, and procedures of an inquiry and processing of the evidence (chapter III, 16); requires that all investigations be characterised by competence, thoroughness, promptness, and impartiality (chapter III, 16), and requires that the scope of the inquiry, and the terms of reference should be framed neutrally to avoid suggesting a predetermined outcomes, (chapter III, 18). In cases involving an allegation of government involvement, the Minnesota Protocol recommends the establishment of a commission of inquiry (chapter III, 21, 22). Such commissions require extensive publicity, public hearings, and the involvement of the families of the victims (chapter III, 21).

<sup>38</sup> Paragraphs 87-92.

<sup>39</sup> Paragraph 144.

<sup>40</sup> Paragraph 121.

<sup>41</sup> Application No. 37715/97, Judgment of 4 May 2001.

<sup>42</sup> See principle 22 of the *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*: Governments and law enforcement agencies shall ensure that an effective review process is available and that independent administrative or prosecutorial authorities are in a position to exercise jurisdiction in appropriate circumstances. In cases of death and serious injury or other grave consequences, a detailed report shall be sent promptly to the competent authorities responsible for administrative review and judicial control.

<sup>43</sup> UN Factsheet 11; see also UN Report of the Special Rapporteur on Extra-Judicial, Summary or Arbitrary Executions, UN Doc. E/CN.4/1988/22.

<sup>44</sup> Principle 11: the inquiry must be independent and not governed by interests of any agency whose actions are the subject of the scrutiny.

<sup>45</sup> Principle 16, not only must family have access to all evidence, they must also be able to present their own. Representation should be afforded to the family of the victim, see Special Rapporteur on Extra-Judicial, Summary or Arbitrary Executions, U.N. Doc. E/CN.4/1988/22.

<sup>46</sup> Principle 10,

<sup>47</sup> Principle 17 of the United Nations Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions.

<sup>48</sup> This is only a suggested list and not compulsory because the notes do not form part of the Coroners Rules, see: *R v Turnbull, ex p. Kenyon*, March 15, 1984 D.C. (unreported).

<sup>49</sup> *R v South Glamorgan Coroner, ex p BP Chemicals Ltd* (1987) 151 J.P. 799, D.C.

<sup>50</sup> The notes to the prescribed form of inquisition recommend that “self-neglect” and “lack of care” be used as a qualification rather than as a separate conclusion. However, these notes to the inquisition have no legal force and it has in recent years been held that the conclusions can be standing on their own, see: *R v Surrey Coroner, ex p. Campbell* [1982] Q.B. 661 D.C.; *R v Southwark Coroner, ex p. Hicks* [1987] 1 W.L.R. 1624, D.C.; *R v Birmingham Coroner, ex p. Home Secretary* (1990) 155 J.P. 107, D.C.; *R v East Berkshire Coroner, ex p. Buckley* (1992) 157 J.P. 425, D.C.

<sup>51</sup> *R v Southwark Coroner, ex p. Hicks* [1987] 1 W.L.R. 1624, D.C.; *R v East Berkshire Coroner, ex p. Buckley* (1992) 157 J.P. 425, D.C.



meant to relate to the physical or mental condition of the deceased,<sup>52</sup> in the circumstances immediately surrounding the death.<sup>53</sup> In line with this, Jervis suggests that should the evidence support the possible conclusion of ‘lack of care’, or another cause aggravated by it, the jury should be directed by the coroner:

- (i) that lack of care refers to “care” in the narrow, physical sense of the word, and has nothing to do with negligence or breach of any duty;
- (ii) that lack of care must be found in the circumstances immediately surrounding the death, and not in general arrangements or more remote events;
- (iii) that for the conclusion to be appropriate some other person had at least the opportunity of rendering care which would have been effective to prevent the death, i.e. there must be a clear causal connection between the lack of care and the cause of death;
- (iv) that the conclusion should be something (usually natural causes) aggravated by lack of care where there is an underlying condition that makes the person dependent on medication or sustenance from others, but that if there is no such underlying condition it should be lack of care standing alone.<sup>54</sup>

Nevertheless, the court acknowledged that there is an obvious danger that such a verdict will conflict or appear to conflict with rule 42 of the Coroners Rules. In order to resolve this conflict the court suggested that the verdict should be careful to refrain from stating that the death was aggravated by the lack of care of any particular person or persons and merely state it was aggravated by lack of care. Thus, no finding that any person owed a duty of care towards the deceased is made, a breach of which would render that person liable for civil or criminal negligence.<sup>55</sup> The court also acknowledged that there is an obvious danger that the overall duty of the coroner in finding out

how the deceased died will be in conflict with rule 42 of the Coroners Rules. It ruled that such a conflict between rule 42 and the statutory duty to inquire “how” must always be resolved in favour of the statutory duty to inquire whatever the consequence may be.<sup>56</sup>

However, even though this may make sense in legal jargon, it is difficult for the family of the deceased or the public to understand, how a verdict of unlawful killing,<sup>57</sup> for instance, does not apportion any blame or criminal liability. Furthermore, it is difficult for the family to understand what the difference between the coronial ‘lack of care’ and the civil ‘negligence’ is. Irrespective of the legal niceties, the key issues for the family are to find out the truth (the stated purpose of the inquest system) and, where appropriate, to see the prosecution of those responsible for the death. Often, these aims conflict. The family will also want an acknowledgement of fault or responsibility where appropriate. They will want this in their own particular case, but they will also want to ensure that justice is seen to be done and that lessons are learnt so that other deaths can be avoided in the future.<sup>58</sup> In practice, families often think that the inquest raised more questions than it answered,<sup>59</sup> and that the remit of the inquest is too narrow, being concerned only with the medical cause of death: the real issues of concern to the family are often not explored.<sup>60</sup>

The privilege against self-incrimination has been described as one of the “basic freedoms secured by English law”<sup>61</sup> It includes the right not to answer questions in civil litigation<sup>62</sup> and in an inquest.<sup>63</sup>

“The right not to incriminate oneself, in particular, presupposes that the prosecution in a criminal case seek to prove their case without resort to evidence obtained through methods of coercion or oppression in defiance of the will of the ‘person charged’.”<sup>64</sup>

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<sup>52</sup> *R v Birmingham Coroner, ex p. Home Secretary* (1990) 155 J.P. 107, D.C.

<sup>53</sup> *R v East Berkshire Coroner, ex p. Buckley* (1992) 157 J.P. 425, D.C.; *R v North Humberside and Scunthorpe Coroner, ex p. Jamieson*.

<sup>54</sup> Matthews, Foreman, *Jervis on Coroners*, 255 at 13–38.

<sup>55</sup> *R v Surrey Coroner, ex p. Campbell* [1982] Q.B. 661, 676; *R v Walthamstow Coroner, ex p. Rubenstein* [1982] Crim.L.R. 509; Matthews, Foreman, *Jervis on Coroners*, 256 at 13–39.

<sup>56</sup> *R v Surrey Coroner, ex p. Campbell* [1982] Q.B. 661, 676; *Re Adam Bithell* (1986) 150 J.P. 273, followed in *ex p. Jamieson*.

<sup>57</sup> Matthews, Foreman, *Jervis on Coroners*, 342 at 13–401 explains that the verdict of unlawful killing does not even name the person unlawfully killed either.

<sup>58</sup> INQUEST, *Submission to UN Committee for the Elimination of Racial Discrimination*, August 2000.

<sup>59</sup> See Inquest Law, issue 1.

<sup>60</sup> See Coles, *Ombudsman: Severin complaint ‘fully justified’*, Inquest Law, issue 2, at p. 1.

<sup>61</sup> *In Re Arouss Ltd (No4)* [1995] 2 AC 75

<sup>62</sup> Section 14(1) of Civil Evidence Act 1968

<sup>63</sup> Rule 22(1), Coroners Rules, 1984, SI 552

<sup>64</sup> *Serves v France* (1997) 28 EHRR 265, para 47. See also *Saunders v UK* (1996) 23 EHRR 313

The privilege can be protected by ensuring that the court or other body with a power to force the answer to questions loses any sanction it may have when the answers will incriminate the speaker. This has been the English way of protecting the right. The European Convention on Human Rights does not necessarily protect the individual from being required to answer questions where this is in the public interest, but it takes the alternative approach of preventing the subsequent use of the answers in a criminal trial.<sup>65</sup> However the Convention will sometimes find a violation of Article 6 at the earlier stage when coercion is being applied solely for the purpose of obtaining evidence for a subsequent conviction.<sup>66</sup> This approach has not been followed by the British courts since the Human Rights Act came into force. In fact the British courts are seemingly at odds with the position now taken in Strasbourg on the protection against self-incrimination more generally.<sup>67</sup>

There are good reasons for arguing that the public interest in obtaining the truth at an inquest is sufficient justification for forcing answers to questions by using the sanction of contempt of court. This is arguably justified even where the answers will force the witness to admit that they have committed offences – provided that these confessions cannot subsequently be used in evidence in any criminal trial. This approach would at least support the rights of the family of the deceased (Article 2) and the fair trial rights of a witness who might in future face prosecution (Article 6).

However, as is generally understood, the inquest is not an adversarial process. There would clearly be a conflict between the inquest and a possible prosecution. It may be justifiable for an employee of the state to be forced to be a witness if this was in the public interest. But there should be a prohibition on the use of any evidence in subsequent criminal proceedings which was given under such compulsion.

The inquest should not be the committal stage of any future criminal prosecution if the inquest is to be effective in its aim to reveal information on the death.

There is no legal reason why new verdicts cannot be given by juries, as the commonly known verdicts are only examples and have no statutory basis.<sup>68</sup> In fact, in line with recent developments under the Human Rights Act, wherever an arguable breach of Articles 2 and/or 3 is revealed a more flexible approach will have to be adopted to the framing of verdicts. This may ensure that the proceedings are more ‘effective’, i.e. capable of leading to the identification of those responsible for the breach of these articles. Furthermore, it would seem obvious that wider and deeper public inquiries into deaths in custody are likely to lead to an improvement in standards and avoidance of further deaths in the future.<sup>69</sup>

#### 4.2.2 Rule 43 of the Coroners Rules

As noted earlier, the rider to a verdict has been abolished. However, in line with rule 43 of the Coroners Rules, the coroner can report the circumstances of a case to the appropriate authority, to ensure that lessons are learnt so that such deaths in future can be prevented or reduced.<sup>70</sup> Given that there are no specific guidelines for the implementation of this rule, practices vary widely among coroners. There is no record kept of rule 43 recommendations made around the country by different coroners or any monitoring or check of whether these are implemented. INQUEST reports that it has often seen coroners make rule 43 recommendations similar or identical to ones made by previous coroners at different inquests. This suggests that lessons are clearly not being learnt. There are some inquests where this rule has been made use of and reports have been made to the authorities.<sup>71</sup> However, more often the family and friends have been the real motor for accountability.<sup>72</sup> There have

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<sup>65</sup> *Saunders v UK*

<sup>66</sup> *Funke v France* [1993] 16 EHRR 297

<sup>67</sup> Compare *Brown v Stott* [2001] 2 WLR 817 with *Heaney and McGuinness v Ireland* [2001] Crim LR 481

<sup>68</sup> Offer, Cockburn, *Inquests into the death of Christopher Walker*, Inquest Law issue 4, at p. 7.

<sup>69</sup> Owen, Friedman, *Inquests and the Human Rights Act - the State's obligation to investigate deaths in custody: a summary of recent developments in the case law*, Inquest Law issue 5, at p. 3.

<sup>70</sup> *R v HM Coroner for Western District of East Sussex ex parte Homborg* [1994] 158 JP 357.

<sup>71</sup> See: Khan, Thomas, *Inquest into the death of Nathan Delahunty*, Inquest Law, issue 2; see also the recommendations made after the Sultan Khan inquest in St Albans which completed on 14 March 2002: the coroner Edward Gordon Thomas concluded that he would write to the Chief Constable making recommendations regarding restraint techniques.

<sup>72</sup> In the case of Nathan Delahunty, it was mainly due to representations by the family that the inquest was re-opened under a different coroner – who then uncovered inconsistencies and made recommendations. It must be borne in mind that the coroner's exercise of rule 43 in the Sultan Khan case was made after the High Court rejected an application on the grounds of the limited scope of verdicts left to the jury by the coroner. In the Alton Manning case, the coroner himself referred the matter to the CPS under rule 28 of the Coroners Rules, see: *Stop Press: Family granted leave for judicial review of decision not to prosecute over death of black prisoner*, Inquest, issue 3.

consistently been calls by families who have been involved in inquests for standard directions and guidelines to assist coroners.<sup>73</sup>

Mechanisms for reporting circumstances and ensuring that lessons are learnt in future have been used far more in Australia (NSW) and Canada (Ontario). There, recommendations are an integral part of the inquest and their implementation is strictly monitored. In Australia, the chief coroner or deputy chief coroner closes the inquest with recommendations. These recommendations are detailed documents, which are available to anyone and are tabled in Parliament, thus exerting pressure for change. Recommendations are also published regularly by the Attorney General's Office.

The fact that recommendations by coroners are on the political agenda ensures that they are monitored and Parliament is under pressure to act on deaths in custody. Furthermore, the electronic database which is currently being set up under the auspices of the Monash University in Melbourne will provide a compilation of all verdicts and recommendations, to be available to every coroner in the State. This will primarily provide standardisation, but it will also be a mechanism to monitor implementation. It may also make the government liable to civil prosecution if a previous recommendation has not been implemented and a death in custody has occurred again under the same circumstances.

In Ontario, the inquest jury gives the verdict and makes recommendations designed to prevent future recurrence. The jury is not led by the coroner. These recommendations are also published centrally. The verdict and recommendations are sent to the parties involved in the specific case. Furthermore, the recommendations are also sent to a list of those who wish to receive them in an effort to keep their procedures up-to-date and to learn from the mistakes of others. The Chief Coroner's Office in Toronto has a designated department that monitors the implementation of the recommendations made. A year

after the recommendations have been sent to the parties involved there will be a letter requesting information on what has been done to implement the recommendations. The Office of the Chief Coroner uses the media to exert pressure on the parties to implement what the jury has suggested.

These experiences demonstrate that the verdict and recommendations can be – and should be – made more use of: they could become a powerful tool for change.<sup>74</sup> These foreign approaches can offer guidance on how this could be done, with the practice in Canada being closer to the current institutional framework in England and Wales.

#### 4.3 The structure of the courts - the jury

Once the coroner has decided that s/he is ready to proceed with a case to be heard with a jury, s/he is obliged to issue a warrant<sup>75</sup> summoning between seven and eleven persons to attend as jurors and inquire into the death. Normally, the coroner's officer will obtain a list from the Crown Court of those persons who are next due to be summoned for jury service there.<sup>76</sup>

However, given that the jurors are chosen in the same manner as the Crown Court jurors, the same practical problems are encountered. There has been considerable criticism recently of the fact that too many people are able to avoid jury service either because of exemptions or because they have been able to persuade the court to excuse them.<sup>77</sup> The consequence is that too many so-called professional and middle-class people are absent from juries, and juries are unrepresentative as a result. Studies have also revealed significant under-representation of women and ethnic minorities on juries. Proposals to reduce substantially the numbers of people able to avoid jury service are likely to be agreed by Parliament in 2003.<sup>78</sup>

There is a real possibility of racial bias among a non-representative jury. Given that deaths in custody are characterised by a considerably higher number of non-

<sup>73</sup> See *Divisional Court quashes Brett Hay Inquisition – R v HM Coroner for Lincolnshire (Lincoln District) ex parte Mrs Annette Hay*, in *Inquest Law* issue 2; also: Cragg, *Review: Practice Notes for Coroners – adopted by the Coroner's Society and released February 1999*, in *Inquest Law* issue 3.

<sup>74</sup> Although the Brodrick report argues to the contrary, at paras 16.51-16.56.

<sup>75</sup> See section 8(2), Form 3 of Schedule 4 of the Coroners Rules.

<sup>76</sup> Dorries, *Coroners' Courts – a guide to law and practice*, at 8-13.

<sup>77</sup> See Sir Robin Auld, *Review of the Criminal Courts in England and Wales*, September 1991.

<sup>78</sup> Baldwin, McConville, *Jury Trials*, at 98; Zander, *Cases and Materials on the English Legal System*, at 415-417; Lloyd-Bostock, Thomas, *Decline of the 'Little Parliament: Juries and Jury Reform in England and Wales*, in Vidmar, *World Jury Systems*, at 69; See also Criminal Justice Bill, published November 2002.

white suspects/prisoners, this is cause for concern.<sup>79</sup>

According to section 8(2) of the Coroners Rules between seven and eleven jurors must be assembled and sworn in. As outlined in the previous section, it is the role of the jury to listen to the evidence, ask appropriate questions if they wish and then reach a verdict based upon the evidence. The coroner will assist the jury by asking questions of the witnesses. The coroner will control the proceedings, sum up the evidence for the jury and direct them as to the relevant law.<sup>80</sup>

In practice, this division of labour puts a lot more power into the hands of the coroner than the jury. Usually the coroner will explain the purpose of the inquest to the jurors, outline their role and explain what they have to decide. The jury is allowed to ask questions only once the coroner and any properly interested persons have done so, and no-one is allowed to address the jury as to the facts of the case.<sup>81</sup> It is the coroner who sums up the evidence for the jury,<sup>82</sup> and it is the coroner who sets down the verdicts for the jury to consider. Lastly, the coroner will direct the jury on the standard of proof. The jury will have to understand the difference between the criminal standard of proof – beyond reasonable doubt, and the civil standard of proof – on the balance of probabilities.

The problem with this division of power is that the jury can be led towards a certain verdict. Summing up by judges has been criticised because of the ‘pre-digestion’ of the evidence – designed in order to save the jury considering ‘irrelevant’ information. Even where judges intend to limit themselves to marshalling the facts in order to provide an agenda for the jury to follow, there is still the danger that subtle and unrecorded body language can influence the jury.<sup>83</sup>

By limiting even the kind of verdicts to be considered by the jury, the coroner is clearly able to lead the jury into a specific direction. Admittedly the jury is not trained in

the complex issues of law, especially the difference between the criminal and the civil standard of proof, and the difference between neglect and negligence. However, too much power in the hands of the coroner, especially in the light of the lack of guidelines for coroners, can jeopardise objectivity.<sup>84</sup>

Some people have questioned the benefits of a jury. It is argued that the jury puts a considerable financial strain on the inquest system. Furthermore, given the dominant role of the coroner in the direction on the verdict and in the discretion and setting of recommendations, the responsibility of the jury is minimal. However, the jury can ensure more openness in the inquest system, a regular form of public scrutiny, and a potential security against bias. It can ensure that the law is a law of the people and not of a professional elite. It would not be in the interest of the inquest system if the general trend of eroding jury trial resulted in similar reforms to the coronial system.

The experience in Ontario may offer a compromise between the abolition and retention of the jury. In Ontario, every inquest has a jury. Furthermore, the jury has considerably more power. It can ask questions and cross-examine witnesses. It delivers the verdict without needing too much help from the coroner and it regularly makes recommendations that are published, filed, and monitored rigorously. Overall, the jury is a far more independent part of the inquest proceedings and has more scope to contribute to the case. This practice in Ontario has not resulted in any substantial problems with the jury struggling with complex issues of the law or differences in civil and criminal standards of proof.

#### 4.4 Disclosure (transparency)<sup>85</sup>

In any adversarial setting in the UK, the parties to the proceedings have disclosure duties that are regulated by the court – and the court can adjudicate where one party considers that another party to the litigation has failed in

<sup>79</sup> Johnson, *Black Innocence and the White Jury*, 83 Michigan Law Review, at 1625; *Sander v UK* case 34129/96, judgment of the European Court of Human Rights, 9 May 2000.

<sup>80</sup> Dorries, *Coroners' Courts – a guide to law and practice*, at 8-17.

<sup>81</sup> Rule 40 of the Coroners Rules.

<sup>82</sup> Rule 41 of the Coroners Rules.

<sup>83</sup> Wochover, *Should Judges Sum up on the Facts?*, (1989) *Crim.L.R.*, at 784; Derbyshire, *What Can the English Legal System Learn From Jury Research published up to 2001*, p. 38.

<sup>84</sup> See for instance *R v HM Coroner for Swansea and Gower ex parte Tristram* (CO/1432/98), where the coroner failed to direct the jury on causation and therefore the verdict could not stand. The court held that public interest requires that a death in custody should be fully and properly investigated where there may be neglect by the authorities, therefore a fresh inquest should be held; see: Offer, Cockburn, *Divisional Court sets out level of fault for Neglect verdicts*, in *Inquest Law*, issue 4, at p. 3.

<sup>85</sup> Special thanks must go to Daniel Machover, of Hickman and Rose, for his valuable contribution to this subsection.

their duty to provide adequate disclosure. Thus, in civil litigation, rules as to 'standard disclosure' of documents relevant to the case have developed, to ensure that parties to litigation are not disadvantaged by lack of access to relevant documents. Part of the rationale for these rules is, of course, to ensure that the parties and subsequently the courts see (and can evaluate the evidential weight and relevance of) documents to enable justice to be administered fairly between the parties to litigation. An adjunct to these disclosure duties is the right to apply to the court for orders for specific disclosure and for those who are not party to the litigation to provide disclosure where they hold relevant material which the court requires to enable justice to be fairly administered.<sup>86</sup>

However, the above rules do not apply to the inquisitorial process of inquests. There are in law no parties, as such, and no 'issues' to be litigated. Further, coroners do not have any obvious statutory powers to order the interested parties (or non-parties) to provide pre-inquest disclosure to each other (or the coroner). Documentary evidence received in evidence at inquests is disclosed to interested parties under rule 37 of the Coroners Rules 1984, but not in advance of the proceedings. Indeed, there is no general duty under the rules for coroners to give advance disclosure to interested parties of documents held by the coroner.

New South Wales (Australia) and Ontario (Canada) both have a duty to provide full disclosure at least four weeks before an inquest commences. In Ontario, the police documents cannot be disclosed because, as in England and Wales, it is argued that these documents are the property of the police. Nevertheless, essential parts of the police report are included in the coroner's brief, which is disclosed to the family. This is more open than the current practice in England and Wales. In practice it has become increasingly common in England and Wales to disclose post-mortem reports before the inquest. However with regard to other documentation, such as witness statements and police reports, this has not been the case.<sup>87</sup> The courts have established that no interested person can require the coroners to produce documents that have been disclosed to him in confidence.<sup>88</sup> It is also argued that the evidence

handed to the coroner by the police, such as witness statements, is the property of the police. This practice has created suspicion among the family members of the deceased. There have been prolonged battles for more transparency over a number of years.<sup>89</sup>

In recent years, the common law duty of coroners to provide advance disclosure (to meet their duty 'to conduct the inquest in a fair manner') has developed. This was set out by Mr Justice Sullivan in his judgment of 2 March 2001 in the case of *R (on the application of Bentley) v HM Coroner District of Avon*:<sup>90</sup>

62. ...Whilst it is true that an inquest is an inquisitorial, and not an adversarial procedure, the Rules clearly envisage that persons falling within rule 20(2) [interested parties] have a role to play in the investigation. They are entitled to examine witnesses, subject to the coroner's right to disallow irrelevant or improper questions.
63. The [interested party's] request for advance disclosure was, on the face of it, a perfectly reasonable one. Certainly, no reason has been advanced by the Coroner as to why it should have been refused. The fact that the Rules do not require advance disclosure is not a sufficient answer. There is an overriding obligation to conduct the inquest in a fair manner. The requirements of natural justice, or fairness, are not immutable. What was considered a fair procedure 20 years ago may well be regarded as unfair by today's standards. By way of example, the view that fairness very often requires the giving of reasons for a decision has been steadily gaining ground over recent years.
64. The Coroner had a discretion to permit advance disclosure of, for example, the post-mortem report and the toxicological results. He had to exercise that discretion fairly, with a view to furthering the purpose of the inquest: ...bearing in mind the claimant's entitlement to participate in the investigation under rule 20. It is difficult to see how the claimant could effectively exercise his rights

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<sup>86</sup> Non-party disclosure, Civil Procedure Rules, Rule 31.17.

<sup>87</sup> Dorries, *Coroners' Courts – a guide to law and practice*, p. 126 at 6.13.

<sup>88</sup> *R v Hammersmith Coroner ex parte Peach* [1980] 2 WLR 496, 502-505; *R v Southwark Coroner ex parte Hicks* [1987] 2 All ER 140.

<sup>89</sup> For more detail, see the struggle to obtain documents in the case of Roger Sylvester, and the pre-inquest hearing by St Pancras coroners on disclosure (25 January 2002).

<sup>90</sup> [2001] EWHC ADMIN 170



under rule 20 if he was kept in complete ignorance of the most basic facts until the commencement of the inquest.

65. The proposition that a person will not be able to participate in proceedings in an effective way in the absence of advanced disclosure is increasingly recognised: see, for example, the changes made by the Civil Procedure Rules in ordinary civil litigation, the provisions of the most recent Town and Country Planning Inquiry Procedure Rules as an example of the way in which disclosure is dealt with in the field of Administrative Tribunals and Inquiries, and the provisions for greatly increased disclosure in criminal proceedings.

66. *In R v Criminal Injuries Compensation Board, ex parte Leatherland and others* (unreported, transcript dated 2nd July 2000), Turner J said this of the Board's long standing policy of refusing to disclose to the claimants in advance of the hearing witness statements made by the police and available to the Board:

*“Any practice which leads to the withholding of material until the day of any judicial or quasi-judicial hearing is calculated to be to the significant disadvantage of the party from whom they have been withheld ... The argument that any injustice can be cured by the grant of an adjournment is nothing to the point. An adjournment may, or may not be granted, and even if granted will involve a represented appellant in extra costs and delay before final resolution of his appeal ... When the straightforward step can be taken of making available to a party to the appeal material which, it is conceded, he will be entitled to receive in any event, it makes no sense at all to say that he must wait and take his chance with obtaining an adjournment of his appeal from the Panel.”*

67. Under the Rules, if documentary evidence is proposed to be admitted at an inquest, persons falling within rule 20(2) will become entitled to see a copy by virtue of rule 37(3(d)). Without advance disclosure they may be placed at a significant disadvantage. In my judgment, the need for advance disclosure is not answered by the proposition that an inquest is an inquisitorial procedure. As mentioned above, persons

falling within rule 20 have a role to play in the procedure. The requirements of fairness should reflect that role. It may well mean that in some cases there is less need for advance disclosure, or that advance disclosure need not be so extensive. But it does not follow that there is no need, in the interests of fairness, for any advance disclosure, particularly if the Coroner intends to rely on documentary evidence alone.

...

72. In the present case, the claimant's request was supported by reasons which have not been gainsaid by any explanation from the Coroner, whether before, during or after the inquest. In the circumstances, I think it proper to draw the inference that there was no good reason for refusing the claimant's request: see the authorities discussed in paragraph 9-056 of *De Smith Woolf & Jowells: Judicial Review of Administrative Action*. There was unfairness because the refusal of any advance disclosure (even of the post-mortem report) meant that the claimant would inevitably be disadvantaged in seeking to participate in the inquest as he was entitled to do under rule 20.

Family members can usually obtain access to relevant documents and items that existed before someone's death (e.g. their medical records, records held by state agencies, the deceased's private documents and belongings etc.). However, as Mr Justice Sullivan and others have recognised, to participate meaningfully at the inquest, families need advance disclosure of the post-mortem reports and the results of tests carried out after death, and copies of all the statements obtained from witnesses as part of internal investigations (e.g. by NHS Trusts or the Prison Service) and police inquiries into the death.

Lawyers acting for bereaved families have not had too much difficulty in obtaining post-mortem reports in advance under Rule 57(1) of the Coroners Rules 1984. However, historically, bereaved families did encounter legal and practical problems in obtaining custody records and forms completed under internal procedures, as well as the internal investigations of state bodies.

Since about 1997 these classes of documents have been more freely available to bereaved families in advance of



inquests. The Prison Service and other agencies now regularly provide voluntary pre-inquest disclosure to bereaved families well in advance of the hearing.

Difficult legal and practical problems continue to arise in relation to two areas. Firstly, the ownership of witness statements (and other documents) provided to the coroner by the police for the purposes of being received in evidence at the inquest.<sup>91</sup> Secondly, the powers (and duties) of the coroner to disclose these documents to the 'interested parties', notwithstanding the judgment of Mr Justice Sullivan in the Bentley case.<sup>92</sup>

The relevance of 'ownership' becomes clearer when one appreciates that the coroner does not have his or her own investigation team. Rather, the coroner's officer will usually liaise on behalf of the coroner with the local police, who will gather the evidence following the death.<sup>93</sup> If the evidence is gathered as part of a criminal investigation then the coroner will have very little input into how or what evidence is collected. If there is no criminal investigation, the coroner might direct the police as to who s/he wants to have interviewed and the evidence s/he is seeking to facilitate the inquiry into the death in question. In either case, the statements remain 'the property' of (i.e. owned by) the police force that has collected them.

A further, rather curious, twist to this question of ownership arises in cases where a death in police custody is, for the sake of transparency and to bring about a semblance of independence, carried out by officers from another police force (under the supervision of the Police Complaints Authority). Here, despite the fact that officers from an outside force have gathered the statements, the force under investigation owns them. This is because the force under investigation has to finance the work of the police officers from the outside force.

The documents that bereaved families most want to see before an inquest are therefore statements that are owned by the police force that investigated the death. The coroner has no power, as such, to disclose those statements. In *R v*

*HM Coroner at Hammersmith, ex parte Peach*,<sup>94</sup> the Divisional Court rejected a submission that denial of witness statement in advance of an inquest was a breach of natural justice:<sup>95</sup>

“It is important, I think, to stress that, as far as I know, there never has been a case in which natural justice was invoked through the denial of documents except when the person to whom the documents had been denied was a person against whom some charge was being made. It is elementary that, if a charge is being made against a person, he must be given a fair chance of meeting it. That often means he must be given documents necessary for the purpose. But there is no charge here being made against Mr Peach, the applicant, and to my mind, try as he will, he fails to get himself in through any of these doors.”

On appeal the challenge to the refusal to provide witness statements in advance of the inquest was not pursued, so the Court of Appeal did not have to consider whether natural justice might require prior disclosure. In *R v HM Coroner for Lincoln, ex parte Hay*,<sup>96</sup> complaint had been made of failure to disclose statements taken by the police, and a witness list. The court in that case concluded:

“In our judgment the decision of this court in *ex p Peach* on the non-disclosure of statements taken by the police still represents authority which this court should follow.”

This outcome becomes particularly contentious where the death in question occurred in police custody. By the late 1990s, the Home Office recognised that it had to address this problem, not least because bereaved families were naturally aggrieved at learning of key evidence about the death of their loved ones for the first time at the inquest itself, despite the fact that the police and coroner had known of this evidence months (and sometimes years) in advance of the hearing. This sense of grievance was most acute in cases where families only realised at the inquest itself that (a) certain lines of inquiry had not been followed

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<sup>91</sup> Machover, *Inquest into the death of Glenn Howard*, in *Inquest Law*, issue 4, p. 4 states that the Metropolitan Police were particularly obstructive in the run up to the inquest. There had been a considerable delay to disclosure and the police continued to withhold disciplinary records and all internal documentation.

<sup>92</sup> *Op. Cit.*

<sup>93</sup> For more detail, see earlier subsection.

<sup>94</sup> [1980] QB 211

<sup>95</sup> *ibid.*, Lord Widgery CJ at page 219.

<sup>96</sup> 19 February 1999.

up, and/or (b) had they known what was in the statements they could have prepared for the inquest differently, e.g. focused on relevant issues for their questions of the witnesses or gone about gathering other relevant evidence themselves.

The response of the Home Office was to establish a working group that produced a voluntary code of disclosure in 1999.<sup>97</sup> Under the circular, police forces are encouraged to provide disclosure ‘in any case not less than 28 days before the date of the inquest proceedings’.<sup>98</sup> However, bereaved families in these cases continue to experience practical problems, particularly in cases involving large-scale disclosure where proper preparation of the inquest requires much earlier access to these documents.

The absence of a clear legal duty is demonstrated by the difficulty securing pre-inquest disclosure in the Glenn Howard case.<sup>99</sup> Despite the HO Circular, relevant information was withheld. A stronger, statutory obligation would lead to standardised practices and would create more confidence in the system. It is argued that there is a conflict between the need for early disclosure and the rights of the police officers who may be subject to prosecution or disciplinary action.<sup>100</sup> It is also suggested that disclosure of some documents will allow witnesses to alter their evidence and may make it more difficult to prosecute or discipline police officers or others responsible for the death. However, whilst these possibilities cannot be ruled out completely, there is little evidence that this has happened frequently. There are already sufficient controls to protect against police officers and witnesses who are willing to change their stories.

It is also possible for a witness to refuse to answer questions or produce documents on the grounds that the

“public interest” prevents him or her from doing so.<sup>101</sup> The principle is:<sup>102</sup>

“...courts have and are entitled to exercise a power and duty to hold a balance between the public interest, as expressed by a minister, to withhold certain documents or other evidence, and the public interest in ensuring the proper administration of justice.”

The scope of this immunity is understood to include non-disclosure of information relating to national security,<sup>103</sup> or the formation of government policy at high level,<sup>104</sup> and documents arising from police disciplinary proceedings.<sup>105 106</sup> Nevertheless, this “public interest immunity” is subject to increasing challenge and it cannot be used, for instance, to prevent disclosure in respect of witness statements obtained during an investigation into the death of a demonstrator alleged to have been struck by a police officer.<sup>107</sup>

In practice, concern has been voiced that the disclosure of investigating officers’ notes and police officers’ pocket books would jeopardise the quality of investigation, since the police would refrain from adding comments, interpretations and recommendations for improvement.<sup>108</sup> The PCA, in its guidelines on disclosure, advises in cases where investigation is concerned with potential criminal liability that all the material obtained must be considered confidential. The principle is that documentary information, witness evidence and answers given to questions during interview have been supplied in confidence.<sup>109</sup> However, the Home Office is taking a slightly wider approach to this. It states that it will very rarely happen that the disclosure of certain material will have an impact on possible subsequent proceedings, whether criminal, civil or disciplinary. And where this does happen, it should be discussed with the Crown Prosecution

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<sup>97</sup> Home Office Circular 20/1999.

<sup>98</sup> Para 17 of the Circular.

<sup>99</sup> Machover, *Inquest into the death of Glenn Howard*, in *Inquest Law*, issue 4, p. 4 states that the Metropolitan Police were particularly obstructive in the run-up to the inquest. There had been a considerable delay to disclosure and the police continued to withhold disciplinary records and all internal documentation.

<sup>100</sup> HO Circular 20/1999: Guidance to the Police on Pre-Inquest Disclosure: Key Issues Emerging from the Review.

<sup>101</sup> See Matthews, Foreman, *Jervis on coroners*, p. 234 at 12-142.

<sup>102</sup> *Conway v Rimmer* [1968] A.C. 910, 952, per Lord Reid.

<sup>103</sup> *Asiatic Petroleum Co. Ltd. V Anglo-Persian Oil Co. Ltd.* [1916] 1 K.B. 822, C.A.; *Ducan Campbell Laird & Co. Ltd* [1942] A.C. 624, H.L.

<sup>104</sup> *Burmah Oil Co. Ltd. v Bank of England* [1980] A.C. 1090, H.L.; *Air Canada v Secretary of State for Trade* (No.2) [1083] 2 A.C. 394, H.L.

<sup>105</sup> *Makanjuola v Metropolitan Police Commissioner* [1992] 3 All E.R. 617, C.A.

<sup>106</sup> For more detail, see Matthews, Foreman, *Jervis on Coroners*, p. 235 at 12-143.

<sup>107</sup> *Peach v Metropolitan Police Commissioner* [1986] Q.B. 1064, C.A.; *Cf Neilson v Laugharne* [1981] Q.B. 736, C.A.

<sup>108</sup> Guidance to the Police on Pre-Inquest Disclosure, *Deaths in Police Custody*, at para. 11.

<sup>109</sup> Police Complaints Authority, *Disclosure during supervised investigations in cases of grave public or family concern*, at para. 4.4.

Service. The public interest would only justify withholding of documents where there was a genuine risk (not simply a remote possibility) that disclosure would have a prejudicial effect.<sup>110</sup> However the identity of police and other informers may need to be protected in order to encourage them to come forward.<sup>111</sup>

From the perspective of the family, any form of non-disclosure will raise suspicion, especially when it involves documentation created and held by the police.<sup>112</sup> Indeed, it is the experience of many families that investigations are ‘conducted for the convenience of the authorities and do not play any part in revealing the true circumstances’.<sup>113</sup> The PCA acknowledges that even though there may be a presumption that evidence and factual information is and should remain confidential during the investigation process, a number of other arguments point in the opposite direction. Disclosure may aid the investigation – given that it encourages witnesses to co-operate, it increases the trust of the family, and it allows for the demonstration of progress.<sup>114</sup> Pre-inquest disclosure must therefore balance the rights of the officers involved and the family carefully so as to achieve a maximum of effectiveness for the inquiry and a maximum of trust from relatives of the deceased. In the vast majority of cases this will mean virtually complete disclosure as there will be few cases in which disclosure will need to be withheld.

#### 4.5 Delays (effectiveness/efficiency)

##### 4.5.1 The inquest proceedings

There is currently no statutory provision setting deadlines for the final disposal of cases before coroners or for how far in advance the (voluntary) disclosure of documents should take place. Nevertheless, much of the dissatisfaction of family members involved in inquests

stems from the fact that these inquiries are stretched over an extended period of time.<sup>115</sup> Finding out how someone has died is an essential part of the bereavement process and of coming to terms with the death. Families are motivated by a need to establish the truth for their own peace of mind, and to prevent others going through the same experience.<sup>116</sup> These aims are severely hampered by a slow inquest process. Numerous cases demonstrate this.

On average, inquest proceedings for death in custody cases start about 1–1.5 years after a death in custody.<sup>117</sup> This is a long period for a family that has turned to law looking for the truth. Nevertheless, the inquest procedure can be delayed still further if the inquest is quashed or subject to judicial review. In such cases, the High Court can order a new inquest and can review all actions and decisions of the coroner, not merely the inquisition.<sup>118</sup> For instance, if the coroner excludes relevant verdicts from the jury’s consideration, this may be subject to review by the High Court.

*In the case of Keita Craig, who died on 1 February 2000, the coroner during the first inquest (13/14 April 2000), did not allow the jury to consider a verdict incorporating neglect, even though he made recommendations that reflected his concern about the care and treatment of Keita Craig. On 13 February 2001 the High Court quashed the verdict and ordered a new inquest with a fresh jury. The second inquest was held on 3 October 2001.<sup>1</sup>*

*In the case of John Sambells, who died on 29 January 1998, the first inquest was held from 25-27 November 1998. However, the belated disclosure of video evidence to the family led to the judicial review of the first inquest. It was the decision of the coroner not to introduce the video evidence. This led to the quashing by the High Court of the original verdict and a fresh inquest before a different coroner. The second inquest in that case took place from 23-25 May 2001.*

<sup>110</sup> HO Guidance to the Police on Pre-Inquest Disclosure, Deaths in Police Custody, at para. 9(i).

<sup>111</sup> *Rogers v Home Secretary* [1973] A.C. 388, H.L.; *D v NSPCC* [1978] A.C. 171, H.L.; *Continental Reinsurance v Pine Top Insurance* [1986] 1.

<sup>112</sup> Munyard, “No Prospect of Legal Aid for Inquest Representation”, Inquest Law, issue 1.

<sup>113</sup> Shaw, PCA: *Relatives ‘too emotional’ for Deaths in Custody Conference*, in Inquest Law, issue 1.

<sup>114</sup> PCA, *Disclosure during supervised investigations in cases of grave public or family concern*, at 3.1, p. 9.

<sup>115</sup> A list of cases will be examined later in this section.

<sup>116</sup> INQUEST, *Submission to UN Committee for the Elimination of Racial Discrimination*, August 2000, at p. 4.

<sup>117</sup> See, for instance, the cases of Rocky Bennett, Glenn Howard, Sultan Khan, and Asif Dad. **Rocky Bennett** died on 31 October 1998 following the use of restraint in the Norvic clinic, an NHS medium secure unit. The Inquest verdict of accidental death aggravated by neglect was returned on 17 May 2001. Glenn Howard had been subject to section 3 of the Mental Health Act 1983; police officers had been requested by NHS staff to visit his address for the purposes of returning him to hospital under section 18 of the Mental Health Act. On the evening of 10 December 1997 he was reported missing; identified and restrained by police officers near his home, he was taken to Sutton police station and after it appeared that he was not well he was taken to St Helier hospital. Glenn was unconscious and remained on the ventilator until his death on 1 January 1999; the inquest started on 15 May 2000 and the jury returned a verdict of accidental death. **Sultan Khan** died in January 2000 after a police restraint and the intake of class A drugs. The inquest commenced in November 2001, and a verdict of accidental death was delivered in March 2002. **Asif Dad** died in January 2001 after police restraint while under the influence of class A drugs. The inquest was held in January 2002 and the verdict of accidental death was delivered in January 2002.

<sup>118</sup> For more detail on the quashing of decisions or judicial review, see the next sub-section.

*Brett Hay* died in prison on 8 July 1996 of diabetic ketoacidosis (which occurs when the blood sugar level becomes too high). During the inquest the coroner refused to disclose the list of witnesses, and the witness statements. He also refused to allow cross-examination of the prison doctor and refused to hear evidence from two inmates on the hospital wing. The coroner advised the jury that a verdict of accidental death was not available. In January 1999 the Divisional Court quashed the inquisition and ordered that a fresh inquest be held by a different coroner.

#### 4.5.2 The subsequent prosecution

One of the most fundamental problems with the whole process is the absence of sanctions for those responsible for deaths in custody, where applicable. Many families struggle to obtain good lawyers, proper disclosure and a sympathetic coroner but even when the inquest jury has made a finding of unlawful killing the difficulties continue. If the CPS then decides not to prosecute officers involved, the families of those who have died at the hands of the State are likely to be justifiably angry and confused – the death has been found by a ‘court’ to have been unlawfully caused but there is no criminal prosecution. The failure of the CPS to prosecute prison and police officers involved in such deaths, even when there is an inquest verdict of unlawful killing, has done little to reduce levels of mistrust.<sup>119</sup>

There have been several cases where an unlawful killing verdict did not result in the prosecution of those responsible, e.g. Alton Manning, Richard O’Brien, and Shiji Lapite.

*Alton Manning* died after restraint in Blakenhurst prison in 1995. After the inquest the jury brought forward a verdict of unlawful killing. In February 1999 the CPS announced its decision not to prosecute.

*Richard O’Brien* was arrested outside a pub in South London on 3 April 1994 after a disturbance broke out. His body was apparently lifeless by the time police officers placed him inside the van. He was transferred to King’s College Hospital where he was pronounced dead on arrival. After the CPS decided not to prosecute, the inquest commenced and the jury delivered a verdict of unlawful killing. The coroner referred the case back to the CPS for further consideration but this has not resulted in a prosecution.

In the case of *Shiji Lapite* the jury also brought back a verdict of unlawful killing, after the inquest heard evidence that he died from asphyxia from compression on the neck consistent with the application of a neckhold. In the light of the jury’s verdict, the coroner referred the case to the CPS, to consider the possibility of manslaughter charges against the two officers involved. The CPS decided not to prosecute.

Family members of Richard O’Brien and Shiji Lapite brought a joint application for judicial review, which came before the Divisional Court on 22 July 1997. As a result, all cases were sent back to the CPS for further consideration. The Attorney General appointed Gerald Butler QC to conduct a judicial inquiry. Subsequently, in the Richard O’Brien case three officers were charged with manslaughter, but all were acquitted in 29 July 1999 – more than five years after the death.

In the case of Alton Manning, the decision by the CPS not to prosecute any of the prison officers involved in this restraint-related death was challenged successfully by the family in the High Court in May 2000. The Lord Chief Justice decided:

“Where an inquest [into a death]...culminates in a lawful verdict of unlawful killing implicating [an identifiable individual] the ordinary expectation would naturally be that a prosecution would follow”.

However, in January 2002 the CPS for the second time did not bring criminal charges against any of the prison officers involved.

*Christopher Alder*, a 37-year-old black man, died on 1 April 1998 after being arrested and taken to a police station in a police van. Upon arrival, he was found motionless in the van. Video evidence showed that he was left unconscious, face down on the floor in the custody suite, until an ambulance arrived. Despite resuscitation attempts, he died.

In August 1999, the CPS announced the names of five police officers to be charged. They were suspended awaiting trial. In August 2000 the jury returned a verdict of unlawful killing following six weeks of evidence. Following the inquest, in June 2002, a prosecution on charges of manslaughter and misfeasance in public office collapsed because of conflicting evidence. The officers were acquitted.

<sup>119</sup> For more detail, see INQUEST, *Submission to UN Committee for the Elimination of Racial Discrimination*, August 2000.

These substantial delays, as well as the discrepancy between the findings of the inquest jury and the criminal justice system, disrupt the grieving process of the family. There is a need to shorten the period before the family can find out the truth and can also be provided with a just remedy. Once again, Australia (Victoria) and Canada (Ontario) may offer some valuable experiences. In Victoria, the coroners, pathologists, police, and a research element (from Monash University) are housed in one building. This practice eliminates the time spent on communications over long distances, liaison through letters, telephone and IT. Furthermore, as has been shown earlier, there is only one post-mortem at which all parties are present. Of course such co-location creates difficulties with independence. However the creation of the IPCC might provide the basis for similar models that might preserve independence but benefit from speed and efficiency.

In Ontario there is again only one post-mortem. There are also several more measures geared towards speeding up the process. As mentioned earlier, all the coroners are medical doctors and attend the scene personally to collect evidence. They also have the authority and training to determine whether, and what kind of post-mortem is appropriate. Every coroner has legal Counsel during the inquest. Lastly, the preceding SIU investigation has a strict time limit during which it has to complete its criminal investigation. The set target is that the SIU closes its case 30 days or less after the incident has been reported.<sup>120</sup>

#### 4.6 Funding for legal work at inquest proceedings

The absence of automatic non-means-related funding for the representation of families at inquests has posed a real problem for families of the deceased.<sup>121</sup> Since 1999 however,<sup>122</sup> it has been possible to secure public funding under the Access to Justice Act.<sup>123</sup> The Legal Services

Commission will fund representation, and some preparation work, if there are exceptional circumstances. Three such exceptional circumstances are: (1) that the case involves a significant public interest, (2) that the case provides an overwhelming importance to the client, or (3) where the withholding of legal aid would make the assertion of a civil claim practically impossible, or where it would lead to an obvious unfairness of the proceedings in breach of ECHR Article 2.<sup>124</sup>

The criteria for ‘overwhelming importance to the client’ ensure that only a very small number of cases receive public funding.<sup>125</sup> Significant ‘public interest’, where the proceedings have the potential to produce real benefits for individuals other than the client, is a more frequently relevant ground on which to apply for funding. Nevertheless, despite the codified criteria under which public funding can be applied for, considerable numbers of bereaved families in practice fund their own representation at inquests into deaths in custody. It is the experience of those representing families<sup>126</sup> that those with limited financial means are too often required to fund their own involvement in controversial inquests. This is a problem in need of urgent remedy.

#### 4.7 Judicial Review – scrutiny by the courts

There is no such thing as an appeal against a decision of the coroner, either with regard to his/her interlocutory decisions on procedure at the inquest or the verdict itself. This means there is no rehearing on the merits.

However, decisions are subject, in some cases, to review by the courts. There are two kinds of review by the courts. Firstly, there is the statutory procedure under section 13 of the Coroners Act.<sup>127</sup> The exercise of the power to quash depends on the view of the High Court as to whether it is

<sup>120</sup> SIU Special Investigations Unit Annual Report 2001-2002, at p. 16.

<sup>121</sup> For more detail, see Thomas, Friedman, Christian, *Inquests – a practitioner's guide*, pp. 119- 129.

<sup>122</sup> See recommendation 43 of the Macpherson report, of the Stephen Lawrence Inquiry, Cm 4262-I, TSO, 1999.

<sup>123</sup> Section 6(8) of the Access to Justice Act, 1999.

<sup>124</sup> For more detail see the Lord Chancellor's guidance; the third ground on which exceptional funding can be granted was added to the revised guidance in November 2001.

<sup>125</sup> ‘Overwhelming importance to the client’ is defined as: [A case which has exceptional importance to the client beyond monetary value (if any) of the claim because the case concerns life, liberty or physical safety of the client or his/her family or a roof over their heads], see Thomas, Friedman, Christian, *op. cit.*, p. 125.

<sup>126</sup> For more detail, see Thomas, Friedman, Christian, *op. cit.*, at pp. 128-129.

<sup>127</sup> See section 13 of the Coroners Act 1988, re-enacting section 6 of the Coroners Act 1887 (as extended by section 19 of the Coroners (Amendment) Act 1926):

- (1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner (“the coroner concerned”) either-
  - (a) that he refuses or neglects to hold an inquest which ought to be held; or
  - (b) where an inquest has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interest of justice that another inquest should be held.



“necessary or desirable in the interests of justice” to hold a new inquest. Thus, if the conduct of the inquest creates a real risk that justice has not been done or has not been seen to be done, the court ought not to allow the inquisition to stand.<sup>128</sup>

The second option for someone dissatisfied with an inquest is to apply for judicial review.<sup>129</sup> The remedies available on judicial review includes certiorari,<sup>130</sup> mandamus,<sup>131</sup> prohibition,<sup>132</sup> declaration,<sup>133</sup> injunction, and damages.<sup>134</sup> An error of law within the coroner’s jurisdiction can be reviewed<sup>135</sup> and an inquisition can be quashed.<sup>136</sup> However, the reviewing court (the High Court) does not quash the decision just because the court might have decided it differently, and it does not substitute its own decision for that of the coroner. It is a question of error in the decision-making process, rather than in the decision itself, which the court is concerned with. If no clear error of law can be pointed to, but the decision is unsatisfactory overall, the applicant should proceed under the statutory power to quash, and not by way of judicial review.<sup>137</sup> Where the court considers that relief should be given, the primary remedy is an order quashing the inquisition, with a further order that a fresh inquest be held. The flexibility of judicial review, as compared with the statutory remedy discussed before, means that the court may grant relief that falls short of quashing the whole inquisition and ordering a new inquest (the only remedy under section 13 of the Coroners Act).<sup>138</sup> However, where the inquisition is quashed (under the statutory power or as

a result of judicial review), the usual consequence is that a fresh inquest is ordered.<sup>139</sup>

*In the cases of Keita Craig and John Sambells, the High Court quashed the inquisition and ordered a new inquest to be held before a new coroner and a new jury. In the Keita Craig case, the verdicts open to the jury by the coroner were expanded and in the case of John Sambells video evidence was disclosed to the jury. In the Sambells case, the family had seen the video after the first inquest but well before the High Court quashed the first verdict and ordered a new inquest. Thus the review is a form of check on the inquest system – and, given the discrepancies in the practices of coroners, a necessary check.*

However there is no form of control over the power of coroners to make recommendations for change under rule 43, to prevent recurrence in the future. Nor is there any effective mechanism to promote their adoption in practice: such recommendations are neither made public nor are they collected centrally, indeed they are not even passed on to other coroners. There is no mechanism to follow up on these recommendations made, in order to see whether the recommendation has any impact in practice and whether changes have come about. And lastly, there are discrepancies as to how coroners make use of rule 43 and due to the lack of control, there is no means to curtail such discrepancies.<sup>140</sup> What is needed is a strict monitoring of recommendations by the coroner made under rule 43, similar to that under the political process in New South Wales or the Chief Coroner’s Office in Ontario.

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127 cont’d

- (2) The High Court may–
  - (a) order an inquest or, as the case may be, another inquest to be held into the death either–
    - (i) by the coroner concerned; or
    - (ii) by the coroner for another district in the same administrative area;
  - (b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and
  - (c) where an inquest has been held, quash the inquisition on that inquest.
- (3) In relation to an inquest held under subsection (2)(a)(ii) above, the coroner by whom it is held shall be treated for the purposes of this Act as if he were the coroner for the district of the coroner concerned.
- (4) ...

<sup>128</sup> *R v Divine, ex parte Walton* [1930] 2 K.B. 29, 378, applied in *R v South London Coroner, ex parte Thompson*, *The Times*, July 9, 1982, D.C.

<sup>129</sup> Since 1977, R.S.C., Ord. 53.

<sup>130</sup> A decision of an inferior tribunal is removed into the High Court to be quashed because it is *ultra vires* or an error of law has been made.

<sup>131</sup> An inferior tribunal can be ordered to perform some duty already imposed upon it which it is neglecting to perform.

<sup>132</sup> An inferior tribunal can be prevented from exceeding its powers in some way which it is threatening to do.

<sup>133</sup> The rights of the parties can be declared.

<sup>134</sup> For more detail, see Matthews and Foreman, *Jervis on Coroners*, 349, at 19–17.

<sup>135</sup> *Anisimic v Foreign Compensation Commission* [1969] 2 A.C. 147, H.L., concerned a statutory tribunal, not a coroner’s court, but is said to be applicable since *R. v Surrey Coroner, ex parte Campbell* [1982] Q.B. 661;

<sup>136</sup> For examples, see Matthews, Foreman, *Jervis on Coroners*, 351 at 19–21.

<sup>137</sup> For more detail, see Matthews, Foreman, *Jervis on Coroners*, 351 at 19–23.

<sup>138</sup> E.g. amending inaccuracies in the inquisition, or deleting a paragraph – the conclusion as to death/ verdict – and remitting the inquisition of the coroner for him to enter such conclusion as he thinks appropriate in the light of the court’s judgment. Everything depends on the individual case.

<sup>139</sup> Under the statutory powers this can be done directly: section 13(1)(a), under the judicial review this is done by seeking, in addition to the order of certiorari to quash the first inquisition, an order of mandamus to hold a new inquest.

<sup>140</sup> In the inquest into the deaths of two schoolchildren, Hannah Black and Rochelle Cauvet, who drowned on a school trip – held by the Assistant North Yorkshire Coroner (Harrogate Magistrate’s Court, February 2002) – the coroner asked the jury to make recommendations.



Another mechanism that might achieve greater public scrutiny and accountability is the public inquiry – called for by many families. This would certainly achieve more public scrutiny, however, there is no procedural or automatic mechanism whereby inquiries can be set up. So far, there has only been one public inquiry following a death in custody, that ordered by the High Court for the Wright case.<sup>141</sup> Other families have called for public inquiries but with no success.

## 5. Conclusion

The present inquest system has, for deaths in custody, only limited effectiveness. For these controversial cases, it is inefficient and offers an obscure mix of inquisitorial and adversarial elements (perhaps best characterised as an adversarial system working under the guise of an inquisitorial one).

The role of the coroner is too dominant and the jury is not able to contribute sufficiently to the proceedings. The process is too slow and too costly, and rarely fulfils the aim of allowing the family, the authorities or the public to find out the truth of what has happened.

The process is not transparent. It is not easily accessible, the language is complicated and there is no person solely responsible for the welfare of the family or for explaining the process. The inquest lacks power because the verdict options are narrowed down by the coroner and the unlawful killing verdict does not have any effect beyond the inquest. Recommendations are not a regular component of the inquest, and if they are made, they are not published, and their implementation is not monitored.

There is a lack of public scrutiny. There is no overseeing, monitoring body to make coroners more accountable. And the family cannot participate effectively due to a lack of compulsory pre-inquest disclosure.

Finally, it lacks a mechanism for monitoring and review – not least of coroners' recommendations resulting from inquests.

Recommendations for change should consider a more streamlined system, more participatory rights for the family, and stricter monitoring of the system.

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<sup>141</sup> *R (Wright and Bennett) v SSHD* [2002] HRLR 1: in a landmark judgment, Jackson J ordered the Home Secretary to establish a public inquiry into Paul Wright's death in prison. The inquiry heard evidence in December 2001 and reported in 2002.

## 5. OTHER REMEDIES

### 1. Introduction

The inquest procedure cannot be isolated from the rest of the legal structure. It is ideally part of a consistent legal system and must be seen to be part of such a system. Thus, as inquests offer no remedy as such, the rest of the system ought to be able to provide a satisfactory remedy (particularly in order to comply with Article 2).

Currently, the system as a whole is failing. So far, not one police officer has been convicted of a homicide-related offence following a death in custody despite eight unlawful killing verdicts following inquests over the last 12 years.<sup>1</sup> If the criminal justice system has not been able to provide a remedy, then the question must be: what alternative adequate remedies exist? Civil litigation is, as it stands, rarely sufficient and only one public inquiry into a death in custody has ever been ordered to date. This section will examine the existing remedies, apart from the inquest, and try to establish what needs to be done to provide a more satisfactory and consistent legal framework. The subsections evaluate the criminal prosecution process, internal disciplinary procedures, civil actions, and public inquiries.

### 2. Criminal prosecution

#### 2.1 Introduction

It is the intended purpose of the inquest to reveal the truth of what has happened. Relatives of the deceased want to find out what happened after a death in custody not least so that such incidents can be avoided in future. Nevertheless, the families also want to see those responsible held liable. This includes both individual and corporate liability, for example where there are systems failures. The inquest is not able to provide that. Whether there should be a criminal prosecution of anyone involved is a decision for the Crown Prosecution Service, usually taken before an inquest has even been opened. If a person has been charged with one

of the offences specified within section 16(1)(a) of the Coroners Act, an inquest will be opened but will almost inevitably be adjourned until the criminal proceedings are concluded, although in theory the hearing can proceed if the Crown Prosecution Service (CPS) agrees.<sup>2</sup> The coroner may also refer a case to the CPS if s/he comes across a criminal offence, or if the jury returns a verdict of unlawful killing. However, prosecutions following deaths in custody are rare,<sup>3</sup> and there is a general dissatisfaction with the current procedures. The closeness of the relationship between the police and the CPS is perceived by some as problematic: the implied accusation is that this closeness can sometimes displace the interests of justice.<sup>4</sup>

#### 2.2 The decision-making process of the Crown Prosecution Service

The decision-making process is governed by the Code for Crown Prosecutors,<sup>5</sup> as a public declaration of the principles upon which the Crown Prosecution Service exercises its functions. The code states:

- 4.1 There are two stages in the decision to prosecute. The first stage is the evidential test. If the case does not pass the evidential test, it must not go ahead, no matter how important or serious it may be. If the case does pass the evidential test, Crown Prosecutors must decide if a prosecution is needed in the public interest.
- 4.2 The second stage is the public interest. The Crown Prosecution Service will only start or continue a prosecution when the case has passed both tests.

The Explanatory Memorandum on the Code for Crown Prosecutors states:<sup>6</sup>

If the evidential test is not satisfied, there must not be a prosecution, no matter how great the public interest may seem in having the matter aired in court.

<sup>1</sup> For more detail, see Bhatt Murphy Solicitors, INQUEST, Liberty, *Response to consultation paper on Attorney General's Review of the Role and Practices of the CPS in cases of deaths in custody*, Appendix, p. 12. NB There have been prosecutions of police surgeons, such as Drs Saha and Salim who were convicted of manslaughter in 1992 of a prisoner named Rawlinson, by prescribing an overdose of drugs.

<sup>2</sup> Dorries, *Coroners' Courts – a guide to law and practice*, at 7.16.

<sup>3</sup> See Bhatt Murphy Solicitors, INQUEST, Liberty, *Response to Consultation Paper on Attorney General's Review of the Role and Practices of the CPS in Cases of Deaths in Custody*, June 2002, at p. 12.

<sup>4</sup> McConville, Sanders, Leng, *The Case for the Prosecution*; see also: Smith: *CPS for corrupt police*, *The Independent*, July 29, 1997.

<sup>5</sup> Issued under section 10 of the Prosecution of Offenders Act 1985.

<sup>6</sup> Crown Prosecution Service, revised Explanatory Memorandum to the Code for Crown Prosecutors, June 1996.

In practice no police officer has ever been convicted for any of the homicide offences following a death in custody. Since 1990 there have been eight deaths in custody where inquests have returned unlawful killing verdicts (one of them reduced to misadventure with contributory neglect at a second inquest); seven of those verdicts were preceded and followed by CPS decisions not to prosecute anyone on charges relating to homicide or any other offence. The decisions not to prosecute were successfully challenged by way of judicial review in three of these cases (O'Brien, Lapite and Manning), eventually resulting in a prosecution in one case (O'Brien).<sup>7</sup>

There may be several reasons for these stark facts. Firstly, of course, police officers are employed to protect life and rarely start out with an intention to take it. Secondly, even if an officer has committed a criminal offence that has led to a death the shortcomings in the investigation, flaws in the decision-making process, and the consequential lack of evidence that a crime has been committed can make successful prosecutions difficult. In previous sections we have considered the problems with the investigation process and the gathering of evidence.

With regard to the decision-making processes of the Crown Prosecution Service, an inquiry was conducted by Gerald Butler QC (commissioned in 1997 and reporting in 1999) into the quality and process of decisions relating to deaths in police and prison custody in 1994. The inquiry focused specifically on the cases of Lapite and O'Brien.<sup>8</sup>

*Shiji Lapite died on 16 December 1994 after being stopped in the street by police officers for acting suspiciously. The cause of death was asphyxia from compression of the neck consistent with the application of a neckhold. The inquest jury returned a unanimous verdict of unlawful killing. No criminal charges were brought.*

*Following a fight outside a public house, Richard O'Brien was arrested for being drunk and disorderly. There was a struggle and Mr O'Brien was restrained on the ground. He was thereafter placed in a police van, still face down, and taken with his wife and son to a police station where he was found to have no signs of life.*

*A pathologist subsequently concluded that the cause of death was postural asphyxia following a struggle against restraint. The jury at the inquest returned a verdict of unlawful killing.*

*However, the CPS was of the opinion that the evidence available, including that presented to the inquest jury, was insufficient to launch criminal proceedings and there was no realistic prospect of convicting any person of any criminal offence arising from Mr O'Brien's death.*

The Butler inquiry was critical of the decision-making process, finding it involved unnecessary duplication of functions and that no one person took responsibility for the final decision. As a response to this finding,<sup>9</sup> the CPS has set up the Casework Directorate, which deals with cases involving death or serious injury in custody.<sup>10</sup> Four staff are based at the London head office, and one at an office in York. However, the inquiry also observed that in such cases (and subject to the evidential test), "it is difficult to imagine circumstances in which it would not be in the public interest for there to be a prosecution".

It is not clear to what extent there has since been any improvement in outcomes in the type of cases highlighted by the Butler inquiry. There are obvious and usually overwhelming public interest factors listed in the revised Code that would justify a prosecution (particularly, for instance, that the possible defendant police officer was in a position of authority or trust and the victim by being detained was vulnerable).<sup>11</sup> However, quite rightly, the public interest test is only considered once the evidential test is met. Public interest cannot determine a prosecution on its own in the absence of sufficient evidence.

It would seem, though, to a lay person (and in particular to the relatives of the person who has died) that a prosecution would follow an inquest into a death that culminates in a lawful verdict of unlawful killing, apparently implicating an identifiable individual or individuals. It is difficult for family members to understand how an inquest jury can return a verdict of unlawful killing and yet prosecution and conviction does not follow. For the relatives of Richard O'Brien and Shiji Lapite,<sup>12</sup> as well

<sup>7</sup> Bhatt Murphy Solicitors, INQUEST, *Liberty Response to the Consultation Paper on Attorney General's Review of the Role and Practices of the CPS*, June 2002, see Appendix and 1.3.

<sup>8</sup> In the Lapite case the CPS decided not to prosecute. In the O'Brien case three officers did face trial for manslaughter but were acquitted.

<sup>9</sup> And the Butler recommendation that cases of death in custody should be dealt with at Central Casework: see Recommendation 1 of the Butler Inquiry, *op. cit.*

<sup>10</sup> For more detail, see Response to the Butler Recommendations, 11 August 1999, document no. 131/99.

<sup>11</sup> See Code at para 6.4 (d) and (h).

<sup>12</sup> For details on these cases, see above; see also: Coles, Murphy, *Police officers acquitted after five year fight for a trial - battle by family of Richard O'Brien has ensured greater public accountability within the CPS*, Inquest Law, issue 3, Winter 1999, 1 at 5.

as those of Oliver Pryce, Leon Patterson,<sup>13</sup> Ibrahima Sey, Christopher Alder,<sup>14</sup> and, most recently, Alton Manning<sup>15</sup> there is a presumption that there must be a fundamental flaw with the system. It is not difficult to understand why those people are likely to want to blame the Crown Prosecution Service for this. Nor is it difficult to understand why some people think that part of the solution is to give the decision to prosecute to another body – one that does not have a close relationship with the police.

*Alton Manning died of respiratory impairment resulting in asphyxia following a struggle with prison officers. He was carried from a cell where he was searched for drugs. It was unclear whether he had been properly restrained or whether he had been in a prone position. In March 1998 the inquest jury returned a verdict of unlawful killing.*

*In February 1999 a prosecutor reviewing death in custody cases then reconsidered the earlier decision not to prosecute. It was decided that there was insufficient evidence for a conviction for manslaughter. The High Court reviewed and quashed that decision and on 17 May 2000 it was held that the decision not to prosecute was flawed and should be reconsidered. In June 2001 again the CPS announced its decision not to prosecute.*

Part of the reason for the difference between the decisions of the inquest and those of the Crown Prosecution Service may lie in the different questions that are being answered. A failure to prosecute may be justified after an unlawful killing verdict in the inquest for a variety of reasons, including the difference between the approach of an inquest jury and of a jury in a criminal trial to their decisions. Before reaching a particular verdict, the coroner and the jury need to be satisfied on the necessary facts to the required standard of proof. For most verdicts, the lesser, civil, standard of proof applies, i.e. “on the balance of probabilities”.<sup>16</sup> But for a verdict of suicide or unlawful killing, the standard of proof is the same as that for a criminal court, i.e. “beyond reasonable doubt”.<sup>17</sup> So the question remains: why, given that the standard of proof for a verdict of unlawful killing during an inquest, and the

standard of proof for a criminal prosecution are the same, does one not lead to the other?

There may be several reasons for this. First the evidential test that must be met before a prosecution can be launched.<sup>18</sup> Evidence admissible at the inquest may not be admissible at the criminal trial. Secondly, although the verdict of unlawful killing may have been justified, it might be that any one of several people might have caused the death, without any proof of exactly which one was responsible.<sup>19</sup> In a criminal trial the prosecution must prove beyond reasonable doubt which person committed the offence: otherwise the prosecution will fail.

Another obstacle to prosecutions is that it may be that juries in criminal trials are less likely to convict police officers than others because of the difficult job that they do, and that this is in practice taken into account by those making the decision in the CPS. In fact the CPS is very clear that this is not a factor that is taken into account. There is no statistical evidence to support the argument that juries have this particular approach. However, academic research on US juries highlights the far greater credibility that police witnesses have compared to witnesses with a criminal record (even in cases involving the prosecutions of police officers following miscarriages of justice). The very few successful prosecutions of police officers involved in miscarriages of justice in the UK arguably support this finding.

Lastly there is a real difference between the approach taken by the inquest jury and the jury in any subsequent criminal trial. The inquest jury may be convinced that the system was at fault and this needs to be changed and a finding of unlawful killing places the responsibility on all those involved for the death. In any subsequent criminal trial a particular individual’s own actions are being assessed and the consequences for that individual of a conviction are very severe. This may be particularly problematic as in many cases the officer will not have acted maliciously or intended to kill.

<sup>13</sup> Leon Patterson was arrested on 21 November 1992 on suspicion of being involved in a cash till snatch. Six days later he was discovered dead in his cell. The (second) inquest jury returned a verdict of “misadventure to which neglect contributed”.

<sup>14</sup> Christopher Alder, a black former paratrooper, died on 1 April 1998 after being arrested and taken to Queen’s Garden Police Station in Hull. He was arrested after a fight outside a night-club and taken in a police van to the station. He was taken into a custody suite and after 13 minutes police officers called an ambulance. Despite resuscitation attempts, Mr Alder died.

<sup>15</sup> The CPS’ previous negative decision in February 1999 was challenged successfully by the family in the High Court in May 2000. However, in January 2002 there was a second decision not to prosecute prison officers following the unlawful killing of Alton Manning.

<sup>16</sup> For more detail, see Dorries, *Coroners’ Courts*, at 9.03.

<sup>17</sup> *R v Wolverhampton Coroner ex parte McCurbin* (1990) 1 WLR 719.

<sup>18</sup> For more detail, see p.4, and also sub-section 2.3, at p. 6.

<sup>19</sup> See Dorries, *Coroners’ Courts*, 9.29.

Lowering the standard of proof would allow more people to be prosecuted and probably convicted but it cannot be right that police officers should have fewer protections in the criminal process than others. Any such proposal would be wrong in principle, likely to contravene Article 6 of the European Court of Human Rights and lead to possible miscarriages of justice.

Some argue that the key obstacle to prosecutions consists of defects in the law itself.<sup>20</sup> The likelihood of a prosecution or a conviction is seen to be affected by the nature of the charge laid against those responsible.<sup>21</sup> The only permissible charge in most cases for an unlawful death in custody is one of murder or manslaughter: if judges and juries are less likely to convict police officers of such serious offences than perhaps a new, less serious offence should be created for these circumstances. Although such an alternative might put police officers in a special position, perhaps this is better than the current situation in which police officers are rarely prosecuted and never convicted – the resulting impression for those outside the system being that police officers are not subject to the rule of law. Some people have suggested a wider range of criminal sanctions to reflect the wide range of circumstances in which the legal standard may be breached. This might involve a consideration of the way in which the potential sanctions may be fitted to the various categories of incidents and the degree of blame which those responsible may be expected to bear.<sup>22</sup> Such attribution of criminal responsibility would necessarily involve the creation of a new offence similar to manslaughter or murder, where lethal force is unlawfully used.<sup>23</sup>

However, even if the current limited options in the criminal law do contribute to the difficulties in securing convictions of the police following deaths in custody, this does not necessarily mean we should accept a watering-down of the law itself. The consequence of amending the law would be that police officers who had acted in exactly the same way as civilians would be treated differently.

Liberty views a reform of the criminal law as one of the last resorts, to be employed only if all else fails, and any proposals to change the law would require a greater justification and more research of the possible outcomes of such a change than is presently available. The rule of law has at its heart the concept that the law should be the same for all and the police should not (without good reason) be subject to a different form of criminal liability than other members of the public. The creation of a different offence, even if this is motivated by the inability to prosecute the police under the current law, would constitute such differential treatment.

### 2.2.1 Discrimination

Previous cases raise the question about whether the criminal justice system discriminates against ethnic minorities. Apart from Richard O'Brien (who was white and Irish), David Ewin and James Ashley, the victims of deaths in custody already mentioned in this report were all non-white.<sup>24</sup> This creates a presumption of racial bias. Tackling minorities' consequent lack of confidence in the law is an urgent priority.

### 2.2.2 Reasons for deciding not to prosecute

In the past the Crown Prosecution Service did not give detailed reasons to the relatives of deceased if it decided not to prosecute an officer. The case of Manning changed that. In that case, the then Lord Chief Justice, Lord Bingham, pointed out:<sup>25</sup>

- Serious questions arising on the available evidence had not been addressed in relation to the crucial issue of the neckhold leading to the death
- The refusal to prosecute was ultimately based on a hypothesis untenable on the available evidence
- A press release issued in the name of the DPP to announce the refusal to prosecute in February 1999 did not accurately reflect the true basis of the decision.

<sup>20</sup> Reference is made to a paper on the legal control on the use of lethal force by policemen and soldiers in Northern Ireland, see Paper for the Standing Advisory Commission on Human Rights, by Professor Tom Hadden, March 1993.

<sup>21</sup> See Tom Hadden, *op. cit.*, at p. 132.

<sup>22</sup> See Tom Hadden, *op. cit.*, at p. 166.

<sup>23</sup> Tom Hadden, *op. cit.*, at p. 168 suggests either (a) the amendment of the law of homicide to permit a charge of manslaughter to be substituted for one of murder in cases where due to a misjudgement excessive force is used, or (b) the introduction of a new criminal offence of causing death by reckless use of firearms, or (c) the introduction of a new, less serious criminal or regulatory offence of breach of the legal rules for the use of lethal force.

<sup>24</sup> A similar situation exists for hospitals.

<sup>25</sup> see also: Bhatt, *DPP under Scrutiny on Unlawful Killing of Black Prisoner - family make vital step in their five year battle for justice*, Inquest Law, Issue 4, Spring 2000, at 1.

The consequence of the case was that the CPS is now under an obligation to give an accurate, reasonable and plausible explanation for a decision not to prosecute in such cases:

The right to life is the most fundamental of all human rights...The death of a person in custody of the state must always arouse concern...If the death resulted from violence inflicted by agents of the state that concern must be profound.

Where an inquest [into a death]...culminates in a lawful verdict of unlawful killing implicating [an identifiable individual] the ordinary expectation would naturally be that a prosecution would follow.

In the absence of compelling grounds for not giving reasons, we would expect the director to give reasons [for decisions not to prosecute] in such a case.

This decision provided the first opportunity for the court to examine the handling of a death in custody case by the CPS since the Butler Report in 1997 and the Report of the European Committee for the Prevention of Torture in 2000. It is also true that by this time there was a greater consensus to seek a more effective decision-making process, with more transparency and accountability. As with the problems experienced during the investigation,<sup>26</sup> and the inquest system,<sup>27</sup> transparency in the subsequent criminal process is a crucial way to combat the lack of confidence in the system and to create more accountability. The onus to reveal reasons and to act in a more open way is even greater where a verdict of unlawful killing was reached by a jury at the inquest.<sup>28</sup>

### 2.2.3 An independent prosecutor?

Given the extent of distrust that families of the deceased and the communities that support them have in the CPS, it has been suggested that the responsibility for prosecuting those responsible after deaths in custody should be removed entirely from the CPS.<sup>29</sup> Those promoting such an approach argue that the historical, institutional and practical relationship between the police and the CPS makes it impossible for the CPS to take a robust approach to the prosecution of “one of its own”. The fact that

prosecution decisions are taken by those in a special unit and reviewed by independent counsel does not, it is said, change the structural nature of this relationship.

The main allegation being made is not that individual CPS staff are guilty of bias but that institutions are so intertwined that their interests are too close. The danger is that even when the two bodies are attacking each other – perhaps over CPS delays or its record on discontinuance of prosecutions – this itself creates institutional pressure not to take a high-profile prosecution of a police officer on a murder charge.

Irrespective of whether these allegations have any basis in reality, they have a substantial effect on the reputation of the CPS in such cases. Even where the CPS has decided perfectly properly not to prosecute, this relationship will contaminate that decision in the eyes of many and will raise questions about bias. The Director of Public Prosecutions has himself asked whether decisions made by the CPS not to prosecute should not be subject to some sort of appeal.<sup>30</sup> An appeal to an independent body would be a welcome development but this then begs a number of questions. Firstly, who would adjudicate such appeals? If appeals were decided by judges, it raises questions about whether the officer would subsequently get a fair trial if the jury was aware that the evidence had already been assessed in this way. (This problematic approach was, nonetheless, adopted by the Government in seeking to change the law protecting against double jeopardy, in the 2002 Criminal Justice Bill).

Secondly, it is likely that every case would be appealed. The nature of such cases is such that the relatives would want to explore every avenue: any decision not to prosecute is likely to be seen as a failure of the justice system. Given the few decisions made by the CPS to prosecute in such cases, the reality of an appeal system would be that the decision was in practice taken out of their hands. A third problem with an appeal mechanism is who would be in charge of a prosecution following a successful appeal. If CPS staff have decided that the prosecution would fail, it is hardly sensible to ask those same people to prosecute after a successful appeal.

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<sup>26</sup> See section two of this report.

<sup>27</sup> See section three of this report.

<sup>28</sup> See also: Attorney General's office, *Deaths in Custody – A Review of the Role and Practices of the Crown Prosecution Service – A Consultation Paper*, April 2002.

<sup>29</sup> Amnesty International Report, *Deaths in Police Custody: lack of police accountability*, May 2000; and also: Harrison and Cunneen, *An Independent Police Complaints Commission*, at 42.

<sup>30</sup> At the Attorney General's Review seminar.



However, the CPS has a wealth of experience. There are only five members of staff in charge of prosecutions following deaths in custody: they have a considerable expertise. Furthermore, one should shy away from systems which would treat prison officers and police officers differently from the public. The criminal justice system should apply equally to all. The real benefit of a separate institutional body to prosecute the police and perhaps prison personnel would lie in the symbolism of greater institutional independence. There is a danger that such a symbolic institution would find it difficult to recruit a sufficient number of properly experienced staff.

Liberty suggested in an earlier report on police complaints that perhaps the Independent Police Complaints Commission could take over not only the role of investigation in these cases but also the role of prosecution. Nevertheless, it is recognised that police officers (and Liberty) believe that a clear separation between the investigation and prosecution of offences should be retained. It is important that the tasks of investigating crimes and prosecuting crimes must be kept strictly separate, which in practice, if the IPCC were to be the separate prosecuting body, would be difficult. This idea was not pursued by Liberty and does not feature in the list of functions for the IPCC set out in the Police Reform Act.

Liberty has not completely rejected the idea of a separate body to deal with prosecutions, but does not wish to pursue it at this point. Instead we prefer to explore ideas to improve the work (and the reputation) of the CPS in the hope that a more drastic solution will not prove necessary. If the CPS continues to make decisions on prosecutions and to prosecute cases, then a review of its existing structure is essential. There might be greater confidence in the role of the CPS if measures were put in place to ensure that there was even greater separation between the prosecution of police officers and the rest of the organisation. A separate department (in a separate building) directly responsible to the DPP with staff only concerned with police prosecutions would help to avoid the perception that police officers were receiving any favoured treatment. Perhaps an advisory committee of expert lawyers could also be set up to assist decision-making. Obviously Liberty would also recommend that guidelines

and regulations must be publicly available and brought to the attention of the family, and that whoever has the job of prosecuting must be required to provide detailed reasons for any decision not to prosecute.<sup>31</sup>

#### **2.2.4 Reasons not to prosecute**

In practice, there can be problems with disclosing all the detailed reasons for a decision not to prosecute. There may be reasons that prevent a prosecution that are not related to guilt or innocence but rather to an actual lack of evidence (e.g. the unavailability of a witness or the disappearance of an important document). It is sometimes argued that it may cause more damage for the relatives to know that a specific person is guilty of the death but that s/he cannot be prosecuted because there is not sufficient proof.

Furthermore, there may be reasons for non-prosecution that are not purely of a factual kind and are not solely based on the lack of sufficient evidence. These reasons may be particularly sensitive, such as an assessment of the credibility or mental condition of the victim or some other witness. It has been argued that the disclosure of such information would cause more damage than it would benefit the family.

However Liberty does not accept that this approach can be justified. Relatives are entitled to know the whole truth even if it is painful.

### **2.3 Attorney General Review**

The problem of public confidence in the CPS in these cases led the Attorney General to establish in 2002 a review of the role and practices of the Crown Prosecution Service in death in custody cases (expected to report in early 2003).<sup>32</sup> Its purpose was to consider the present practices of the Crown Prosecution Service and to assess whether any changes need to be made. This review did not include an evaluation of individual cases but rather an examination of the fundamental approach and practices of the Crown Prosecution Service. In line with that, the consultation focused on the Crown Prosecution Service and prosecution decisions, who takes the decision, accountability and transparency. It was trying to establish, among other things:

<sup>31</sup> For more detail, see: Harrison, Cunneen, *An Independent Police Complaints Commission*, at 43.

<sup>32</sup> Attorney General, *Deaths in Custody: A Review of the Role and Practices of the Crown Prosecution Service – A Consultation Paper*, April 2002, London; following the announcement by Parliamentary Answer on 13th December 2001.

- what the role of the Crown Prosecution Service should be at the investigation stage
- what significance should be attached to an unlawful killing verdict delivered after an inquest
- how the Crown Prosecution Service should approach the evidential test
- whether the current Crown Prosecution Policy on giving reasons is satisfactory
- what the proper role of the bereaved families and those representing them is in influencing the decision to prosecute
- how far reasons for prosecution/ non-prosecution should be disclosed.

This consultation process took place in two stages. The first was a consultation paper, which sets out the background to the questions above.<sup>33</sup> This paper was then discussed at a consultative workshop.<sup>34</sup> In the second phase of the consultation, a seminar was held, during which discussion took place amongst some of those consulted.

In the light of the coroners review at the Home Office, this consultation was particularly useful in the sense that it may result in a more consistent and streamlined approach to death in custody cases. At the same time, however, this consultation indicated that the aim was limited - to improve existing arrangements, with the CPS remaining in charge of the prosecution of those responsible, rather than to create a separate institution or set up any appeal mechanisms.<sup>35</sup> There was no suggestion the evidential test needs to be changed.<sup>36</sup> And there was an indication that transparency, with regard to reasons for non-prosecution, would continue to be limited by public interest immunity.<sup>37</sup>

## 2.4 Judicial Review

Theoretically, decisions not to prosecute can be judicially reviewed on the basis that they were made in

breach of the Code of Practice or are so perverse that no reasonable prosecutor could have made them.<sup>38</sup> Nevertheless, practice has shown that a person may face considerable obstacles in challenging a decision by the CPS not to prosecute by way of judicial review.<sup>39</sup> Unless the bereaved family are very wealthy, they will need to be financially eligible and the case will need to satisfy the Funding Code requirements of the Legal Services Commission (LSC). The courts use their power to review sparingly,<sup>40</sup> and where a review is instituted this is not necessarily a guarantee that the CPS will subsequently make a different decision. This was most recently demonstrated by the case of Alton Manning.<sup>41</sup>

The scrutiny of the court at the hearing in this case in May 2000 focused upon the quality and adequacy of the explanation for the decision not to prosecute which the CPS was compelled to provide. The then Lord Chief Justice Lord Bingham ruled that the decision of the CPS not to prosecute any prison officer in connection with the restraint-related death of Alton Manning was unsustainable in law.

In many cases where a person dies in custody no one will have committed any crime and even with the best system of investigation, the best evidence and the most robust prosecutors no prosecution should ever be brought. However, in other cases those guilty of offences will escape, because of faults in the system which produces evidence (or fails to do so) or failures by those who make decisions as to whether there should or should not be a prosecution.

The remedy of judicial review of decisions not to prosecute however is not always satisfactory. As can be seen from the Manning case, even the High Court decision that quashed the decision not to prosecute did not result in a subsequent prosecution. In early 2002, for the second time in three years, the Crown Prosecution Service decided not to bring criminal charges against any of the prison officers involved in Mr Manning's death.<sup>42</sup> Thus, the High Court

<sup>33</sup> This consultation paper was circulated in May 2002.

<sup>34</sup> Monday, 13 May 2002.

<sup>35</sup> See consultation paper at 4.9

<sup>36</sup> see consultation paper, Annex 1 at 21.-41.

<sup>37</sup> See consultation paper at 5.8 – 5.15.

<sup>38</sup> Hilson, *Discretion to Prosecute and Judicial Review*, [1993] 2 Q.B. 118; see also: *R v DPP, ex p. C* [1995] 1 Cr.App.R. 136.

<sup>39</sup> This was reaffirmed by Lord Bingham C.J. in *R. v DPP, ex p. Manning and Another* [2000] 3 W.L.R. 463.

<sup>40</sup> *R v DPP, ex p. C* [1995] 1 Cr.App.R. 136.

<sup>41</sup> For a description of the case, see section 2.2.

<sup>42</sup> INQUEST, *Second decision not to prosecute prison officers following unlawful killing of Alton Manning*, 25 January 2002, at <http://www.inquest.org.uk/> (Press Releases).

may well be an important safeguard, but only in cases where there has been a procedural flaw, such as where the failure to prosecute was unreasonable or where cogent reasons were not given. It does not function as an appeal as to the merits of the decision.

Although the Human Rights Act brings Article 2 into domestic law, the judicial review court is still generally concerned only to intervene in decisions which are patently unreasonable. However, the real obstacle to more prosecutions at the moment is a combination of the lack of evidence available and the approach of the decision-makers in the CPS. These problems cannot be solved with judicial review. Liberty believes that reform must take place in the process of investigation and in the decision-making of the Crown Prosecution Service.

However the process of judicial review is not without its virtues because it will often shed more light on the prosecution process. Firstly, the Crown Prosecution Service will have to justify its decision in writing in evidence and in court. Secondly, even though the disclosure rules in judicial review cases are inadequate, often further material may be disclosed in the context of the proceedings. The signal that this sends out is that judicial review is a means that leads to more disclosure. The remedy may not result in a subsequent prosecution (only in rare cases will this happen) but it will always result in ensuring the CPS has to justify its decision in detail. Furthermore, it leads to the relatives being given more information and it will nearly always require the CPS to reconsider its decision (even if this is only as part of the process of having to justify this decision to the High Court). However, only those entitled to public funding (the very poor) or the very wealthy will be able to take advantage of this system. This in itself demonstrates a problem with the system as a whole.

## 2.5 Conclusion

Any recommendations for change must tackle the real substantive problems concerning the prosecution of those responsible for criminal offences. An effective investigation and an efficient decision-making process for prosecutions are essential. Any prosecution system needs to promote trust and confidence and it will only be able to do so if it guarantees transparency and independence.

There are four possible recommendations for change:<sup>43</sup>

- Leave the procedure for prosecution as it is, with any improvements to be recommended by the Attorney General's review
- Create a special unit within the current Crown Prosecution Service
- Create a completely separate body, or
- Contract the prosecution of those responsible after death in custody out (i.e. privatise the prosecution, contract distinguished human rights solicitors). This last option is discussed in more detail in the next chapter.

## 3. The disciplinary hearing

### 3.1 Introduction

Even if the criminal prosecution fails (or does not start), those involved in a death can still be subject to internal discipline. Disciplinary action against a police officer can be initiated in two ways. Firstly, a complaint may be made against a police officer by a member of the public and this will be recorded under the Police Act and investigated, sometimes under the supervision of the Police Complaints Authority. At the conclusion of the investigation, the senior officer of the relevant police force in charge of discipline must report to the Police Complaints Authority with proposals, if any, for disciplinary action. The Authority can determine, using the statutory powers available to it, whether or not any police officer should face at a formal disciplinary hearing allegations of a breach or breaches of the Police Code of Conduct. The second way in which an officer can face discipline is as a result of an internal complaint or allegation.

Although any disciplinary proceedings resulting will be conducted under the same Regulations as apply in the case of public complaints, the Police Complaints Authority will not be involved continuously. It will only be involved in finally determining the disciplinary outcome if the complaint has been referred to it, and it has agreed to supervise the investigation. In practice, nearly all death in custody investigations are now referred to the Police Complaints Authority with a request that it supervise the investigation. The Police Complaints Authority invariably

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<sup>43</sup> To be discussed in the section on recommendations, see chapter 6.

agrees to such supervision and, accordingly, obtains the power to determine the final disciplinary outcome.

Thus, in those cases where the Police Complaints Authority is involved, disciplinary decisions in relation to police officers<sup>44</sup> are taken initially by the police employer, which must then satisfy the Authority as to the suitability of its recommended decision. It is not a system which requires agreement between the police and the Authority. The Authority frequently recommends the conduct of an officer be referred to a disciplinary hearing although the police force has not proposed this.<sup>45</sup>

Once it has been decided that a disciplinary hearing will take place, the arrangements for convening the hearing and for presenting the case to it are a matter entirely for the employing police force.<sup>46</sup> Hearings are presided over by an Assistant Chief Constable with two officers of Superintendent rank. The complainant may attend the hearing and may be supported by a friend or relative but not a legal representative. Hearings are not open to the public: they are held in private and no report of their proceedings or decisions is automatically published.

### **3.2 The disciplinary process**

The fundamental principle behind the police disciplinary system is that the chief officer has responsibility for the discipline of his or her police force. There is only limited independent intervention represented by the ultimate decision-making power of the Police Complaints Authority in relation to disciplinary action that follows public complaints or supervised investigations. Other professions have two disciplinary processes, the first in the hands of the employer, which is a private process, and the second independent of the employer and conducted by the profession as a whole. Whilst Liberty does not accept that, for example, the disciplinary tribunal of the solicitor is adequate, at least this process is independent of the employer. The danger with employer-controlled disciplinary systems is that the employer may have reasons not to take proper action against an employee or may wish to settle a case or claim without publicity. Those dealt with

by professional disciplinary bodies may have greater sanctions applied against them – they may be banned from practising in their profession.

The police disciplinary procedure is different. Police officers are not subject to the same degree of professional regulation, although dismissal by one police force would render it impossible to find employment as a police officer in another. Secondly, a police officer has no right to challenge his or her dismissal in an employment tribunal.<sup>47</sup> Accordingly, the internal disciplinary hearing system needs to comply as far as possible with the provisions of natural justice.

Guidance is issued to police forces by the Home Office governing the investigation of unsatisfactory performance complaints and misconduct procedures. This is only guidance, however a failure to adhere to it could be an issue at any subsequent hearing since it may attract a claim that the proceedings amount to an abuse of process. So its effectiveness lies only in the fact that there may be grounds of civil liability should the guidance not be followed.

Liberty believes that there is a need for a more independent approach. Concerns have been voiced that when conducting reviews, PCA members may be unduly influenced by disciplinary recommendations made by chief officers or their delegates. In Liberty's view the proposed IPCC should take more responsibility for finally determining the outcome of investigations. The Police Reform Act has changed not only the investigation system but also the disciplinary process.<sup>48</sup>

### **3.3 Sanctions following police disciplinary proceedings and their adequacy**

The aim of disciplinary proceedings following an investigation should be to determine whether a police officer is fit to continue to hold their office or rank and whether or not further training, advice, guidance or support should be given to them. However, and particularly in cases following deaths in custody, such proceedings have evolved into another mechanism of

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<sup>44</sup> This does not relate to civilian police staff, over whom the Police Complaints Authority has no jurisdiction.

<sup>45</sup> And where this happens, the police usually agree to the recommendation. If the police do not agree then the Authority has the statutory power to order the bringing of proceedings, and will do so.

<sup>46</sup> Except that under the guidance the Authority must be consulted about the case if it has recommended or directed the bringing of proceedings.

<sup>47</sup> Although, s/he has the right to appeal to the Police Appeals Tribunal.

<sup>48</sup> Though much of this remains to be decided, in regulations yet to be published.

public accountability. The most drastic sanction available to a disciplinary tribunal is dismissal. But while this may help to prevent future misconduct which may have contributed to an avoidable death, it is not something that particularly benefits a grieving family.

Thus, disciplinary action may not be seen as an adequate remedy for the family of someone who has died in police custody. Many families, given the consequence of the error of the officer – the death of their relative – will not accept that even dismissal is a real remedy. This is not to say, however, that disciplinary measures should be underestimated as a form of managerial and public control over the policing service.

### 3.4 Conclusion

Liberty hopes that the Police Reform Act and the creation of the new Independent Police Complaints Commission and accompanying changes to the police disciplinary system will produce a more effective investigation and outcome in relation to complaints of police misconduct. Change needs to reflect the important themes referred to in this report of transparency, independence and effectiveness. The forthcoming regulations and the establishment of the IPCC after April 2004, its funding and working practices need to reflect these principles for this change to occur.

## 4. Civil action

### 4.1 Introduction

A civil action against the police is primarily designed simply to recover compensation. However there are considerable advantages for relatives to civil actions following deaths in custody. Firstly, the relatives will be in control of the process – they will be the claimants. Secondly, the rules on disclosure are clearer, more robust and as a result the relatives will in fact be given documents that were not disclosed in the inquest. Thirdly, at the trial the officers themselves will have to give evidence and can be questioned (and cross-examined) directly by the lawyers acting for the relatives.

However, civil actions do not provide a suitable remedy for the family of the deceased for several reasons. A civil action is unlikely to result in disciplinary action even if the plaintiff is ultimately successful. Furthermore, so far as we are aware, no civil action following a death in custody has ever led to a criminal prosecution. Lastly, a plaintiff can only bring civil action either if s/he has been dependent on the deceased in some way, or under the Law Reform Miscellaneous Provisions Act 1934. Under the latter Act, if there is a surviving cause of action, e.g. negligence, one may not have to be a dependent to bring a claim.<sup>49</sup>

### 4.2 Actions after death

Section 1(1) of the Fatal Accidents Act gives a right of action to “dependants of a deceased person whose death was caused by any wrongful act, neglect, or default” such as would, if the death had not ensued, have entitled the person injured to recover damages.<sup>50</sup> Dependants are defined in section 1(2) and include spouses, parents and grandparents, children and grandchildren, nephews, nieces and cousins and any person who had been living with the deceased in the same household for a period of at least two years immediately before the death as husband, wife, parent or child.

This statutory right of action currently denies damages and access to justice for unmarried couples, gay couples, and any dependency or relationship that does not fall into those mentioned categories and people living in these relationships are unfairly discriminated against by this procedure.<sup>51</sup> A husband, wife, or parents of an unmarried minor are entitled to damages for “bereavement” in the sum of £7,500.<sup>52</sup> Other damages are awarded as are proportionate to the injury, resulting from the death, to the dependants respectively.<sup>53</sup> Such damages are assessed on the basis of the “value of the dependency”, in other words, the dependants are entitled to that sum of money that will replace the “material benefits” provided to them by the deceased. This statutory right to damages provides compensation for material benefits only.

However, in a dependent relationship there is more involved than the material benefit. Such value is not

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<sup>49</sup> In the *Wright* case, both a Fatal Accidents Claim and a Law Reform Miscellaneous Provisions Act claim were brought.

<sup>50</sup> See section 1(1) of the Fatal Accidents Act 1976.

<sup>51</sup> There have been some unsuccessful challenges to the scope of the Fatal Accidents Act under the Human Rights Act.

<sup>52</sup> See section 1A(3) as amended by S.I. 1990 No. 2575.

<sup>53</sup> They can also get funeral expenses as damages for pecuniary loss.



measurable and it is different from relationship to relationship. Currently the compensation for “bereavement” is extremely low. Nevertheless, the situation is no different to other European constitutional democracies. This underlines the fact that the current civil remedies available are often not appropriate. The consequential effect of low damages will often be that legal aid will not be available for those that seek to sue.<sup>54</sup>

A possible improvement to the current situation would be a reform of the current civil action provisions. There is a need to provide more recognition and greater compensation (in value as well as in eligibility of persons) for cases of death in custody. One suggestion would be to incorporate the role of the inquest system into the civil system. A reform of this kind would aim to give the inquest system more prominence and power, which it is lacking currently. Furthermore, it would provide the deceased with a suitable civil law remedy. And lastly, disclosure is greater in civil actions than in inquest, and powers to order to disclose and to require the attendance of witnesses are greater.

#### 4.3 Conclusion

Persons connected with the deceased rarely have an adequate civil law medium available for redress, to acknowledge their grief and to provide some form of real compensation for their loss. The civil remedy will only ever be able to deliver compensation. It is unlikely to lead to criminal or disciplinary sanctions. Even the financial compensation will be paid not by the officers responsible for the death but by the police authority.

#### 5. Remedy on European level

Lastly relatives do have a right to seek a remedy from the European Court of Human Rights. Article 2 provides:

1. Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is proved by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
  - (a) in defence of any person from unlawful violence;
  - (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
  - (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

There may also be cases of deaths in custody which involve other rights, for instance, claims may be made for violations of Article 3 if the deceased was subject to torture, inhuman or degrading treatment or punishment before they died, or as a result of the actions that led to their death.

The procedure for making an application is relatively straightforward. It is not, however, a speedy process – it can take five years. Applications are initially allocated to a chamber of the court, which will decide whether the application is admissible.<sup>55</sup> Inadmissible and unmeritorious cases will be sifted out by committees of three judges. In fact over 95 per cent of cases never make it past this stage. Unlike cases in the courts of the United Kingdom the decision to allow a case to continue is usually made on the basis of the papers alone, although the Court does still sometimes direct an oral hearing on the question of admissibility. If a case is declared inadmissible there is no right of appeal, there are no further steps that can be taken, and no further applications can be made concerning the same facts.

If the case is not declared inadmissible at this stage it will be ‘communicated’ to the government and the government will make its ‘observations’ in writing. The applicant will then be given a chance to respond in writing to these observations. Sometimes the Court will allow supplementary observations and responses. The Court will set time limits for these processes and after they are complete the Court will reconsider whether or not to declare the case inadmissible. If the case is again declared admissible, the parties file further submissions known as ‘memorials’. Such submissions must set out the case as a whole. There may then be a hearing, though often this is

<sup>54</sup> The Legal Services Commission adopts a cost benefit approach except where a case is found to have a significant wider public interest in which case the cost benefit approach does not apply.

<sup>55</sup> The details of the procedure are set out in Article 28 to 46 of the European Convention on Human Rights and the Rules of Procedure of the European Court of Human Rights.

now dispensed with and cases are decided on the basis of the papers alone.

The public funding scheme (legal aid) of the United Kingdom does not generally cover complaints to the Court.<sup>56</sup> Very limited legal aid may be provided by the Court but only towards the end of the examination of admissibility (after the case has been communicated). Legal costs are recoverable where a complaint is successful, but the Court will not award costs at anything like the rate that might be paid in a public funding domestic case. On a positive note, there are no fees payable to the Court and there is no liability to meet the costs of the government in any event.

Applications must be made within six months of having exhausted any remedies in the domestic courts. The time limits for lodging an initial application are extremely strict and extensions of time will rarely be granted. There is an application form to complete but sending a letter setting out the basic facts and all the relevant Convention articles within six months will be sufficient to stop time running. The Court will then send a copy of the application form and automatically give another six weeks for its completion.

Nevertheless, the remedy at European Court level is unlikely to provide the family directly with an appropriate remedy. Even successful cases are unlikely to lead to prosecutions or disciplinary actions against police officers although compensation might be available. Cases in the European Court of Human Rights rarely involve the disclosure of further information. However, successful cases in Strasbourg often lead to changes in law or procedure, which will benefit those in the future if not the individual applicant in the case.

## 6. Public inquiries

### 6.1 Introduction

Most public inquiries are non-statutory,<sup>57</sup> the chair does not have the powers to compel anyone to appear and anyone appearing and giving evidence does so voluntarily.

The Tribunals and Inquiries Act 1992 does allow inquiries to compel witnesses to attend and give evidence but this is not often used. There has only been one case in recent years of an inquiry following a death in custody, namely the independent investigation into the death of Paul Wright<sup>58</sup> – and witnesses were not compelled to attend.

Paul Wright died in custody following an asthma attack, for which he did not receive adequate medical attention. An inquest was held on 29 April 1997. The inquest produced a verdict of death by natural causes. A civil suit for damages was finally settled out of court in November 2000, the Home Office having admitted liability in April 2000.

Despite an admission of liability for causing death, the authorities failed to investigate the circumstances surrounding Paul's death or to identify the individuals responsible. The Home Secretary had initially rejected a request for an inquiry. Nevertheless, in June 2001 Mr Justice Jackson heard an application by the mother and the aunt of Mr Wright, represented by Liberty, alleging that the Secretary of State for the Home Department was in breach of Article 2 (right to life), Article 3 (inhuman and degrading treatment) and Article 8 (privacy and family life). The application was upheld and on 27 June Mr Justice Jackson ordered that the Home Secretary:

“Do promptly, and in any event within three months institute an independent public investigation into the circumstances surrounding the death of Paul Wright on 7 November 1996, taking all reasonable steps to enable the inquiry to be effective and providing for full participation by the claimants”.

On 4 September 2001 the Director General of HM Prison Service, with the agreement of Home Office ministers, invited Dr John Davies (a medical doctor) to lead an independent investigation into the death of Paul Wright and to report findings and recommendations to the Home Secretary. The terms of reference for this inquiry were:

“To carry out an independent public investigation into the circumstances surrounding the death of Paul Wright on 7 November 1996, taking all reasonable steps to enable the

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<sup>56</sup> For a brief analysis see page 155, Wadham and Mountfield, *Blackstone's Guide to the Human Rights Act*, second edition, 2000.

<sup>57</sup> Inquiries will always be non-statutory for prison deaths.

<sup>58</sup> Commissioned by the Secretary of State for the Home Department. Dr Davies chaired a public inquiry into the death of Paul Wright. The oral hearing took place in Leeds on 17–18 December 2001. The final report was published on 11 July 2002.

investigation to be effective and providing for full participation by the claimants and to take account of the judgment of Mr Justice Jackson and of comments and references to cases and principles contained therein and to report findings and recommendations to the Home Secretary.”

The oral hearing of this inquiry lasted two days, although the Chair had access to the files of the Prison Service as well during the course of his inquiry and met with some witnesses outside the hearing. The inquiry came to the conclusion that Paul Wright died from suffocation due to an asthma attack. It did not establish the guilt of any of the persons involved but merely sought to establish the medical facts of the death, which the family felt were already known and admitted. The family was concerned that the inquiry failed to answer key remaining questions that they had about the death of Mr Wright.<sup>59</sup>

## 6.2 Public inquiries

Public inquiries as they stand currently are not a useful remedy following deaths in custody. They are a time-consuming and expensive procedure and do not lead to the kind of solution that the family is seeking. The Wright inquiry, as the only example available so far, shows that the family was not able to establish individual responsibility for the death of Paul but merely how the asthma attack killed him.

Generally public inquiries are only set up after substantial political pressure. In most cases an investigation into an individual death in custody will unfortunately never attract that much interest. The success of an inquiry depends on financial resources and the power to summon witnesses, obtain documents and require witnesses to answer questions. Currently there is no specific budget designated for such inquiries and not all inquiries are given the statutory powers on witnesses and documents. There is also no responsible institution (outside the political process) that is in charge of setting up such inquiries, reporting on the findings, and monitoring the success. Currently the decision to set up an inquiry is in the hands of, usually, the

Home Secretary. The importance and publicity surrounding a case may influence a decision on whether or not to set up an inquiry.

For the public inquiry process to be a normal, available remedy, as envisaged in this research, it would need to be a part of the framework rather than an additional and ad hoc remedy for aggrieved family members that is only available in the most high-profile and controversial cases.<sup>60</sup> It would also be important to remove the decision to set up an inquiry from the political arena. A new institutional structure would not necessarily have to be set up specifically. Instead it could form part of the work of, for instance, a Human Rights Commission.<sup>61</sup> The need for such a Commission with powers to set up inquiries is currently being considered by the Parliamentary Joint Committee on Human Rights. When a family is grieving for a loved one, the last thing they should have to do is take the Home Secretary to court to force him to hold an inquiry.<sup>62</sup>

There are of course other options for inquiries. Parliamentary inquiries with all the powers to call for papers and witnesses can be set up by Select Committees but again these are ad hoc and dependent on political interest. Obvious candidates for such inquiries are the Home Affairs Select Committee in the Commons or the Joint Committee on Human Rights. The latter, a committee of both the Lords and Commons, has been considering for some time whether to investigate deaths in custody but should it finally decide to do so it is unlikely to investigate particular deaths but rather the more general issues.

## 6.3 Conclusions

Public inquiries currently do not have the financial and institutional power to provide an appropriate remedy. If they are to be a useful remedy it would be necessary to separate the decision over setting up an inquiry from the political decision-makers. There would also be a need to create the financial means and the statutory framework for such a remedy, so as to provide it with the powers to make it effective.

<sup>59</sup> For more detail, see Liberty press release, 11 July 2002 – at [www.liberty-human-rights.org.uk](http://www.liberty-human-rights.org.uk)

<sup>60</sup> This scheme could be comparable to the Wright case. This case was not high-profile, there was no media interest or public campaign. The right to this inquiry was won through the Courts, not through political influence.

<sup>61</sup> Following the announcement of the Justice Minister in Scotland, a Human Rights Commission for Scotland is to be created, whose task it is to provide guidance to public authorities, to provide advice to the Scottish Parliament on legislation after introduction, to monitor and report on law and practice, and to investigate and report on human rights issues in relation to public policy. For more detail see “Justice”, 10 December 2001, Scottish Executive: [www.scotland.gov.uk](http://www.scotland.gov.uk).

<sup>62</sup> Even though it has been acknowledged that the Prison Service seems to be more sensitive about dealing with families since the Mubarek case.

## **7. Conclusion**

Currently, there are real substantive problems concerning the prosecution of those responsible for criminal offences. Effective investigation and an effective decision-making process are needed. Disciplinary hearings, civil actions, or remedies at European level are not

appropriate remedies for the family of the deceased. And public inquiries do not have the financial or institutional power to provide a remedy. Thus, in order to restore trust and confidence, the system for criminal prosecution of death in custody cases must be overhauled. The system must become more independent, more effective, and speedier.

## 6. RECOMMENDATIONS FOR CHANGE

### 1. Introduction

The previous sections have highlighted severe shortcomings in the current systems. Article 2 of the European Convention on Human Rights, the right to life, enshrines the most fundamental right and one of the basic values of the democratic societies making up the Council of Europe.<sup>1</sup> Specifically for deaths in custody, the deprivation of life is even more problematic because the state has a positive duty to secure life and it has to take responsibility for the care of those in institutions because they inevitably have a substantially reduced capacity to take care of themselves. The consequence is that the State as a whole must be presumed to have failed if a person dies in its care, or custody.

The state has also failed in its role if it does not investigate the death properly and, where criminal offences have been committed, prosecute those responsible. If someone has died there is a need to investigate whether there is a fault in the system, a fault that may put other lives at risk.

This section will summarise the shortcomings and failures in the investigation, the inquest and the other remedies, as highlighted in the previous chapters; and will offer some recommendations for change. The section analyses several models that might provide a better system and then concludes with those that might be the most appropriate.

### 2. Shortcomings in the investigation

#### 2.1 Introduction

Our overall conclusion is that the remedies currently available for the friends and family of someone who has died in custody are insufficient and inappropriate. The previous section has highlighted shortcomings in the investigation. These shortcomings will be summarised so as to provide a basis for the following sub-section, which makes recommendations for change.

#### 2.2 The investigation

The system as a whole does not create sufficient public confidence. The investigation of deaths in police and prison

custody is not effective, is secretive, too slow and not sufficiently independent. The authorities involved in such cases too often do not take responsibility for their actions and appear defensive.

The parallel, overlapping, conflicting and confusing roles of the police, the PCA and the coroner create problems and reduce both the effectiveness of the system and the confidence that others might have in it. Coroners do not, and cannot, supervise investigations because they do not have sufficient resources, experience or training. Coroners do not have the time themselves or the resources to employ others to secure the scene, preserve and obtain the evidence or conduct the investigations. In theory, the police have a supportive role to the coroner. However, in practice this does not work and the police are not subject to the direction of the coroner. Furthermore, the position and role of the pathologist is not clear.

The relatives of the deceased are too often excluded and marginalised. From the perspective of the relatives, the investigation can often appear not so much as a search for truth but as an attempt to avoid blame, to frustrate disclosure, to restrict the remit of the investigation and to denigrate the deceased. As a result, relatives and their supporters have little confidence in the system.

It is not clear to what extent future changes will improve the current situation. As a result of the Police Reform Act and the creation of the Independent Police Complaints Commission (IPCC) all 'controversial' police-related deaths will be investigated in the future by the IPCC itself. It seems to be the clear intention of the Home Office and others that this should certainly include deaths in custody. The challenge between now and when the new system starts, in April 2004, is for the IPCC to be able to find and train enough sufficiently experienced staff to avoid the need to rely too much on seconded police officers.

Lastly, the anticipated improvements to the remedies after deaths in custody are too limited. Even though the IPCC will also be able to investigate cases where a 'non-officer' member of a police force is alleged to have been involved in a death in custody, it will not be able to investigate deaths that do not involve the police force: deaths in prisons and secure hospitals will remain to be investigated by the police and by inadequate internal mechanisms.

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<sup>1</sup> For more detail, see *McShane v United Kingdom*, European Court of Human Rights, judgment of 28 May 2002, Strasbourg.

## 2.3 Recommendations for change

Several models were considered by Liberty during the period of this research. These include:

- (1) to improve the investigatory role of the police
- (2) to create a completely separate commission to investigate all controversial deaths
- (3) to give coroners an investigatory role
- (4) to give members of the upcoming IPCC an investigatory function in deaths in other institutions
- (5) to mirror the role of the IPCC in other institutions by, for instance, putting the Prisons Ombudsman on a statutory and independent footing
- (6) to establish an over-arching commission that would bring together the concerns that arise from deaths in custody but would not investigate individual cases.

(1) It has been suggested that taking the investigations away from the police would be a mistake. It is a key underlying value of the rule of law within the criminal justice system that it operates in the same way for all, whether the suspects are police officers or civilians. According to this view all cases should be investigated by those whose job it is to uphold the law – the police themselves. Thus, any proposals should not create new institutions but should instead involve the creation of new mechanisms to ensure that the police undertake the investigation properly.

Nevertheless, such a system would not deal with the major criticism of the current system, i.e. the fact that the police investigate themselves and in many cases are not trusted to do so by the families of the deceased and the communities from which they come. The current arrangements are never likely to create sufficient public confidence, no matter how effective the investigation actually is. In fact, many of the families of those who have died express the view that they want the investigation to be the same as for any other homicide and have not demanded preferential treatment. However, the practice over the recent past suggests that this system does not work. **We have concluded that deaths in police custody must be investigated independently.** As long as the same legal rules apply to the mechanism used for

investigation, prosecution or conviction there is, strictly speaking, no differential treatment and no violation of equality under the rule of law.

(2) A second option would be the creation of a completely separate commission to investigate all forms of deaths in institutions or at the hands of the state. Such a Commission would have many advantages. It would allow greater consistency in investigations, make it much easier to build up expertise in investigating deaths, and it could create a powerful force for change. Proponents for such a Commission include INQUEST and the United Friends and Families Campaign.

However, the disadvantages of this proposal may outweigh the advantages. It does not tackle the root problems, i.e. deficiencies in the investigation of police complaints more generally. Furthermore, the relatively specialised remit of such a Commission might prevent the development of expertise across the policing area.<sup>2</sup> The same would be true for the investigation of deaths in prisons and in secure hospitals. The other complaint mechanisms in those jurisdictions would not benefit directly from the experience of investigating deaths. Also, there would be some degree of artificiality as to which cases were investigated by the Commission. For example, cases where a person was injured but did not die in police custody would have to be investigated by a different body even though the issues and problems are no different to similar cases where the person died from the injury.

This proposal also has some other practical problems. While such a Commission could certainly guarantee independence it would cut across the progress made on the establishment of greater independence in police complaints (the IPCC). The creation of the Independent Police Complaints Commission gives the authorities a good reason not to take any other steps at present.

(3) Another suggestion would be to give Coroners further powers and their own staff to investigate deaths. This would have the flexibility to ensure that any controversial death was investigated independently. It would take the investigation away from the police (see suggestion (1)) and it would ensure that all deaths, i.e. police, prisons and secure hospitals were investigated independently (see suggestion (2)).

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<sup>2</sup> Expertise that should be developed by the IPCC.



However, the problem with this process is that it would mix the investigatory stage with the adjudication. Thus the coroner would have to take an initial view of what the lines of investigation should be but later rule on the same issues at the inquest itself. Also, unless significant changes are made to extend the skills and the experience of coroners, this option would not be viable in practice.

(4) The fourth alternative would be to build on the creation of the Independent Police Complaints Commission. The IPCC will have its own investigators and this potentially secures the necessary independence. However, due to practical reasons, it is likely to employ or have seconded to it ex- or serving police officers (at least when it first starts work). This process needs to be managed carefully. Liberty has previously recommended that there should be a certain minimum ratio (e.g. 75:25) of non-police investigators to protect independence.

IPCC staff will need to be properly trained, monitored, and supervised. The process of investigation needs to be quicker and there needs to be proper liaison with the relatives, the coroner and other parties. Work will need to be done to ensure that transparency is a priority and that investigation reports are disclosed immediately. Further, if this option were to be pursued, there would need to be an internal department to provide Scenes of Crime Officers and this would need to be justified economically. At the very least it would be necessary to ensure that there are sufficient resources to deal with each new death immediately and thoroughly.

In practice it is most likely that the immediate control of the scene can only be undertaken by the home force, however, once the Independent Police Complaints Commission has been notified the investigator can take control of the investigation. Sanctions against forces that do not comply with instructions may be necessary.

This model does not resolve the problems with regard to investigations in prisons and secure hospitals – unless the IPCC's remit were extended to cover those institutions too. This option could be run as a pilot project initially and if successful, the IPCC's powers could be expanded.

There are however a number of significant difficulties with this option. First, the process of establishing the IPCC and getting it to work efficiently and effectively (including ensuring that the investigation is independent) is

a difficult task. Already the date for the IPCC going live has slipped a year to April 2004. Expanding its remit now or within the first years of its life could erode its ability to carry out its current task and might make it more likely that it will fail. Secondly, unless its remit was extended not just to deaths in custody but to other serious complaints in prisons and hospitals, it would suffer from the disadvantages set out above.

(5) **Liberty favours the option of developing a separate and parallel complaints mechanism to the IPCC for prisons and for hospitals for the independent investigation of deaths.** It may well be that institutional links could be built between those bodies to ensure that the advantages of one Commission (see above) could be captured without the disadvantages. Of course significant improvements would need to be made to the current systems for dealing with complaints in prisons and hospitals to bring them at least in line with the powers and resources of the IPCC. For instance consideration needs to be given to the possibility of the Prisons Ombudsman being given a more significant remit, being appointed independently, having statutory powers and having investigators to investigate deaths in prisons. At the moment, the post of the Prisons Ombudsman is too strongly connected with the Home Office.

Liberty and INQUEST believe that the lack of genuine demonstrable independence from the Prison Service leaves the Ombudsman's role vulnerable to criticism that it is not a truly independent body. Many of his staff are Home Office employees on secondment which again, without radical change, would undermine confidence.

INQUEST believes that the relationship which the Ombudsman has to maintain with prison staff to perform his current role of investigating prisoner complaints is likely to be at odds with the role of investigating deaths in custody. The Ombudsman needs good working relationships with prison staff to be effective when investigating prisoner complaints. If he were then involved in, for example, taking statements from prison officers which might lead to prosecution or civil proceedings, it is difficult to see how the two roles can be reconciled. Currently investigations by the Ombudsman are almost entirely paperchases – it is rare for the Ombudsman to undertake investigations which require a fact-finding mission.

The Prison Service has been looking at ways of

strengthening investigations of deaths in prison and in particular through bringing in an independent element. It put out a consultation paper about this in December 2001, setting out options.

One of these options was that investigations should be conducted by the Ombudsman instead of the Prison Service. The Ombudsman is willing to take on this role as long as there are sufficient powers and resources to fulfil this role effectively. A government white paper noted that such a critical appointment should have a clear statutory basis: legislation on this can be expected in 2003.<sup>3</sup>

**(6) Liberty also supports the creation of a separate, over-arching commission.** This body should act primarily not as an investigator, but as a Standing Commission on Custodial Deaths.

Deaths in custody should be independently investigated, and no longer be carried out by a state agency. There should be an independent body set up to deal with each institution, to investigate deaths in custody and other serious allegations. These new bodies would then be able to help the institutions to learn any lessons from mistakes which resulted in deaths, as well as from other complaints made by those detained. The creation of one body to investigate all the deaths in all the institutions would not have this key virtue.

We also believe that this proposal is realisable in practice. The IPCC will be in place in 2004 to deal with deaths in police stations; and steps are already being considered to improve the resources and independence of the Prison Ombudsman.

Neither giving Coroners further powers and their own staff to investigate deaths, nor expanding the remit of the IPCC to investigate deaths in prisons and hospitals, are sensible or likely to be possible in practice. Liberty favours the option of developing separate and parallel complaints mechanisms to the IPCC for the independent investigation of deaths, serious injuries and other serious allegations in prisons and hospitals. We also think that a similar approach should be taken to other institutions where people are detained, including reception and detention centres for asylum seekers.

However, we realise that there are many common concerns that arise between deaths in different custodial settings and that separate bodies to investigate specific deaths do not easily allow those concerns to be addressed on a more holistic basis. There are a number of ways in which this problem could be dealt with.

First, institutional links could be built between the IPCC and those new bodies that we propose, to ensure that common concerns are dealt with, common lessons are learned, and the bodies can work together for change. Representatives from each agency could be involved as well as those working with bereaved people, non-government organisations etc.

However, Liberty's preferred option, as stated above, is the creation of a separate, over-arching Standing Commission on Custodial Deaths. Its mandate should be to bring together the experiences from the separate investigatory bodies set up to deal with police, prison, hospital deaths and others. Such an over-arching body could identify key issues and problems, develop common programmes, research and disseminate findings where appropriate, and ensure services work together for change. Lessons learned in one institution could be promoted in other institutions, best practice could be promoted, and new policies designed to prevent deaths could be drafted and implemented across all institutions. Differing policies could be identified and changes suggested (for example with regard to restraint techniques, where it appears that every institution has differing policies).

We do not think that this Commission would usually investigate individual cases or duplicate the work of the other investigatory bodies – although it should have powers that would allow it to intervene as an interested party in an inquest where appropriate. It should also have the power to hold a wider inquiry in circumstances where there was a consistent pattern of deaths; or where several deaths had occurred in a particular institution, or as a result of similar circumstances symptomatic of a deeper systemic malaise. It should certainly be able to insist on access to documents and have the power to summon witnesses (powers similar to those given to the Commission for Racial Equality or the Equal Opportunities Commission) for the purpose of such an inquiry.

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<sup>3</sup> White Paper on the Criminal Justice System, *Justice for All*, July 2002, at para. 6.39.

Except when conducting inquiries we do not think that this Commission needs substantial resources. We suggest that its membership could include representatives from the other investigatory bodies, although there should also be other independent members who should represent or reflect the interests of people detained in these institutions.

### 3. Shortcomings in the inquest system

#### 3.1 Introduction

Several shortcomings have been highlighted in the coroners' inquest system. However, the inquest cannot cure the defects in the investigation outlined above; and any system proposed for the future needs to ensure that the preceding investigation is effective.

The following sub-sections will summarise the shortcomings of the inquest system and will then make recommendations for change. Liberty was aware of the ongoing coroners' review undertaken by the Home Office and hopes that the ideas in this report will be considered by the review team.

#### 3.2 The inquest system

The current inquest system is not sufficient because it does not provide the family with an effective remedy and the process itself has several flaws. There is a lack of transparency, because disclosure is not provided as of right, it is not provided early enough and there are too many exceptions which allow material to be kept secret. The process is adversarial in practice in these cases but it is confusing because it purports to be inquisitorial.

Coroners are not appointed with sufficient powers to be truly independent when dealing with controversial cases, and they lack the necessary skills and training. The jury is too restricted in its ability to frame verdicts and cannot make recommendations. The 'verdicts' are not really verdicts at all and do not identify who is responsible, or provide for accountability and liability. The 'judgments' given by the inquest jury as to responsibility do not lead to any form of legal liability. This creates anomalies and a lack of consistency within the system as a whole.

There is a failure to learn lessons from deaths because the findings and recommendations of coroners are not published, and recommendations are not monitored or

followed up. Riders have been abolished. Lastly, the lack of sufficient funding for lawyers for the relatives violates the principle of 'equality of arms'.

#### 3.3 Recommendations for change

Two views have emerged on how the system could be amended so as to provide an effective remedy after a death in custody:

- (1) abolish the current inquest system completely and replace it with something else
- (2) improve the current system and make it more effective.

With regard to the latter, two options must be examined:

- (2) (a) to incorporate the coronial system into the civil courts system, and
- (2) (b) to hold on to the inquisitorial role of the coroner but to improve and update the inquest system.

(1) By abolishing the inquest system and replacing it with an alternative system, the proceedings in England and Wales could be brought in line with other European systems. However, the experience and expertise that has been developed so far by coroners and others would be lost. Furthermore, the need for a transparent and effective process of investigation as it arises under Article 2 of the European Convention on Human Rights would not be satisfied if not replaced with another appropriate model.

Civil actions are only possible where there are relatives who can claim compensation for loss, and civil actions are only possible for the very poor (with public funding) or the very wealthy who can afford to pay for their own lawyers. Furthermore, civil courts focus on issues of liability and are not particularly good at exposing the truth. In cases where there is no evidence of a tort being committed no action can be taken.

The criminal process is also flawed and would be even more inadequate as a remedy if this is the only forum following a death. The small numbers of prosecutions and the absence of convictions would suggest that this remedy is unlikely to provide a sufficient system of redress. The need to identify actions of a particular individual as violating the criminal law and finding sufficient evidence to meet the higher standard of proof (beyond reasonable

doubt) are problematic. The reluctance of the Crown Prosecution Service to prosecute and the reluctance of juries to convict police officers remain real issues.

**Liberty’s view is therefore that the current system should be radically improved – still, where possible, using the expertise that has been developed so far by coroners.** This option might leave the Independent Police Complaints Commission in charge of the investigation with the coroner having only an adjudicatory role (although some of the other options for investigation set out above are compatible with such a role). However, without substantial amendment, the current system will not tackle real problems such as inconsistency in the adjudication of coroners, the discrepancy in the standards being applied and the lack of experience of coroners in some areas or districts with such controversial deaths.

**(2) (a)** One option discussed is to integrate coroners into the civil justice system. They would have to be replaced or re-appointed as judges, such as district, circuit or High Court judges. The seniority of the judge sitting as a coroner would depend on the level of seriousness of the case involved. There would be a right of appeal to the High Court on a point of law (rather than families and others having to rely on the discretionary remedy of judicial review). We also support the approach that the Review Team have taken that **the Attorney General’s role in granting his “fiat” (permission), before cases can go to the High Court seeking to quash the decision of an inquest, should be abolished.**

Clearer rules of procedure are needed for inquests, incorporating a number of key changes outlined in this report. The family should be a party and have the right to be properly represented. The inquest system would be generally adversarial, providing the coroner with an adjudicative role (although retaining some inquisitorial powers such as the ability to call witnesses). The inquisitorial role might also need to be available if no one was able to represent the interests of the deceased. The family and all interested persons should be given all the powers of a party to civil litigation, i.e. the powers to cross-examine, to address the jury, and to call witnesses. All the evidence presented to the inquest should be liable to cross-examination. Legal representatives or properly interested persons themselves should be able to sum up the evidence and to address the jury as to the facts.

The usual rules of disclosure in civil proceedings would apply to the inquest, as would the other legal safeguards. District judges (coroners) would be selected via an open process (advertisement) with clear criteria (they should all have legal qualifications and job descriptions), be properly trained (and be obliged to undertake continuing professional training) and have their performance subject to regular monitoring. A proper complaints mechanism should be established. Appointment would be undertaken at a national level, and pending the establishment of a fully transparent judicial appointment commission would be by the Lord Chancellor. We fully support the proposal of the Coroners’ Review Team that “the appointment of coroners should involve an assessment of their suitability to work with bereaved families and individuals.”

This approach might reflect some elements of the Scottish system (for instance the fact the coroner/procurator fiscal is a qualified lawyer). With regard to jurisdiction it may be advisable to increase the powers of the coroners’ court. Coroners could continue to control evidence (as would a judge in civil proceedings), assisting the jury to reach a verdict. In contrast to the Scottish system however, **all controversial deaths in England and Wales should be heard by a coroner and a jury.** It has been suggested that it is in the interests of the families for the inquest system to remain inquisitorial and that an integration into the civil courts would make the system more adversarial. As a result, it might not reveal as much of the truth as possible. Nevertheless, Liberty believes that this option will result in fairer inquests and as a result a more open system.

Given that the inquest is the only effective means of investigation, we do not recommend that it is a committal stage in the criminal process. Liberty did carefully consider this option but rejected it.

**Liberty also believes that the privilege against self-incrimination should be abolished so that police officers and others are forced to give evidence and answer questions in the inquest.** As we have suggested earlier on in this report, any evidence that is thereby given should not be admissible in criminal proceedings.

**(2) (b)** In addition, some more detailed amendments are essential to increase effectiveness and confidence in the

amended system. To enhance transparency, coroners should provide specific justification for any witnesses they want to call themselves. It was suggested that perhaps, to strengthen the power of the coroner, the coroner should have 'counsel to the inquest' as is common in public inquiries. There are some virtues in this but Liberty was concerned that this might undermine the position of the parties (particularly the relatives) and might continue to marginalise their involvement in the process.

**There should be a full review of existing verdicts, with a verdict indicating negligence or a failure in a general duty of care introduced to the prescribed list.** The parties could draw up and the coroner could agree specific questions for juries to answer. A model similar to jury trial in civil cases (such as cases alleging unlawful police detention) could be adopted, i.e. precise questions of fact would be agreed between the judge and the parties. Juries should be allowed to use narrative verdicts allowing expression of issues of concern in those cases not suited to prescribed verdicts. Where the jury considers that negligence or a failure in a general duty of care contributed to a death, this could be added as a rider to the principal verdict.

**Properly interested persons should have the right to legal representation at inquests and in deaths in custody cases.** Means testing for public funding should be abolished in death in custody cases. Liberty believes this is justified because of the importance of the issues, and because of the crucial importance of representation (means testing is not required in other circumstances – for instance, free legal advice is available for those detained at police stations and for the representation of children in family cases in the courts).

Liberty considered a third option, of increasing the powers of the coroner to act as investigators. This could be one way around setting up additional investigatory bodies for each institution (police, prisons, and psychiatric hospitals), yet it would also create the problem that the coroner would then act as adjudicator and investigator. Liberty does not therefore support this recommendation. Coroners do not have the training to secure a crime scene. Such a dual role would create controversy in the eyes of many including some coroners but, perhaps most importantly, in the eyes of the family. It could create the

possibility of coroners pre-judging the case before they have heard the evidence.

Liberty also contemplated whether the inquest system should decide criminal liability (or at least provide an alternative committal process again), given that we are proposing such major changes to the inquest proceedings. However, integration of the inquest system into the criminal system is opposed on the basis that the underlying aims of the two systems are quite different. The verdict after an inquest is concerned more with the corporate criticism of the police if any is appropriate, i.e. the inquest examines whether the system failed as a whole. The criminal system focuses on the prosecution or the establishment of liability of the individual officer, and as such is more personal. Consequently, this idea was rejected by the Advisory Committee.

## **4. Shortcomings with regard to other remedies**

### **4.1 Introduction**

The inquest procedure should be part of a consistent legal system. This involves a certain harmony with the civil and criminal procedures. However, despite unlawful killing verdicts at inquests there have been few prosecutions and no successful ones, i.e. no convictions. It is also the case that existing remedies available in civil litigation or as a result of internal disciplinary procedures are neither appropriate nor sufficient for these very serious cases. Public inquiries are rare and can never be guaranteed as a standard or regular statutory system of redress.

Given the shortcomings of the inquest system as it stands currently and the flaws in the remaining legal system, the families of the deceased are left without an effective remedy. The following sub-section highlights the shortcomings of the other remedies and makes recommendations for improvement.

### **4.2 The other remedies**

Civil action currently plays a relatively minor role after a death in custody because it is purely about compensation, does not often contribute to the finding of the truth, and is only likely to be pursued if the family member has been financially dependent on the deceased. Indeed 95% of civil



actions are settled outside of the courts and the parties who settle do not necessarily find out any more about the cause of the civil wrong. For instance, even though there was compensation in the Wright case – unusual because the mother was financially dependent on her deceased son – Article 2 required that there was an inquest, and then, as a result of problems with that process, a public inquiry to establish the truth.<sup>4</sup>

Disciplinary proceedings taken against the police officer involved offer another method of redress. However, for the family, it does not provide a real remedy. The family wants to find out what has happened, who is responsible, and they want to see those individually responsible held liable. Disciplinary proceedings will rarely satisfy them because the most severe remedy is the loss of employment. Disciplinary proceedings are further flawed by their current rules. For instance, although the family can attend any subsequent disciplinary proceedings, they cannot have a legal representative. Disciplinary proceedings in the prison service have even less accountability and there is even less transparency.

Criminal prosecution is the most appropriate “other” remedy for deaths caused by agents of the state. It is a mechanism that holds those individually responsible directly liable. Currently the Crown Prosecution Service prosecutes in cases involving death in custody. However, prosecutions against police officers often never get started and those that do have never ended in a conviction.

The evidential test for prosecutions prescribes that there must be enough evidence to provide a realistic prospect of conviction, i.e. that it is more likely than not that the defendant will be convicted on the proper standard of proof – beyond reasonable doubt. There is a great deal of concern regarding who has the responsibility for the decision-making in such cases, and regarding the accountability and transparency of that process. There is no statutory obligation to reveal the reasons for non-prosecution to the family – even though in practice this is now taking place.<sup>5</sup>

Theoretically decisions not to prosecute can be judicially reviewed on the basis that they were made in breach of the law (including of course the ECHR) or are so perverse that no reasonable prosecutor could have made them. Nevertheless, in practice this rarely results in a successful challenge, and even where a judicial review is successful and the original decision not to prosecute is quashed, it rarely results in a different decision subsequently by the Crown Prosecution Service.

There is anecdotal evidence that juries tend to be biased in favour of police witnesses in criminal trials compared to other witnesses, some of whom may have criminal convictions. Police, prisoners and staff of secure hospitals are seen as people who protect the public and it is difficult for juries to punish them.

### 4.3 Recommendations for change

With regard to criminal prosecution after deaths in custody, three options were considered on how the system could be improved:

- (1) create a completely separate body responsible for these prosecutions
- (2) transfer the responsibility of charging to another (existing) body, or
- (3) leave the procedure as it is but make amendments to improve the Crown Prosecution Service’s role.

(1) Public confidence in the impartiality of prosecutions of those responsible for a death in custody could be achieved, by transferring this duty from the Crown Prosecution Service to a new, separate body. This would answer the need for greater independence and less perceived conflicts of interest. There is a perceived bias in the police and CPS which some of those bereaved would argue prevents viable prosecutions going ahead. It has been argued that this is reflected in all-too-often nonsensical analysis of evidence by the CPS.<sup>6</sup> Others state that there is clearly a danger that the Crown Prosecution Service

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<sup>4</sup> For more detail on this case, see the earlier section on ‘other remedies’.

<sup>5</sup> A Direct Communication with Victims policy has been officially adopted since September 2001; however, the CPS also met with families before the policy was adopted on the basis of a pilot project. Furthermore, if no prosecution is to take place, the CPS now sends a detailed letter to the family setting out the reasons for this decision.

<sup>6</sup> For more detail, see the submission of Birnberg & Co as cited in Harrison, Cunneen, *An Independent Police Complaints Commission*, 42.



appears to make judgements involving the police that are not properly balanced.<sup>7</sup> The interests of the police and the CPS are too close and the danger of contamination is ever present regardless of how much individual staff try to preserve their integrity and independence.

However, to set up another independent body simply for the prosecution of police officers is likely to attract resistance. The expense of another separate body with a separate infrastructure would be a particular concern considering the very low number of cases it would have to handle. Furthermore, there are currently only five experts dealing with cases of deaths in custody. These five experts comprise a valuable source of expertise that should not be excluded from any future decision to prosecute.

(2) There were several suggestions on how to transfer the responsibility for prosecution – or perhaps just the charging process – to another, existing body. One would be that the Independent Police Complaints Commission should conduct the investigation and, where appropriate, charge the person responsible for the death (rather than the charging process being passed on to the police or the CPS). The onus to continue with the prosecution would still rest with the Crown Prosecution Service once it took over the prosecution. This option is superficially attractive but is unlikely to have anything more than a symbolic effect in practice.

An alternative approach would be to enhance the powers of the coroner's court. The verdict could act as the committal stage for any subsequent criminal trial and the onus would again then be passed on to the Crown Prosecution Service to continue with the prosecution. The question of criminal liability was excluded from the verdict of the coroner in 1977,<sup>8</sup> and the coroner's power of committal was removed. In this option, criminal liability could be partly determined by the coroner and the verdict of the jury would be more significant.

This alternative would guarantee the independence that is needed to raise public confidence in the current criminal system after deaths in custody. However, there may be a problem if this was combined with the coroner's role as investigator. The Independent Police Complaints

Commission, or the inquest court, must ensure that the investigation and the prosecution are separate and completely independent. This separation must be safeguarded. The dangers involved in this option are in the vesting of conflicting powers in the same body: and of powers and processes which are significantly different.

(3) A third option would be to leave the system as it is but to improve the current performance of the Crown Prosecution Service. This could involve the creation of a special unit, perhaps directly responsible to the Director of Public Prosecutions and separate from the rest of the CPS. This option would have the advantage of continuity and consistency – the role of the CPS would stay the same and everyone would be dealt with in the same way. It would also allow the experience and expertise so far to be utilised efficiently. An alternative would be for this unit to be based in the office of the Attorney General and responsible to him.

Whatever system is proposed, however, there need to be greater opportunities for enhanced scrutiny of the system. This involves a clear legal requirement that extensive reasons are given for non-prosecution in such cases. The family also needs to be kept informed throughout the decision-making process and during the prosecution itself. In this respect Liberty welcomes the review by the Attorney General of the system within the CPS of prosecutions following deaths in custody.

It has been suggested that there should be the possibility for an appeal if the CPS decides not to prosecute. An appeal would be more advantageous than a judicial review.<sup>9</sup> The availability of an appeal presupposes something more than a review of the legality of the process as in judicial review. Any appeal would have to allow an examination of the merits of the decision not to prosecute. However in practice, if this was implemented, every single decision not to prosecute would be probably be appealed. Thus all controversial decisions would be decided by the appeal process – the practical result being to shift the decision on whether to prosecute to the appeal body.

Secondly, it is not clear who would sit on such an appeal body. If they were judges, two questions arise. What are the consequences of judges making decisions about

<sup>7</sup> For more detail, see Home Affairs Committee Report – *Police Complaints and Disciplinary Procedures*, First Report, Vol. 1, 1997.

<sup>8</sup> Criminal Law Act of 1977. For more detail, see Dorries, *Coroners' Courts*, at p. 12.

<sup>9</sup> This idea was floated by the Director of Public Prosecutions at a 2002 seminar.

prosecutions before trials? And would such decisions be less likely to be challenged in judicial review proceedings?

The third issue that would need to be resolved if an appeal system was created is who should take on the prosecution if an appeal was successful. It hardly seems sensible in a controversial case to send the prosecution back to the CPS after an appeal. To ask the CPS to prosecute – the very same body or person who decided that there was no realistic prospect of prosecution – is not likely to create any more public confidence than exists in the current flawed processes. The chances of such a prosecution being robustly pursued seem remote.

Several other more detailed options for change have been considered. These include:

- (1) an amendment to the Code for Crown Prosecutors, adding a presumption that there should be a prosecution if there was an unlawful killing verdict in the inquest
- (2) a requirement that all deaths in custody should be investigated as homicides by the police (as already occurs in some areas), and
- (3) the possibility of the creation of a new criminal offence especially for deaths in custody and/or police officers.

(1) An amendment to the Code for Crown Prosecutors could either create a presumption that there should be a prosecution or could make it virtually automatic after an unlawful killing verdict. It would also mean that the evidential test did not become an insurmountable hurdle because of ‘over-analysis’ by the Crown Prosecution Service.<sup>10</sup> However, at the same time, it would mean that cases could still be screened as they progressed to avoid them failing at a later stage. If the case does not have a reasonable prospect of succeeding it will still fail, whether that is established before the case comes to court or during the court proceedings. Indeed, it would result in more emotional distress for both the deceased family who may have had high expectations which will be frustrated if the case has gone to court but failed and for the police officer who would be subject to an unnecessary prosecution. There is thus a great benefit in screening the cases beforehand. How this is done and who this is done by is a different matter.

(2) All deaths in custody should be investigated at the very start as homicides. This suggestion again highlights the central role that the investigation plays in the whole process after a death in custody. The securing of evidence is the basis for the inquest proceedings and for any criminal prosecution. Any flaws during the investigation will jeopardise the later process. Liberty believes this is a sensible suggestion and may help ensure better investigations pending the time when the IPCC takes over the role.

(3) Another suggestion involved widening the range of criminal sanctions to reflect the wide range of circumstances in which the legal standard may be breached. This may involve considering the way in which the potential sanctions may fit the various categories of incidents, and the degree of blame which those responsible may be expected to bear. However, conceding that the current limited options in the criminal law contribute to the difficulties in securing convictions against the police following deaths in custody should not necessarily lead to the watering-down of the law itself. The consequence of amending the law will result in police officers, who acted in exactly the same way as civilians, being treated differently. The law should be the same for all, and the police should not be subject to a different form of criminal liability than other members of the public. The creation of a different offence, even if this is motivated by the inability to prosecute the police under the current law, would constitute such differential treatment.

#### 4.4 Other recommendations

Whatever system is created, improvements need to be made in the use of pathologists. One way to do this would be to set up a legal framework to structure their procedures in these cases. The work of pathologists itself also needs to be monitored. This could be done, for example, through an institute such as the Royal College of Pathologists (which already oversees the education, training and assessment of pathologists and the setting of standards for practice).

The coroner and the pathologist should proceed with their duties quickly in order to enable the release of the body to the bereaved as soon as possible after the death.

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<sup>10</sup> This was a problem identified by Judge Gerald Butler at a recent seminar organised by the Attorney General.

## 5. Overall conclusion and recommendations

The system for investigating deaths in custody needs fundamental reform. In particular:

- The dominant link with the police in investigations must be broken
- Every death in custody must be investigated as a possible homicide
- All custody deaths must be investigated independently. The IPCC must be in charge of the investigation into police custody incidents; a reformed and more independently-organised prison ombudsman system should be in charge of the investigation into prison deaths; and an equally independent system must be created for deaths in psychiatric hospitals
- An over-arching standing commission should be created to learn lessons from deaths in any institution in which a person has been detained; to monitor progress on preventing deaths and recommendations from inquests; and to spread good practice
- Liberty re-emphasises that, in the long term, the majority of investigating personnel in the IPCC must not be police-related: the ratio of non-police to police must be at least 3:1.

Further:

- Coroners should have a more judicial role, adjudicating over an adversarial process – but they should retain some inquisitorial powers (e.g. to call witnesses)
- There must be a right to legal representation: means testing for legal aid in inquests concerning deaths in custody should be abolished
- Relatives of the deceased should have the rights of a formal party to civil litigation
- The inquest must be more accessible, language must be simplified, and a designated person must be assigned responsibility for the welfare of the family and for explaining the process
- The inquest jury must be retained for all inquests into controversial deaths
- The jury must have more powers
- Recommendations must be a regular component of the inquest verdict. These must be published, their implementation must be monitored, and a publicly accessible database must be created
- Pre-inquest disclosure must be compulsory
- The process must be speedier
- The role of the Attorney General in giving fiats as a preliminary to overturning inquest decisions should be abolished
- CPS performance must be improved – possibly through creating a separate, specialist deaths in custody unit reporting directly to either the Director of Public Prosecutions or the Attorney General
- Coroners could be integrated into the civil justice system. A new right of appeal to the High Court of points of law should be established
- The privilege against self-incrimination should be abolished – but evidence thus given should not be admissible in any subsequent criminal trial
- There should be a presumption in the Code for Crown Prosecutors that a prosecution will follow a verdict of unlawful killing, subject to the evidence test
- Clearer procedures and monitoring are needed for the work of forensic pathologists
- A Chief Coroner or President of Coroners could help implement monitoring, raise standards, ensure regular training, publish guidance on good practice and deal with complaints.

## APPENDICES

### 1. UNLAWFUL KILLING VERDICTS AND/OR PROSECUTIONS FOLLOWING DEATHS IN CUSTODY SINCE 1990<sup>1</sup>

| <i>Name</i>           | <i>Ethnicity</i> | <i>Date</i> | <i>Custody</i>                                       | <i>Prosecution</i>                               | <i>Inquest</i> | <i>Verdict</i>  |
|-----------------------|------------------|-------------|--|--|----------------|---|
| 1. Oliver Pryce       | Black            | 1990        | Cleveland Police                                     | No   | Yes            | Unlawful killing  |
| 2. Omusase Lumumba    | Black            | 1991        | Pentonville Prison                                   | No   | Yes            | Unlawful killing  |
| 3. Leon Patterson     | Black            | 1992        | Greater Manchester Police                            | No   | Yes            | Unlawful killing (first inquest); Misadventure contributed to by neglect (second inquest) |
| 4. Joy Gardner        | Black            | 1993        | Metropolitan Police / Immigration & Nationality Dept | Yes – acquitted                                  | No             | N/A   |
| 5. Richard O’Brien    | Irish            | 1994        | Metropolitan Police                                  | Yes – acquitted                                  | Yes            | Unlawful killing  |
| 6. Shiji Lapite       | Black            | 1994        | Metropolitan Police                                  | No   | Yes            | Unlawful killing  |
| 7. David Ewin         | UK White         | 1995        | Metropolitan Police (shooting)                       | Yes – acquitted (jury could not agree a verdict) | No             | N/A   |
| 8. Alton Manning      | Black            | 1995        | Blakenhurst Prison                                   | No   | Yes            | Unlawful killing  |
| 9. Ibrahima Sey       | Black            | 1996        | Metropolitan Police                                  | No   | Yes            | Unlawful killing  |
| 10. James Ashley      | UK White         | 1997        | Sussex Police (shooting)                             | Yes – acquitted                                  | No             | N/A   |
| 11. Christopher Alder | Black            | 1998        | Humberside Police                                    | Yes – acquitted                                  | Yes            | Unlawful killing  |

### 2. Research trip to Toronto, July 2002, death in custody project

#### 2.1 Contacts

|                           |  |
|---------------------------|--|
| <b>Dr James Cairns</b>    | <i>Deputy Chief Coroner for the province of Ontario</i>                          |
| <b>Peter A. Tinsley</b>   | <i>Director Special Investigations Unit, Ontario, Mississauga</i>                |
| <b>Rose Hong</b>          | <i>Communications Manager, Special Investigations Unit, Ontario, Mississauga</i> |
| <b>Tam Goossen</b>        | <i>President of the Urban Alliance on Race Relations, Toronto (NGO)</i>          |
| <b>Audi Dharmalingam</b>  | <i>Founding member of the UARR, Toronto</i>                                      |
| <b>Julian N. Falconer</b> | <i>Falconer Charney Mackilin, Toronto (representing families)</i>                |
| <b>Peter J. Pliszka</b>   | <i>Toronto (represents police)</i>   |

#### 2.2 Information

The trip was successful in putting the current research into a broader perspective, allowing for international comparison and demonstrating some very useful practice. The office of the coroner in Canada (Ontario) has its roots in the English model, however over the years the system in Canada has undergone changes. In Canada, the system of inquiring into deaths is a provincial responsibility, and each Province has a slightly different system (some have a coroner’s system, some have a medical examiners system: in some provinces coroners are lay people, in other provinces they are physicians, and in some provinces they only have pathologists). This comparison focuses on the province Ontario (coronial system, largest Province, and dealing with the most deaths). The following can be concluded:

- All coroners by law must be medical doctors.
- Because of the size of the Province, local doctors are used as part-time coroners.

<sup>1</sup> Bhatt Murphy Solicitors, Liberty, INQUEST, *Response To Consultation Paper On Attorney General’s Review Of The Role And Practices Of The CPS In Cases Of Deaths in Custody*, p. 12.

- There are approximately 350 coroners spread across the Province (30,000 deaths a year).
- There are about 100 inquests a year – if this investigation reveals criminality the police take over, and they lay charges.
- Most inquests run for 3–4 days, the most complex ones run for 2 or 3 months.
- Custody deaths lead to mandatory inquests.
- Coroners examine the circumstances and make a decision whether there should be an autopsy (by a pathologist: local hospital pathologist for straightforward case, forensic pathologist for controversial case).
- Police who have jurisdiction in the area where the death occurred will supply to the coroner as many investigators as are needed.
- There is a Crown Attorney as the coroner's Counsel at every inquest.
- Every inquest has a jury consisting of five members.
- The number of autopsies performed is very low: Out of the 30,000 deaths that the Ontario office investigates, they do 8,000 autopsies – the main reason for that is because their coroners are physicians and a lot of natural deaths can be determined by the coroner without autopsy; however, every death in custody has an autopsy.
- If someone is in police custody and dies, that is reported to the Chief Coroner's Office; it is also reported to the independent Special Investigations Unit (SIU) – headed by a lawyer and independent of the police, although many of its investigators are ex-police officers. The SIU is a provincial investigative agency which investigates any serious injury or death in police custody.
- The SIU examines whether they are to lay criminal charges or not. When the director decides that no charges will be laid (e.g. because it was self-defence) it comes to the Chief Coroner's Office, an inquest will take place and the coroner will use his own investigators or will go to another police department.
- If the custody death occurs in prison, Ontario brings the police in.
- One of the downsides of having an SIU: you cannot have an SIU in every city, so they have a small number of investigators in comparison to the police service, so they will never be there with the first ambulance, or the first police car. The 'golden hour' is still in the hands of the police and they have to contain the scene. But in Ontario this hasn't been a major problem.
- A death in custody is an SIU scene. The SIU interviews the witnesses (police are not allowed to speak to witnesses until SIU has spoken to them). Police may have a parallel investigation but that is for their own purposes. The SIU investigates and decides whether to charge.
- If there are still issues that need to be resolved (suicide watch, video tapes not working etc), the case will come back to the office of the Chief Coroner and an inquest will address issues of public safety or prevention that will obviously not fall under the criminal code.
- There are levels of monitoring of coroners: (1) the provinces are divided into different regions and each region has a full-time supervising regional coroner, a member of the chief coroners office; all the reports and investigations that the coroner does are sent to the regional coroner. (2) the office of the Deputy Chief Coroner monitors the regional coroners. All requests from police, insurance companies, lawyers, etc come to him and by forwarding documents, he has a chance to review those files. The supervising regional coroner and the deputy chief coroner are on call 24h 7 days a week. Furthermore, every case that a coroner thinks should be autopsied will be sent in to the Chief Coroner's Office in Toronto, where a round of specialists meets and looks at the case, discussing whether it needs an autopsy (this round meets every morning).
- The autopsy by the Chief Coroner's Office (within their building in Toronto) is perceived as thorough and independent of both police and SIU.
- The family is not present at the autopsy but the police are.
- If there is an inquest, coroners will carry out an investigation. When that is done, the date of the inquest is announced. At least a month before the inquest, there will be a meeting with all the parties that will have standing and they will be given full disclosure of all the material. (Where there is no inquest: when investigation is completed, the family can request disclosure in writing. Chief Coroner's Office will provide them with coroner's report, with autopsy report, with toxicology report. Family do not get the police report, because that is not the property

of the coroner (but families can apply to the police for that report).

- Whatever is going to be brought up at the inquest, the full brief is disclosed to all parties. It is disclosed with an undertaking that it cannot be used for any other purposes until the inquest is completed.
- The jury makes all the decisions: who, when, where and how.
- The jury can make recommendations. Office of the Chief Coroner sends those recommendations to all the parties involved/ relevant to the case and an answer is expected from them. One year after the inquest those responses will be published.
- The recommendations are not legally binding but they are processed centrally.
- Not every inquest is published in full. There is an annual journal that reviews inquests that have taken place, listing the verdict and the recommendations.
- For the province of Ontario there will be an electronic record.

### 2.3 Conclusions/ implications for the project

- The large number of autopsies in England and Wales may be explained by the fact that the coroner is a lawyer and needs support by a doctor to determine the cause of death (whereas in Canada coroners are physicians trained to do this medical investigation).
- Ontario has the Special Investigations Unit (similar to IPCC) that investigates police-related deaths and serious injuries. This guarantees independence.
- The role of the coroner in Ontario is seen as being the guardian of public safety and prevention.
- Greater confidence is achieved due to full disclosure before an inquest into a death in custody to family and all parties who have standing.
- Inquests, and their juries, are more powerful in Ontario. The jury is not led by the coroner when giving the verdict, and can make recommendations which will be followed up and monitored.
- The coronial system uses the press to pressurise for change.

## 3. Joint research trip (INQUEST and Liberty) to Australia – death in custody project

01.07.2002–14.07.2002

### 3.1 Contacts

**Prof. Chris Cunneen** *Director of the Institute of Criminology, University Sydney Law School*

**Brett Collins** *Spokesperson, Justice Action, Sydney*

**Brendan Thomas** *Executive Officer, Aboriginal Justice Advisory Council, Sydney*

**Gayle Kennepe** *Researcher, Aboriginal Justice Advisory Council, Sydney*

**David McDonald** *National Centre for Epidemiology and Population Health, formerly director of the Australian Institute of Criminology responsible for deaths in custody, Canberra*

**Jenny Mouzos** *Research Analyst Manager, Australian Institute of Criminology, Canberra*

**Lisa Collins** *Policy, Australian Institute of Criminology, Canberra*

**Paul Williams** *Director, Australian Institute of Criminology, Canberra*

**Jacky Mileedge** *Senior Deputy State Coroner for New South Wales*

**Peter Mathews** *Executive Officer, Coroners Court Sydney*

**John White** *Coroners Court Sydney*

**Joe Hedger** *Policy Officer, Human Rights and Equal Opportunities Commission, Sydney*

**Darren Dick** *Director Social Justice Unit, Human Rights and Equal Opportunities Commission, Sydney*

**David Brown** *Coroner Melbourne*

**Graeme Johnstone** *State Coroner Victoria*

**Jaccinta Heffrey** *President of Coroners Society Australia, Melbourne*

**Dr David Ranson** *Deputy Director, Victorian Institute of Forensic Medicine*



### 3.2 Information

The trip was successful in putting the current research into a broader perspective, allowing for international comparison and demonstrating some very useful practice. Australia is a federal system and the Commonwealth Act does not cover inquest procedures. Each federal state has its own laws and practice. However, from the States visited (New South Wales and Victoria) the following can be concluded:

- There is a transparent, open and centralised system (centralised within the individual state not the federal state).
- There seems to be more public confidence.
- Following the Royal Commission into Aboriginal Deaths in Custody, State Coroners and Deputy State Coroners have been set up: with sole responsibility for deaths in custody; more training; more powers.
- Investigation: there is more independence even though no separate body to police exists; in two states, a unit overseeing police has been established: ethical standards department (Victoria) and police integrity unit (NSW). Investigation takes place on behalf of coroner, s/he is seen as investigator, on call 24h to visit scene.  
Victoria: homicide squad visit scene; Melbourne: coronial services, police and pathologist within one building, including research element (Monash University); upon completion family is sent copy of everything on investigation before the inquest.
- Inquest: there is only one post-mortem; body returned to family; coroners cover reasonable cost for burial of withheld body parts. All relevant organs and blood will be sent off for analysis. Police and family can be present at post-mortem, observe through glass window in seated viewing room and may ask questions through microphone linked with pathologist.
- Coroners' main aim is prevention: every inquest is published, including recommendations.
- Rule 19 of Coroners Act (Victoria): if police charge someone there is no inquest, or power to refer case to DPP during/ after inquest.
- Extensive powers of coroner: can compel witnesses, detention if witness fails to turn up, only coroner can give bail if witness held.

- Recommendations (NSW): detailed, documents can be viewed by anyone, recommendations are tabled in parliament and this way exerts pressure to comply on ruling party, publicised by Attorney General's Office.
- Suicides: chamber findings, inquest not held; but thereafter hearing becomes a public document, family can request an inquest to be held (can be carried out by non-state coroner: i.e. any magistrate or clerk of the court – they are all qualified to be coroners).

### 3.3 Conclusions, impact for the project:

Australian coroners' system guarantees:

- Transparency
  - all documents are disclosed to family before the inquest and inquest is published
- effectiveness
  - centralised
  - Monash project: electronic database
- prevention of future deaths in custody
  - coroner's recommendations are powerful
- consistency
  - latest project by Monash University (Victoria) sets up central database where all inquests including recommendations will be published electronically for coroners from all States
- Independence
  - the coroner is in charge of the investigation and not the police
- Promptness
  - witnesses can be compelled, only one post-mortem, no jury
- Public scrutiny
  - publication of all inquest documents, including recommendations
- High standard
  - since Royal Commission recommended setting up State Coroner and Deputy State Coroner, this has been implemented with specialist training and funding.

#### 4. Terms of Reference of the Advisory Committee

To advise and assist The Civil Liberties Trust in respect of the project to consider and investigate methods of investigation post a death in custody. Whilst the project will concentrate on the process following a death in police custody it will also consider the issues arising from deaths in prison and other institutions where people are compulsorily detained. Furthermore, and subject to resources, the project will also look at the extent to which the issues that arise from such deaths are relevant to other deaths for which police officers may be responsible.

The project will culminate in a report, which will be published by The Civil Liberties Trust. The authorship and findings of the report will be those of The Civil Liberties Trust.

The role of the Advisory Committee is to advise and assist the project. The Committee will meet on a 6–8 weekly basis until summer 2002 and consider papers prepared by the researcher, which outline the general concerns, problems identified and possible solutions proposed. It is hoped that a broad spectrum of opinion will be brought in and discussed.

*(For a list of members of the Advisory Committee, please see the Acknowledgements at the front of this report)*

#### 5. Definition of deaths in police custody

Deaths in police custody include situations where the deceased was in police detention as defined by section 118(2) of the Police and Criminal Evidence Act 1984, i.e. where the deceased was arrested or detained in charge of a constable, and where the deceased was otherwise in the hands of the police. This, inter alia, covers deaths:

- when suspects are being interviewed by the police but have not been detained
- when persons are actively attempting to evade arrest
- when persons are stopped and searched or questioned by police
- when persons are in police vehicles (other than whilst in detention)
- when there is a siege situation or ambush
- when persons are in care of police having been detained under the Mental Health Act
- when children or young persons are in police protection under the Children's Act 1989.

The Home Office is proposing to define four categories of deaths:

- Fatal road traffic accidents involving police officers
- Fatal shooting incidents involving police officers
- Deaths in police custody
- Deaths following other types of contact with the police.

This research looks at the system for investigating all controversial deaths involving police contact that require investigation. This includes all the above categories.

#### 6. Index of common abbreviations

|      |  |
|------|--|
| ACPO | Association of Chief Police Officers     |
| CPS  | Crown Prosecution Service                |
| DPP  | Director of Public Prosecutions          |
| IPCC | Independent Police Complaints Commission |
| PACE | Police & Criminal Evidence Act 1984      |
| SIU  | Special Investigations Unit (Ontario)    |
| UFFC | United Friends & Families Campaign       |