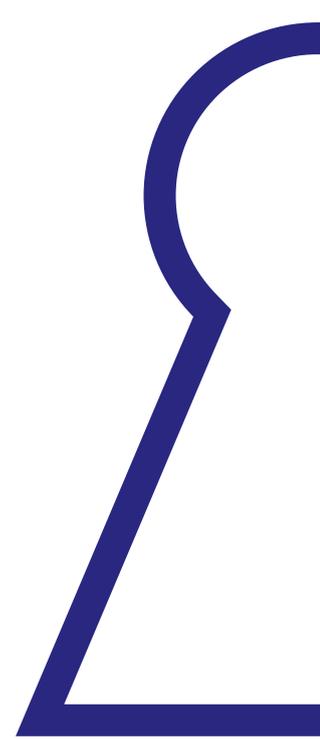




# **Learning from Death in Custody Inquests: A New Framework for Action and Accountability**

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## 1.0 Introduction

For thirty years INQUEST has monitored inquests into deaths in custody. One of the striking features of this work has been our repeated experience of attending inquest after inquest where the same issues are identified as possibly contributing to the death. A number of factors explain this including: the narrow and restricted remit of the inquest; the prevention of discussion or reference to previous similar deaths; and the lack of an effective mechanism to ensure action is taken on the basis of inquest findings. This feature of our work has contributed to the development of our critical analysis of the investigation of deaths in custody and also to our work to improve the current system. This report aims to be part of that process.

While the coronial service can and does make a vital contribution to the prevention of deaths and the conditions of safe custody, that input is at risk of being critically undermined by the failure (1) to recognise the value of properly-collected data; and (2) to monitor compliance with and/or actions based on the findings and reports that emerge from inquests. The essential argument of this report can be expressed in compressed form: **the more effective use of narrative verdicts and Coroners Rule 43 reports<sup>1</sup> is overwhelmingly likely to assist in the saving of lives.**

This matter is not simply a technical question, nor one of mere procedure, but rather a matter of foremost importance that goes to the heart of the United Kingdom's treaty obligations as a signatory to the European Convention on Human Rights (ECHR) to foster, maintain and scrutinise its article 2 ECHR duties in mediating the relationship between the state and the citizen.

The critical evaluation and onward dissemination of the combined findings of the inquest – both the verdict and rule 43 report – constitute a powerful tool for harm prevention embedded within the inquest system. This report identifies and explains why this tool has proved largely ineffectual historically. In short, this is because the existing system is flawed. The lessons to be learned from the contents of these verdicts and reports are far too frequently lost: they are analysed poorly or ignored; misunderstood or misconstrued; dissipated or dismissed. Consequently, there is an overwhelming case for the creation of a new mechanism. The indispensable constituent parts of this fresh structure are that there should be a central oversight body tasked with the duty to collate,

1. See Appendix 3 at page 31; the Coroners Rules 1984 can be read online at [bit.ly/CR1984](http://bit.ly/CR1984). We refer to these as rule 43 reports throughout this document.

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analyse critically and report publicly on the accumulated learning from coronial narrative verdicts and rule 43 reports. Further, there must be public accountability, accessibility and transparency.

The conclusions of this report are based on a critical review of the evolution of the law and practice relating to narrative verdicts and the use by coroners of rule 43 powers in inquests into deaths in prison and in police custody or following police contact<sup>2</sup> and a unique analysis of a sample of narrative verdicts and coroners' rule 43 reports arising from such inquests (see Appendix 1: Methodology). The report presents the data in a range of formats to demonstrate and illustrate the detail included in narrative verdicts and rule 43 reports (see Section 5 and Appendix 2). The report also documents recent developments and changes in law and practice. Whilst this report does not include the outcomes of inquests into deaths in mental health detention, we think the conclusions and recommendations are equally applicable to these deaths and would be usefully read by those involved in relevant regulation and inspection bodies including the Care Quality Commission.

Most deaths in state detention or involving state agents take place within a system of dependency and control. There is a body of statutory and common law authority that recognises the special role of an inquest when someone dies in situations where they are dependent upon or subject to the control of the state.<sup>3</sup> In addition the Human Rights Act 1998 (HRA) obliges the coroner to consider whether the deceased died as a result of the state violating her or his right to life (article 2) and whether the state subjected the deceased to inhuman or degrading treatment (article 3).

Deaths in custody represent the extreme end of a continuum of near deaths and injuries and a proactive post-inquest strategy in response to verdicts and reports can not only avert deaths but also risks to custodial health and safety generally. In the past, narrative verdicts and/or rule 43 reports produced by inquests have informed changes to custodial policies and practices. However, such positive developments have been piecemeal and often in spite of rather than because of the current system. This report argues that this vital learning – the accumulated knowledge we as a community have gleaned collectively when contact between the citizen and the state has ended in disaster, death or tragedy – must be put on a more secure footing. We have before us an unmatched opportunity to make changes for the better in this intensely sensitive and important area. We urge that the opportunity is not squandered.

2. Throughout the report we refer to these deaths as 'deaths in custody.'

3. Thomas, L, Straw, A and Friedman, D. *Inquests: A Practitioner's Guide*, Legal Action Group (second edition) 2008.

## 2.0 Background to the project

Coronial inquests into deaths in custody are a potential monitoring tool for standards of custodial care and can contribute to preventing future deaths. INQUEST has documented a recurring theme common to virtually every bereaved family:

*By seeking legal representation to assist them through this long, complex and daunting process they hope to prevent future deaths; in contributing to that objective some meaning and purpose can be given to their loss.<sup>4</sup>*

4. Shaw, H and Coles, D. *Unlocking the Truth: Families' Experiences of the Investigation of Deaths in Custody*. INQUEST 2007, p90.

5. *R v. Secretary of State for the Home Department ex parte Amin* [2003] UKHL 51.

Lord Bingham<sup>5</sup> recognised that preventing similar deaths was one of the main purposes of the inquest and thereby humanely connected the needs of the bereaved with the duties of the state to investigate adequately.

The combined findings of the inquest in the form of a narrative verdict and/or rule 43 report have huge potential. In describing the preventative lessons that could be learned from the identification of inadequacies in custodial health and safety – failings in the standard of care, treatment and supervision of the deceased – the authorities are put on notice as to action necessary to prevent future fatalities. A proper framework for responding to the findings could provide a new avenue to address these problems and potentially have a deterrent effect, preventing future deaths and in maintaining confidence in public bodies by addressing the accountability gap that currently exists.

### **Corporate Manslaughter and Corporate Homicide Act 2007**

This has added urgency for custodial agencies following the implementation of the death in custody provisions in the Corporate Manslaughter and Corporate Homicide Act 2007 which came into force on 1 September 2011. The provisions create a new legal framework in which custodial agencies should receive and respond to the combined findings of inquests. The Act created an offence whereby an organisation could be found guilty of corporate manslaughter if the way in which its activities were managed or organised resulted in a death and amounted to a gross breach of a relevant duty of care to the deceased (s.1). Section 2(1)(d) of the Act means the offence can be applicable to custody providers.

### **The Human Rights Act 1998**

The implementation of the Human Rights Act 1998 made significant changes to the legal framework governing inquests into deaths that raise questions of state and corporate accountability. However, bereaved families and their legal teams have been the driving force behind securing practical applications for these changes, and making the HRA and its associated rights under the ECHR a functioning reality. In particular, INQUEST has worked with families and lawyers to press for a more purposeful interpretation of their core rights, a broader scope of inquiry and the opportunity for the delivery of more meaningful verdicts by juries. The use of narrative verdicts in particular has already shown its potential as a tool for enhancing the participation of the jury in the analysis of systemic failure. As such, it is developing into a crucial expression of democratic accountability and aid to the prevention of unnecessary future deaths.

Despite these steps forward both narrative verdicts and rule 43 reports remain under-used and under-analysed. There is undoubtedly more work to be done and this report aims to contribute to that work and illustrate its importance.

## 3.0 Narrative verdicts

### The impact of *Middleton*: introducing narrative verdicts

In 2004 in the case of *Middleton* (a self-inflicted death in prison), the House of Lords considered how the introduction of the Human Rights Act has changed the coroner's duties and the legal scope of inquests. Their judgment introduced significant changes to the inquest system, particularly in relation to deaths in custody.

INQUEST intervened in the case and drew the Lords' attention to the high number of self-inflicted deaths in custody, and the shortcomings of the inquest system in delivering meaningful conclusions about the responsibility and accountability of state agencies in relation to those deaths. In their judgment, their Lordships were clearly concerned about the high death rate in custody and in that context the importance of extending the investigative duty beyond exposing past violations but also to “**promote measures to prevent or minimise the risk of future violations**” (our emphasis).<sup>6</sup>

Inquest juries can now return narrative verdicts detailing the key issues and establishing any relevant disputed facts. Since *Middleton*, narrative verdicts have been returned with increasing frequency in cases concerning deaths in custody and other inquests. The Ministry of Justice reports:

*Verdicts were returned at some 29,400 inquests in 2010, nearly 400 less than in 2009... Unclassified verdicts, which category includes narrative verdicts, represented 14 per cent of the total, and verdicts of suicide comprised 11 per cent in 2010... The category to see the largest rise in 2010 was unclassified (including narrative) verdicts, which were up 10 per cent, from 3,800 in 2009 to 4,200 in 2010.<sup>7</sup>*

### The potential benefits of narrative verdicts

An inquest verdict returned by a jury of ordinary men and women has powerful public significance. This is particularly so when they are adjudicating as the independent fact-finding body over the conduct of state institutions and state officials. Most of the deaths relevant to this report engage article 2 of the ECHR, often referred to as the right to life. Article 2 imposes a duty on the state to carry out an effective investigation

6. *R v. HM Coroner for West Somerset and others ex parte Middleton* [2004] UKHL 10.

7. *Deaths Reported to Coroners in England and Wales, 2010*. Ministry of Justice Statistical Bulletin, May 2011.

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into a death. The combination of the investigation and inquest is normally the way in which the state carries this out and inquests held in these circumstances are now referred to as article 2 inquests.

Maintaining public confidence is recognised to be a central purpose of an article 2 inquest. As Mr Justice Stanley Burnton said in his judgment on *Middleton* in the High Court:

*In a democracy, the defects of the workings of the state should be open to public scrutiny and, where appropriate to adverse public findings.*<sup>8</sup>

The case of *Middleton* found that to satisfy article 2 the inquest requires the jury come to conclusions on what they consider to be the main issues directly relating to “in what circumstances” the deceased came by his or her death.<sup>9</sup> This is wider than the usual function of an inquest when the inquest verdict is restricted to answering in short form the questions: who was the deceased, where they died, when they died and how (the means by which they came to their death).

The fuller account given in narrative verdicts has a range of potential benefits and the value of the jury’s verdict is well recognised in the case-law: an “inquest verdict can have a significant part to play in avoiding the repetition of inappropriate conduct and encouraging beneficial change.”<sup>10</sup>

First, it can act as a valuable learning tool for state agencies responsible for implementing policy and practice and make a significant contribution to the prevention of similar future fatalities. Common subjects of narrative verdicts now include delays in discovering a self-suspension; identifying key systemic communication failures between different professionals and other system failures; lack of first aid training; delays in arranging transfer to hospital; and the non-availability of suitable emergency equipment. As the Prisons and Probation Ombudsman for England and Wales (PPO) noted in his Annual Report 2007–2008: “The difference between a death in custody and a successful resuscitation may literally be no more than a matter of seconds.”

Second, a narrative verdict has the potential to make the inquest a more meaningful and fulfilling process for bereaved families, who can see a verdict that reflects the evidence heard on a range of key issues. This can help give families a sense that the court has done all that is possible to establish the important facts about how and why the deceased died and assist them in coming to terms with their traumatic bereavement.

Third, narrative verdicts can allow coroners’ courts to record comments on failings that have not directly contributed to a death, but caused unnecessary distress both to the individual as they died and to the deceased’s family. By way of example, an inquest jury identified serious

8. *R v. HM Coroner for West Somerset and others ex parte Middleton* [2001] EWHC Admin 1043.

9. *Middleton* [2004].

10. *R v Inner South London coroner ex p Douglas Williams* [1998] EWCA Civ 1343.

failings in the care extended to the deceased while he was in prison and concluded that prison staff had refused to remove the deceased's handcuffs as his life expired because this would have been contrary to "prison policy." The jury's vindication of the family's concerns in these respects assisted the family in dealing with their loss. It also indicated to the prison authorities that their policy had a significant negative impact, even if it did not cause the death.

Fourth, a narrative verdict can serve a useful public purpose and can act as a historical record for generations to come. It can allay legitimate public concerns through the public identification of systemic failures, publicise the death – and may be referred to if the failure is not addressed and leads to another death.

### Current limitations on the impact of narrative verdicts

Although significant steps have already been taken towards realising these benefits, several limitations restrict the impact of narrative verdicts.

First, misunderstandings persist about the function of narrative verdicts. The following observation in the executive summary of the Ministry of Justice report cited above demonstrates this problem:

*There was also a large rise in the number of non-specific verdicts, a category which includes narrative verdicts which are a factual record of how and in what circumstances the death occurred; often used where the cause of death does not easily fit any of the standard verdicts. (our emphasis)*<sup>11</sup>

In fact, narrative verdicts should be used whenever standard short-form verdicts are insufficient to encapsulate the jury's conclusions on the main issues relating to the death.<sup>12</sup> This definition of the function of narrative verdicts could appear very close to the Ministry of Justice's definition. In fact, its scope is significantly different. In the case of *Middleton*, the case of *Amin*<sup>13</sup> was used to illustrate the true function of a narrative verdict. In *Amin*, a prisoner was killed by his cell mate. The standard verdict of unlawful killing would have "easily fit" the cause of death. Therefore, under the Ministry of Justice's definition, a narrative verdict would not be required. However, as Lord Bingham of Cornhill stated in *Middleton*, "a verdict of unlawful killing would not have enabled the jury to express any conclusion on what would undoubtedly have been the major issue at any inquest, the procedures which led to the deceased and his killer sharing a cell."

Unless everyone involved in the inquest process understands the function of a narrative verdict, it is very likely that their scope will be underestimated and they will be underused. This misunderstanding has been further added to by a recent editorial in the *British Medical Journal*<sup>14</sup> which reflects concerns amongst public health professionals about how

11. *Deaths Reported to Coroners in England and Wales, 2010, op. cit.* at paragraph 3.2.

12. *Middleton* [2004], para 31.

13. *Amin* [2003].

14. "Coroners' verdicts and suicide statistics in England and Wales", *BMJ* 2011; 343:d6030.

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the use of narrative verdicts is affecting the accurate recording of suicide figures which have implications for public health strategies. Developing a shared understanding across professions about their purpose and function is important.

Second, even where narratives have been used, there has been a lack of understanding of how they should be used. This has caused some coroners to limit inappropriately the parameters of what a jury may include in its narrative. *Middleton* notes that the coroner has a broad discretion in directing the jury but this discretion relates only to “the means of eliciting the jury’s factual conclusions” i.e. the form or manner in which the conclusions are elicited. It should not be used in such a way as to prevent the jury reaching conclusions on important, relevant issues.

In the case of *Lewis*,<sup>15</sup> a coroner had prevented the jury from considering deficiencies in the training, equipment and guidance extended to the officer who found the deceased hanging in his cell. The coroner reasoned that there was no evidence that these issues caused or contributed to Karl Lewis’ death. The Court of Appeal reviewed this decision and found it had been unlawful. The purpose of the narrative verdict is to bring to light, as far as possible, the full facts surrounding the circumstances of a death and “to expose culpable and discreditable conduct with a view to rectifying dangerous practice and procedures.”<sup>16</sup> This inevitably involved considering evidence relating to facts that did not strictly speaking cause the death. *Lewis* has gone some way to clarifying this issue. However, it is clear from our casework monitoring that not all coroners are applying this policy uniformly or have a shared understanding of its function.

Third, even when full narrative verdicts are given, they are not being properly utilised as a valuable resource for analysis and learning. Currently there is no collation, analysis or central publication of narrative verdicts. If narrative verdicts are left to gather dust away from public scrutiny and analysis, they will not be able to achieve their full potential as a preventative tool. In particular, as matters currently stand, the likelihood is that at most the local institutions or police force will learn the wider lessons from a narrative verdict, not (say) police forces nationally, still less those responsible for all institutions of detention nationally.

15. *R on the application of Keith Lewis v HM Coroner for the Mid and North Division of the County of Shropshire (Secretary of State for Justice as an Interested Party)* [2009] EWCA Civ 1403.

16. *Amin* [2003].

## 4.0 Coroners Rule 43 reports

17. Coroners Rules 1984 r43. Sometimes rule 43 reports are mistakenly referred to as coroners' recommendations.

One of the most important powers a coroner has is to announce<sup>17</sup> that he or she intends to report the circumstances of death to those authorities who have the power to take action to prevent the recurrence of such fatalities. Rule 43 of the Coroners Rules 1984 (see Appendix 3) gives the coroner this power and it is the coroner's alone.

### Coroners (Amendment) Rules 2008: The development of rule 43

18. Shaw and Coles *op. cit.*, p106. INQUEST gave evidence (written and oral) to the Parliamentary Joint Committee on Human Rights (JCHR) in 2004; published in House of Lords House of Commons Joint Committee on Human Rights (2004) *Deaths in Custody: Third Report of Session 2004-05, Vol II*, Ev150. The Stationery Office, 2004.

Until the introduction of an amendment to the Coroners Rules in 2008, there was no central collation or monitoring of rule 43 reports as INQUEST has frequently documented.<sup>18</sup> There was no requirement that rule 43 reports should be shared with bereaved families. Neither was there any requirement for those about whom the reports were made to respond. The lack of follow-up communication with families after the inquest was also frustrating and distressing for bereaved families, and the failure to inform them of action taken in response to the problems identified during the inquest can damage the whole experience.

Following successful lobbying by INQUEST, the then Minister of State for Constitutional Affairs, Harriet Harman MP announced the government's intention to strengthen the public protection role of coroners in a written ministerial statement of 30 January 2007. She stated:

*Families often express their wish that something positive might come out of a coroner's inquiry and hope that relevant agencies will take preventative action so that the death of their family member is not in vain. The increased focus on the ability to learn lessons, and to share information and best practice, will help families to achieve closure, as well as prevent future deaths, and address public interest issues about health and safety.*

The then government sought to address how the coronial process might be more focused upon prevention.

On 17 July 2008, the Coroners (Amendment) Rules 2008 (see Appendix 3) amended rule 43 of the Coroners Rules 1984 by statutory instrument. The amended rule 43 means that:

- a. Coroners now have a wider remit to make reports to prevent future deaths. It does not have to be a similar death.

- b. A person who receives a report must send the coroner a written response within 56 days, outlining what action has been taken in response to the report or giving an explanation if no action has been taken.
- c. Coroners must provide interested persons to the inquest and the Lord Chancellor with a copy of the report and the response.
- d. Coroners may send a copy of the report and the response to any person or organisation with an interest.
- e. The Lord Chancellor may publish the report and the response, or a summary of them.
- f. The Lord Chancellor may send a copy of the report and the response to any other person or organisation with an interest other than a person who has already seen the report and response by the coroner.

### The potential benefits of rule 43 reports

Rule 43 reports can play a valuable role in preventing future similar deaths. A number of coroners already value the important role they have in the prevention of future fatalities and make regular use of their power under rule 43.<sup>19</sup> The trend towards the making of rule 43 reports was reinforced by the inclusion in the Coroners and Justice Act 2009 (which is yet to be implemented) of a duty<sup>20</sup> to do so where relevant. This has the powerful potential to improve institutions of detention and enable wider society to learn from a death.

Although many bereaved families find their experience of the inquest difficult for a wide range of reasons not discussed here,<sup>21</sup> if the coroner openly acts under rule 43 it can help the family to know that their relative's death may contribute directly to the prevention of future deaths.

19. See *Inquest Law* magazine, issues 1- 24 (INQUEST 1998 - date)

20. See Appendix 4.

21. See Shaw and Coles, *op. cit.*.

### Current limitations on the impact of rule 43 reports

Although the amended rule 43 creates considerable powers for coroners, their interpretation of those powers is varied and practice is inconsistent. There are a number of interrelated problems. The delay in many inquests taking place means that the response of authorities to concerns raised during the inquest can be dismissed as no longer relevant. Some coroners will not make reports on matters that the authorities say have already been addressed. Others will report on matters of concern relating to the death irrespective of causation or whether they believe action to have been taken.

In our view it is crucial for coroners to report matters of concern identified during the inquest both as a record in the specific case but also because of the potential learning about similar risk factors that could be relevant at a national level in other custodial settings. Given the lack of any mechanism to interrogate actions taken in response to a death this additional layer of accountability is important.

Some coroners have adopted a dynamic approach to their power under rule 43 and will:

- Invite submissions from legal representatives on the content.
- Make the report public at the conclusion of the inquest or on their website.
- Circulate copies to the media and/or interested organisations e.g. INQUEST.
- Encourage the responses to the rule 43 report to be copied to all interested persons.

These positive examples contrast with others who have refused on request to send copies of either the verdict or rule 43 report and any responses received to INQUEST.

### **Lack of detailed monitoring, analysis and follow up**

No mechanism currently exists to monitor and subject to public scrutiny action taken in response to coroners' findings and inquest juries' verdicts. There is no national publicly-accessible database and rule 43 reports are not published centrally other than as a very short summary in the Ministry of Justice bulletin (see below).

Current difficulties with obtaining access to rule 43 reports cannot be underestimated. It is telling that INQUEST, a small charity, maintains a record of all rule 43 reports arising from its casework, a resource that has been used by coroners and others in the absence of any other national database. This is an indication of how inaccessible they are to the institutions to which they apply – for example if an individual prison or police force wanted to see whether other prisons/police forces had experienced deaths that might be relevant to their learning, there is no mechanism for direct access to the full reports, only the filtered information that is periodically provided which lacks sufficient detail to make it instantly useful.

Additionally, the lack of an effective mechanism for monitoring the action taken in response to rule 43 reports is crucial, particularly where they have commented on serious and systemic problems within an institution, and action that needs to be taken to prevent other deaths occurring.

There are numerous examples where deaths have occurred in the same institution or in similar circumstances where a rule 43 report has been made previously.

A graphic example of this is that of HMP & YO1 Styal. Six women died there in the 12 months between August 2002 and August 2003. At the conclusion of an inquest into a previous death in Styal prison in 2001 the coroner made a rule 43 report about the need to set up a detoxification regime for women withdrawing from drugs. This was not implemented until after the sixth death had occurred, which was over two years after his report was issued.

### ***Analysis of the Ministry of Justice Bulletins – Summary of Reports and Responses under Rule 43 of the Coroners Rules***

Some welcome steps have been taken in relation to the collation of reports and the Ministry of Justice Coroners Unit now collates and publishes bulletins containing short summaries of rule 43 reports. However, these are filtered, are scant in detail and not a comprehensive overview of the reports other than in isolated cases. Further, the information presented by the bulletins is incomplete since it looks only at rule 43 reports and not narrative verdicts.

During the period covered by this report two bulletins relating to rule 43 reports and responses were issued by the Ministry of Justice. Covering the period between 17 July 2008 and 30 September 2009 they indicate that a total of 371 reports were made and according to their analysis 24 relate to deaths in custody. It is not clear, however, how they define such deaths.

The first *Summary of Reports under Rule 43 of the Coroners Rules and Responses*, published in June 2009, indicates that 207 rule 43 reports were issued in England and Wales between 17 July 2008 and 31 March 2009. Of those, 13 relate to deaths in custody. In the section entitled 'Trends and Rule 43 Reports which have wider implications', which is decidedly cursory, none of the reports relating to deaths in custody are referenced.

In the second *Summary of Report* relating to the period between 1 April and 30 September 2009, 164 rule 43 reports were made. 11 reports relate directly to deaths in custody. There are also 14 mental health reports, although the summary does not provide detail as to whether these related to deaths of patients detained under the Mental Health Act. The section entitled 'Trends and Rule 43 Reports which have wider implications' has some descriptions of reports but there is no analysis of what action has been taken in response to the reports and whether recommendations have been implemented. The only public detail available is whether or not a response has been received at all, but no indication of the content of the response(s), still less any analysis of what is and is not being addressed.

Even when information from rule 43 reports or responses is made publicly available, no systematic, comprehensive qualitative analysis is conducted to ensure trends and key issues are identified. As a result of these limitations, rule 43 reports too often go underused, are insufficiently disseminated and under-analysed.

## 5.0 Data analysis of narrative verdicts and rule 43 reports

To illustrate the potential value of narrative verdicts and rule 43 reports, INQUEST conducted a short study.

Between 1 January 2007 and 31 December 2009, INQUEST received 50 rule 43 reports relating to deaths in custody<sup>22</sup> (see Table 1). This report has analysed all 50 with the aim of identifying emerging themes and issues. We have also analysed 30 narrative verdicts returned at inquests into deaths in custody held during this same period. These verdicts were a sample of those that included pertinent observations relating to the circumstances of the death where preventative lessons could be learned as compared to some narrative verdicts that were purely descriptive and did not address any of the systemic issues.

22. From inquests held between 1 January 2007 – 31 December 2009.

### Emerging themes and issues from both narrative verdicts and rule 43 Reports

This analysis has identified trends and patterns in deaths in custody that require improvements in custodial practices and procedures. These have been raised repeatedly in both narrative verdicts and rule 43 reports. These are summarised here. For a more detailed account of our findings, see Appendix 2.

The key issues and themes that we identified fell into the following categories:

- Communication problems
- Drugs
- Restraint
- Health care
- Training
- Records
- Suicide/self-harm
- Cell design/Cell Sharing Risk Assessments/Custodial Health & Safety
- Mental health

Within these categories, the following issues were identified:

**Communication problems** such as lack of communication/information-sharing between:

- prison staff (at shift handovers etc);
- police and prisons;
- prisons and prison units;

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- prisons and prison staff;
- prisons and prisoners;
- Prison Service and external agencies (i.e. Probation Service, NHS);
- Youth Offending Teams (YOT) and Youth Justice Board (YJB);
- social workers and YJB;
- police and attending psychiatrists.

### Drugs

- The use of drugs, illicit or otherwise, including the risks of certain restraint methods when the person being restrained was concealing drugs in their mouth.

### Restraint

- Use of control and restraint techniques, including police and NHS training in the recognition and restraint of those with mental illness and/or behavioural disorders;
- inadequate training in the dangers of restraint methods.

### Health care – resources and treatment of patients, including:

- lack of healthcare beds and cells;
- lack of information at assessment (i.e. previous prison/medical records);
- inadequate access of records by healthcare staff;
- failure of staff to make enquiries;
- staff inadequately trained in first aid/resuscitation techniques;
- failure to review missed doctors' appointments.

### Training – staff not adequately trained in:

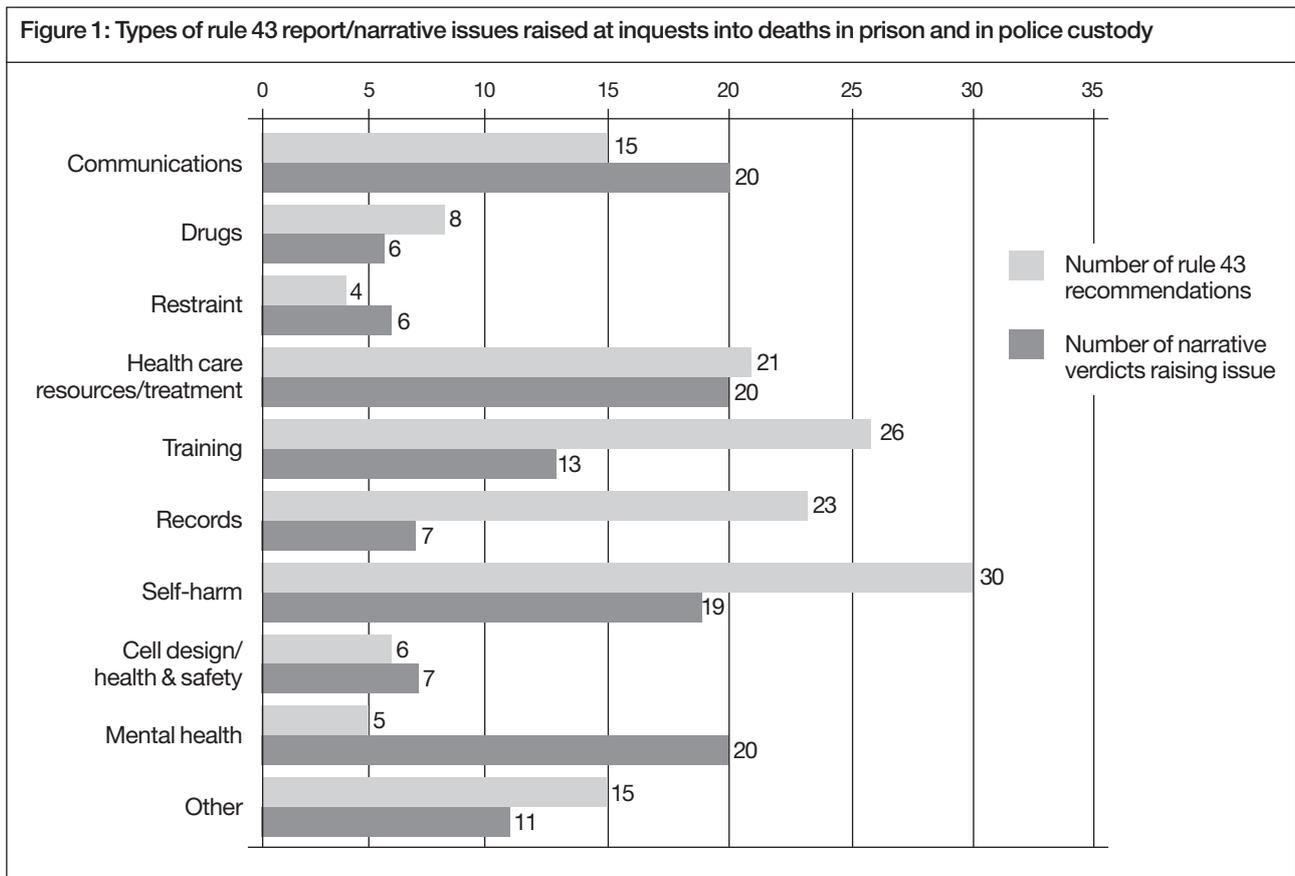
- first aid and/or resuscitation techniques;
- mental health issues including police and NHS training in the recognition and restraint of those with mental illness and/or behavioural disorders;
- dangers of restraint methods/ positional asphyxia/excited delirium.

### Records – including:

- lack of access to previous records (i.e. prison/medical/police records);
- incomplete sets of prison records;
- failure to make enquiries about records;
- inadequate record-keeping.

### Suicide/self-harm

- inadequate ACCT assessment/inappropriate decision-making;
- review of ACCT procedures/mental health care provision;
- inadequate observation/monitoring/supervision of at-risk prisoners;
- inadequate staff training in self-harm and suicide prevention or in first aid/resuscitation techniques;
- delays in discovering a self-suspension;
- delays in arranging transfer to hospital;
- non-availability of suitable emergency equipment.



**Cell design/Cell Sharing Risk Assessments/Custodial Health & Safety**

- issues of the physical design and layout of cells and other areas relating to the health and safety of detainees in the built environment;
- inappropriate use of segregation cells/review of segregation unit procedures;
- inappropriate accommodation/hazardous cells (e.g. ligature points) and/or environment;
- non-availability of suitable emergency equipment.

**Mental health – including:**

- the inappropriate placement of mentally-ill people in prison;
- inadequate staff training in mental health issues;
- assessment of suitability for persons to be detained in police cells.

In a small number of the reports analysed issues were raised about broader procedures and policies relating to the operation of the criminal justice system and the police and penal estate. Given the size of the sample used in this pilot review, they are statistically insignificant. In a systematic and comprehensive study of the data these could be addressed.

### Spread of the data between rule 43 reports and narrative verdicts

It was interesting to note that a number of issues raised by juries in narrative verdicts were not addressed by coroners in their subsequent rule 43 reports. Our findings indicated that any analysis of the potential learning points arising from inquests must consider *both* the narrative verdict and any rule 43 reports. An analysis which only considers rule 43 reports can miss key pieces of information and fail to capture some of the essential points considered by a jury, particularly where a coroner has not for whatever reason covered these in a subsequent rule 43 report.

### Comparative analysis of rule 43 reports and narrative verdicts from inquests into deaths in prison

Within our sample there were 42 inquests into deaths in prison where rule 43 reports were made. In these 42 cases, 36 (86%) narrative verdicts were returned of which 31 were critical and five descriptive. In the remaining six prison cases only short form verdicts were returned.

Issue	Rule 43 reports (42)	Narrative verdicts (36)
Communications	14 (33%)	9 (25%)
Staff record-keeping	21 (50%)	4 (11%)
Staff training	23 (55%)	5 (14%)
Drugs	6 (14%)	2 (6%)
Use of restraint	3 (7%)	2 (6%)
Inadequate health care	20 (48%)	8 (22%)
Poor mental health care	4 (10%)	8 (22%)

Within our narrative verdicts sample there were 25 inquests into deaths in prison. In these 25 cases, 10 (40%) rule 43 reports were made.

Issue	Narrative verdicts (25)	Subsequent rule 43 reports (10)	
		Reports raising same issue as narrative	Reports raising issues narrative did not
Communications	15 (60%)	2 (20%)	1 (10%)
Staff record-keeping	7 (28%)	1 (10%)	5 (50%)
Staff training	11 (44%)	2 (20%)	2 (20%)
Drugs	2 (8%)	0 (0%)	1 (10%)
Use of restraint	3 (12%)	2 (20%)	0 (0%)
Inadequate health care	16 (64%)	4 (40%)	0 (0%)
Poor mental health care	15 (60%)	3 (30%)	0 (0%)

## 6.0 Current context and possibilities for reform

Our critical review of the evolution of the law and practice coupled with our analysis of the small sample of rule 43 reports and narrative verdicts demonstrates the rich potential of a systematic approach to extracting the learning from the combined findings of an inquest. Properly conducted inquests and coronial findings and recommendations have a crucial role in the scrutiny of custodial deaths. The breadth of information they provide can help with identifying trends or problems which are capable of being addressed through intervention.

The themes that emerge from the analysis of the sample will come as no surprise. Whatever mechanism is put in place must be situated within the same operational framework that applies to those who have the power to make decisions about procedure and policy. The findings of any inquest jury and rule 43 reports should be available to all engaged in thinking about and legislating for social and criminal justice policy. Any mechanism that does not directly involve senior management runs the risk of remaining a talking shop. The repetitive nature of the findings points to some serious systemic problems, particularly within prisons.

Whilst not the subject of this report, the endemic delays in the current inquest system are hugely problematic, frustrate the learning process and can lead to an accountability gap. This is compounded by the wide variation in approach and practice in different coroner jurisdictions. The legal framework also places limitations on the extent to which individual deaths can be considered in their context. The inquest focuses on the death in isolation from others that have occurred in similar circumstances and does not ordinarily refer to previous narrative verdicts and/or rule 43 reports that have identified relevant systemic and procedural problems.

However, the findings of inquests – rule 43 reports and critical narrative verdicts – are only useful if acted upon. The public interest requires responses to inquest findings to be transparent and accountable. This report argues that proper creation, publication, dissemination and analysis of both narrative verdicts and rule 43 reports could benefit a wide range of institutions and people. The question is how this can best be achieved. How to ensure implementation of the recommendations contained in the combined findings is not a phenomenon isolated to inquests; it applies to other types of inquiry findings across a range of settings. As Downham and Lingham argue:

*....nowhere is there any focus on the process by which recommendations arising from such investigations should be followed through to implementation. This is the missing link in the chain which should exist between the incident, the investigation and lessons learned.*<sup>23</sup>

No administrative framework has yet been developed to maximise the preventative role of the coronial system. There is no mechanism or institution charged with monitoring coroners' approaches to narrative verdicts and rule 43 reports or the data contained in these verdicts and reports. Nor is there any monitoring of the implementation of recommendations, action taken or any assessment as to their impact in preventing deaths.

INQUEST has drawn attention to this issue at relevant forums: the Ministerial Group on Suicide in Prisons; the Forum for Preventing Deaths in Custody; the Independent Advisory Panel on Deaths in Custody; and the Ministry of Justice Coroner Service Stakeholder Forum. We have also raised the issue with parliamentarians, in particular during the passage of the Coroners and Justice Act 2009 and with the Joint Committee on Human Rights as part of evidence to their inquiry into deaths in custody.<sup>24</sup>

Other jurisdictions provide useful blueprints when considering pathways to reform. Mechanisms for reporting and ensuring accountable learning are far more developed in New South Wales, Australia and in Ontario, Canada and are an integral part of the coroners system and strictly monitored. In Australia, findings are tabled in parliament and they are therefore on the political agenda and are potentially a vehicle for change.

## Recent Developments

In the last ten years the following changes and proposals have been central to the debate on this issue:

### Ministerial Council on Deaths in Custody

In 2008 the creation of a three-tier Ministerial Council on Deaths in Custody was announced by the Ministry of Justice, following publication of *The Fulton Review*.<sup>25</sup> It replaced the Ministerial Roundtable on Suicide and the Forum for Preventing Deaths in Custody, and is funded jointly by the Ministry of Justice, Department of Health and the Home Office. Its first meeting was held in June 2009.

The first tier consists of a Ministerial Board on Deaths in Custody, which replaced the Roundtable and has wider terms of reference to include all types of death in state custody (prison; approved premises; police; revenue and customs; immigration; psychiatric hospitals). INQUEST is an independent member of the Board. The second tier of the Council is the Independent Advisory Panel (IAP) whose role is to provide independent advice and expertise to the Board. The IAP is supported by the Practitioner and Stakeholder Group, a group representing practitioners and stakeholders to be formed on an *ad hoc* basis.

23. Downham, G and Lingham, R. 'Learning Lessons: Using Inquiries for Change,' *Journal of Mental Health Law*, Spring 2009.

24. House of Lords House of Commons Joint Committee on Human Rights (2004) *Deaths in Custody: Third Report of Session 2004-05, Vol II*, Ev150. The Stationery Office, 2004.

25. Fulton, Robert. *Review Of The Forum for Preventing Deaths in Custody – Report of the Independent Reviewer*. Ministry of Justice, 2008

INQUEST and the IAP have placed the arguments for more effective monitoring and analysis of inquest outcomes on its agenda. However, in our view the Ministerial Council alone cannot solve the problems identified in this report. First, its broad remit is unlikely to allow a proper focus on the task of analysing and reporting on the data contained in rule 43 reports and narrative verdicts. Second, its limited resources and secretariat do not provide it with the capacity or independence to undertake the kind of systematic analysis required. Both the Ministerial Board and the IAP are staffed by a very small secretariat from within the Ministry of Justice meaning there is insufficient distance from the government department responsible for prisons.

The Ministerial Council is a vital tool in trying to ensure that preventative lessons are transmitted across different sectors. However, to be truly effective, it requires another organisation to feed it detailed analysis and data.

### The Office of the Chief Coroner

The plans to implement the reforms to the inquest system legislated for in the Coroners and Justice Act 2009 were interrupted during 2010/11 when the new government stalled the process and attempted to abolish the Office of the Chief Coroner via the Public Bodies Bill. However, in November 2011 they accepted the view of Parliament that the post should be created and His Honour Judge Peter Thornton QC was appointed in May 2012. On accepting the post, he stated:

*Openness, inclusiveness, thoroughness and fairness must be at the heart of this process if it is to be effective and serve the needs of the public.<sup>26</sup>*

The role of the Chief Coroner is intended to spearhead reform of the system and, through the Coroners and Justice Act 2009, Parliament gave the post holder specific and significant powers to tackle deep-seated issues relating to the operation of the coroners system as a whole. The Ministry of Justice's *Job Description and Main Activities of the Chief Coroner*<sup>27</sup> make clear that the post is envisaged to be a judicial and leadership role.

In the legislation the Chief Coroner has a range of powers to improve the functioning of the inquest system, including the following that are most relevant to this report:

- I. Drive up standards in the system through training (s. 37 of the Act gives the Chief Coroner powers and responsibilities to make regulations about training). It is envisaged the Chief Coroner will issue guidance to coroners on ways of working, lay down practice directions, set national standards of service (s.42 of the Act and paras 8-9, *Main Activities of the Chief Coroner*).
- II. Work with the Lord Chancellor and Ministry of Justice to make regulations and rules overhauling practice and procedure at inquests

26. Appointment of Chief Coroner Judicial Office news release <http://www.judiciary.gov.uk/media/media-releases/2012/appt-chief-coroner>

27. *Main Activities of the Chief Coroner* contained in *Reform of the coroner system – next stage* (consultation paper CP06/10), pp97-101. Ministry of Justice, 2010. Available at [www.justice.gov.uk/consultations/docs/coroner-reform.pdf](http://www.justice.gov.uk/consultations/docs/coroner-reform.pdf)

(s.43(2) sets out regulations that may only be made if a judicial office holder, envisaged as the Chief Coroner, agrees).

- III. Develop and operate an effective scheme for ensuring that recommendations and warnings relating to public safety emerging from coroners' investigations are brought to the attention of those responsible for creating the relevant risks, regulatory bodies and the public. Critically, the Chief Coroner will be able to take steps to ensure that such recommendations and warnings are acted upon (para 20 *Main Activities of the Chief Coroner*).
- IV. Monitor the performance of the coronial system, including via provision of an annual report to the Lord Chancellor addressing, amongst other things: levels of consistency between coroner areas; the number of investigations that have been ongoing for over a year; identification of specific resource issues; and any other matters which the Chief Coroner wishes to bring to public attention (s.36 of the Act and paras 11-12 of *Main Activities of the Chief Coroner*). The annual report will be published and laid before Parliament, offering an opportunity for further scrutiny and debate.

One approach would be to charge a governmental department with conducting an analysis of this data. This would follow the model adopted in Ontario, where a specialist designated department monitors the implementation of the recommendations made by coroners.

The Coroners and Justice Act 2009 creates a framework in which this model could be developed. Alongside the 2008 amendment to the coroners rules, the Act made some important changes to the way matters are reported by coroners and responded to by custodial agencies.<sup>28</sup>

However, even if the Office of the Chief Coroner was properly resourced to conduct the required analysis there is still no mechanism to ensure that relevant government departments and public authorities act on that analysis, nor is there any power to compel institutions/custodial settings to act on the recommendations.

## Standing Commission on Deaths in Custody

The failure to ensure there is a robust mechanism for prevention of further deaths in detention or involving state agents has underpinned INQUEST's longstanding proposal for a Standing Commission.<sup>29</sup>

We proposed that such an overarching body could look beyond individual deaths and identify key issues and problems arising from the investigation and inquest process and monitor the outcomes and progress of inquest findings, develop policy and research, disseminate findings where appropriate and encourage collaborative working.

The Standing Commission would have an independent secretariat and a board which would include representatives from community, family and other interested groups alongside those already represented on the Ministerial Board.

28. See Appendices 3 and 4.

29. Shaw and Coles, *op. cit.*, p134; Goldson, B. and Coles, D., *In the Care of the State? – Child Deaths in Penal Custody in England & Wales*, INQUEST 2005, p105; *Deaths in Custody: Third Report of Session 2004-05 Vol II*, 2004, Ev150; Vogt, Greta S., and Wadham, John, *Deaths in Custody: Redress and Remedies*, Liberty 2003.

## 7.0 Conclusions – what does this report show us?

### **The potential power of rule 43 reports and narrative verdicts**

This report has shown how these two mechanisms have the potential to help prevent future custodial deaths, improve standards of custodial care, ensure that the human rights of detainees are protected, and play a role in holding the state to account. However, in the absence of any framework for the overview and scrutiny of findings and compliance the current system is failing.

### **The importance of consistent and appropriate use of rule 43 reports and narrative verdicts by coroners**

Evidence indicates an uneven approach between coroners to the making of rule 43 reports. Practice is limited, variable in quality and inconsistent. It is too dependent on individual good practice. This report has made the case for eliminating these limitations and inconsistencies so as to unlock the true potential of rule 43 reports and narrative verdicts.

### **The importance of publication and dissemination**

This potential will remain largely untapped without centralised, systematic publication and dissemination of both rule 43 reports and narrative verdicts. Access to this information is vital to ensure that relevant institutions and agencies benefit fully from the insights provided by this data. However important as this is, it does not ensure that analysis is undertaken on a comprehensive and systematic basis.

### **The importance of comprehensive and systematic analysis**

Our study of a small sample of rule 43 reports and narrative verdicts shows that proper analysis of these documents can reveal a wealth of insights into the causes of contentious deaths. This can help identify both specific issues and general thematic trends. This in turn can provide a basis for the development of effective evidence-based policy and practice that has the potential for reducing deaths in custody, making it possible (for example) for the lessons from one death in one custodial setting to significantly reduce the risk of future deaths or near deaths across all institutional settings in England and Wales. At present, at best the lessons from a death are learned only within a given institution or police force.

### **Accountability following deaths in custody**

There is no mandatory requirement to act on any on rule 43 report. Coroners' recommendations are not legally enforceable. With the incorporation of deaths in custody into the Corporate Manslaughter Act however there is the need for proper monitoring and analysis to see whether action has been taken to rectify dangerous practices and systems identified during the course of an inquest. This is an important instrument for accountability.

It is not sufficient to place the information in the public domain and hope that it will be put to good use. There must be new mechanisms, framework and tools in place to ensure that agencies are publicly accountable for their decisions on whether or not to comply with recommendations made. In this way greater active and accountable learning may be achieved and bereaved families and the public reassured that the conditions or circumstances resulting in a death have been acted upon in the hope that future deaths and injuries are averted.

This can only be achieved by creating a permanent institution with an obligation to conduct comprehensive and systematic research and analysis of narrative verdicts and rule 43 reports.

## 8.0 Recommendations – what needs to be done to address shortcomings

On the basis of these conclusions, INQUEST proposes five key recommendations:

**Ensuring a consistent approach:** Narrative verdicts and rule 43 reports must be widely understood and consistently used by coroners and others engaged in the inquest system. Where a rule 43 report is not made following an inquest into a death in prison, in custody or following police contact, the coroner should be obliged to give his/her reasons for deciding not to do so. Further, narrative verdicts must always consider all relevant issues surrounding the circumstances of the death, as required by law. To this end, mandatory training should be provided and guidance issued to coroners on best practice for drafting practical and effective rule 43 reports and eliciting effective narrative verdicts. The presumption should be that these are placed in the public domain unless exceptional reasons exist otherwise.

**Gathering and publishing comprehensive data:** A publicly-accessible database of narrative verdicts and rule 43 reports should be compiled and maintained. The first step towards reform will be ensuring full access to information.

Scotland and Australia provide examples of what can be done. In Scotland summaries of some Fatal Accident Inquiries, particularly in cases where there is wider public interest are published on the website of the Scottish Judiciary.<sup>30</sup> The summaries provide details of the case, the main findings of the inquiry and a link to the sheriff's full determination. Australian governmental agencies have funded the development and maintenance of a National Coroners Information System.<sup>31</sup> This is an online publicly-accessible database containing all information arising out of inquests. Its aim is for information collection and retrieval to assist in both the investigation and with prevention strategies. This approach provides an effective model of how to disseminate and publish data. It allows relevant institutions to use the information and opens the door to third sector bodies, academic institutions and others conducting useful research and analysis.

In the first instance a **specialist custody death database** could be established with details of all rule 43 reports and narrative verdicts categorised by custodial setting and issues raised. This would assist coroners in the provision of timely specialist information where previous

30. <http://www.scotland-judiciary.org.uk/10/0/Fatal-Accident-Inquiries>

31. [www.ncis.org.au](http://www.ncis.org.au)

deaths have occurred in similar circumstances and help the development of knowledge between coroners' jurisdictions and between regulation, inspection and oversight bodies. **In the short-term resources could be made available for this to be established by the Independent Advisory Panel on Deaths in Custody.**

**Disseminating data:** Both narrative verdicts and rule 43 reports should be sent directly to all relevant bodies, including government departments, detention institutions and investigatory, inspection, regulatory and oversight/watchdog bodies.

**Comprehensive and systematic research and analysis of data:** A permanent institution should be charged with conducting comprehensive research and systematic analysis of the data provided by both narrative verdicts and rule 43 reports. This can help in the identification of issues, trends and problems and ensure cross-sector learning.

Ideally, this should be a Standing Commission on Deaths in Custody independent of the Ministry of Justice, Department of Health and Home Office. In the absence of this broader reform in the short term consideration should be given to the creation of a research post situated within the Office of the Chief Coroner to conduct this work.

**Publication and dissemination of analysis:** Reports detailing this analysis should be sent directly to all relevant bodies, including government departments, detention institutions and investigatory and regulatory bodies. In order to ensure full accountability, they should be sent to Parliament, in particular the Joint Committee on Human Rights and the Home Affairs Select Committee. They should also be placed on all relevant websites.

### **The need for a more co-ordinated role on post-inquest learning from regulation and inspection bodies**

There needs to be a co-ordinated response by the regulation, investigation and inspection bodies to the post-inquest role. The jurisdiction of the coroner ceases when a finding is made and a response to a report is received, even if it is felt that the response was inadequate. The current level of resourcing means that coroners are not able to continue this monitoring and follow-up role.

None of the investigation bodies, (the Prison and Probation Ombudsman, Independent Police Complaints Commission), government departments and agencies (National Offender Management Service, Home Office, Department of Health, UK Border Agency, Ministry of Justice) or inspection bodies (HM Inspectorate of Prisons, HM Inspectorate of Constabulary, Healthcare Inspectorate of Wales, Office for Standards in Education, Children's Services and Skills [Ofsted]) have the following up of issues that have emerged as part of an inquest within their remit. Indeed until more recently they would not

even receive copies of any rule 43 report unless a coroner specifically sent it to them, nor the responses to those reports.

Further, the Independent Monitoring Boards and Custody Visitors who could be alerted to relevant matters of national learning through the publication of reports or alerts and play an oversight role in following up actions taken in response to a death in a particular institution or setting, do not have these responsibilities within their remit. Consideration should be given to the potential role of the UK's National Preventive Mechanism that was established following the UK's ratification of the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment (OPCAT).

### **Integration of investigation and inquest findings and follow-up**

There needs to be a multi-disciplinary approach to developing an effective follow-up mechanism. This should ensure that findings and recommendations made as part of the investigation are integrated, and that issues emerging in narrative verdicts and rule 43 reports that have both local and national learning potential are identified.

This relates to:

1. Mode of investigation and its findings and recommendations.
2. Inquest process findings and recommendations.
3. Post-death/-investigation and inquest action plans.

In all of above there is the need for auditing and follow-up over a specific time period.

At present the accountability void means that matters are in danger of disappearing into the ether. Even where good practice exists, such as the Prison and Probation Ombudsman/Independent Police Complaints Commission *Learning the Lessons* bulletins/briefings and HM Chief Inspector of Prisons' (HMCIIP) thematic reports, there is no systematic case by case timeline of actions taken in response to the individual death and how this impacts nationally and its relevance in terms of cross-sector learning.

### **Short-term recommendations**

Within the context of current resource problems, at the very least there needs to be a report to Parliament on coroners' recommendations following all custodial deaths containing details of rule 43 reports and narrative verdicts and the thematic issues emerging.

The Chief Coroner should sit on the Ministerial Board on Deaths in Custody. Further, article 2 cases, deaths in police custody, in prison and in immigration and psychiatric detention should be brought within the remit of the Board.

## **Final thoughts**

In order to maximise learning from inquests we suggest a new framework needs to be created to enhance and support learning and to facilitate greater accountability of the agencies involved. In this way active and accountable learning may be achieved. Families and the public will then be reassured that the conditions or circumstances resulting in a death have not only been examined and scrutinised, but that the findings have been acted upon in the hope that future deaths and injuries are averted. This can only be achieved by creating a permanent institution with an obligation to conduct comprehensive and systematic research and analysis of narrative verdicts and rule 43 reports.

## Appendix 1 – Methodology

This short pilot project analyses a sample of the narrative verdicts and coroners' rule 43 reports made at the conclusion of a selection of inquests into custodial deaths that were INQUEST's cases. The inquests were held between January 2007 and December 2009.

The date of the deaths range from August 2000 to September 2008, reflecting the time that can pass from death to the conclusion of the investigation and inquest.

The deaths took place in prison and in police custody or following contact with police officers.

During this time period (January 2007 – December 2009) there were 164 inquests held into deaths in prison or police custody/following police contact that were INQUEST's cases. 133 were into deaths in prison; 31 related to the police. We have looked at a sample of 67 of these cases.

During the time period a total of 50 rule 43 reports arising from these cases were returned. These were passed to INQUEST by a) the families and/or their lawyers and b) either by direct request from or at the instigation of the coroner, and these are the sample used in the report.

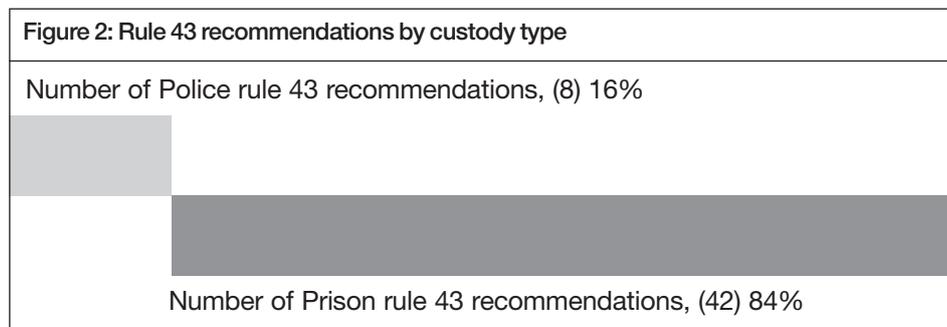
We have selected 30 narrative verdicts that raise critical issues; these relate to 13 of the cases where a rule 43 report was made and 17 additional cases.

To analyse these 67 cases, we identified key areas of concern raised by narrative verdicts and rule 43 reports already held on our cases database and the results were then linked to a comprehensive spreadsheet for detailed analysis.

The casework team also contacted lawyers they had worked with on individual cases to obtain as many narrative and rule 43 texts as possible from those inquests where we did not have detailed information prior to the start of the research project to add to what was already available. Where necessary we contacted coroners directly to obtain this information. Much of the data entry and initial analysis was conducted with the assistance of two interns and one volunteer.

We analysed the resulting data sets and following project discussions designed graphs and tables to demonstrate the emerging findings. During this process several modifications to the data sets were made in light of those findings, notably shortening the timeframe to cover the years 2007-2009 inclusive. This allowed us to concentrate on available data from the complete texts of narratives and rule 43 reports to focus the sample more tightly. During this process both the cases database and the linked analysis spreadsheets underwent extensive improvement and modification to enable us to approach the data from as many angles as possible. These systems will also enable future research to be added smoothly into the existing project systems.

## Appendix 2 – Detailed findings and statistics



### A. DEATHS IN PRISON

#### Rule 43 Reports

42 of the 50 (84%) rule 43 reports in the sample relate to deaths in prison.

Of these:

- 34 (81%) refer to male prisoners;
- 8 (19%) concern female prisoners;
- 12 (29%) were prisoners from from black and minority ethnic (BAME) communities.

The issues raised by the reports include the following:

- 14 (33%) communications;
- 21 (50%) staff record-keeping;
- 23 (55%) staff training;
- 6 (14%) drugs as a factor in the prisoner's death;
- 3 (7%) the use of restraint by prison staff on the prisoner;
- 20 (48%) inadequate health care;
- 4 (10%) poor mental health care.

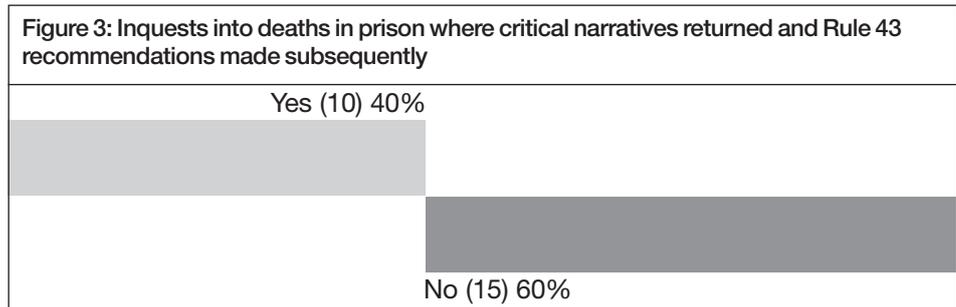
The sample of rule 43 reports includes **36/42 (86%)** self-inflicted deaths. However, only **30/42 (71%)** of those rule 43s regarding deaths in prison actually raised issues relating to self-harm, while just **5 (12%)** made reference to cell design and/or health and safety concerns.

10 (24%) are included in our research sample of narrative verdicts listed below.

Of the 42 rule 43 reports relating to deaths in prison:

- 31 (74%) were made after critical narrative verdicts.
- 6 (14%) were made after short-form verdicts.
- 3 (7%) were made after descriptive narrative verdicts.

We do not have the full text of the narrative currently available for 2 (5%) verdicts.



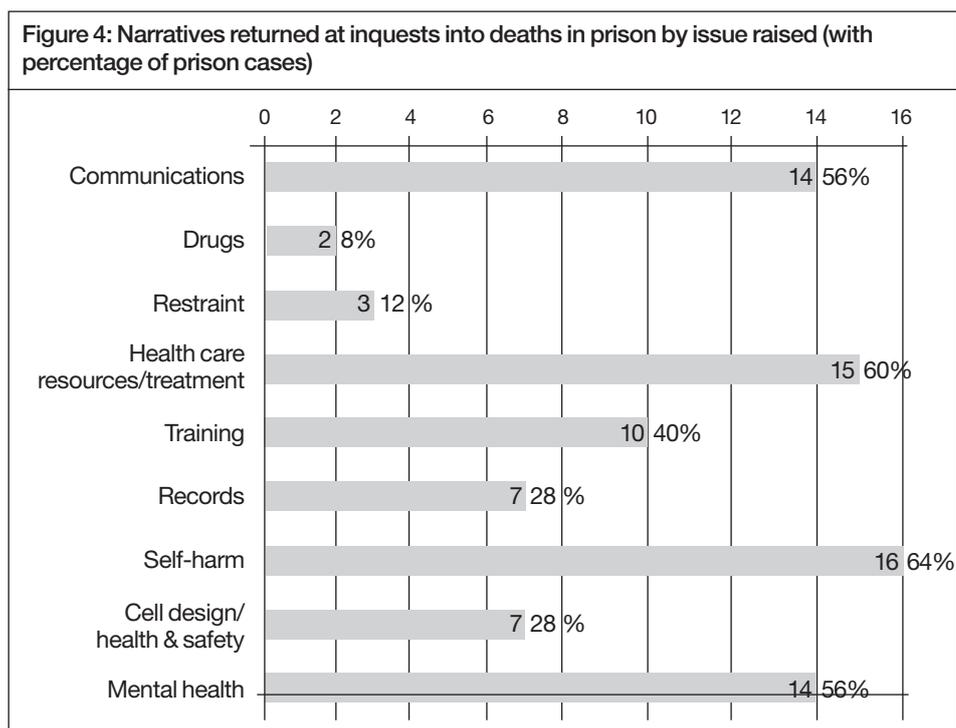
### Narrative verdicts

25/30 (83%) of the narrative verdicts in the sample relate to deaths in prison. Of these:

- 19 (76%) were male prisoners;
- 6 (24%) were female prisoners;
- 7 (28%) were prisoners from BAME communities.

The issues raised in the narrative included:

- 14 (56%) communications;
- 7 (28%) staff record-keeping;
- 10 (40%) staff training;
- 2 (8%) drugs as a factor in the prisoner’s death;
- 3 (12%) the use of restraint by prison staff on the prisoner;
- 15 (60%) inadequate health care;
- 14 (56%) poor mental health care.



The sample of critical narrative verdicts at inquests into deaths in prison includes **16/25 (64%)** self-inflicted deaths and **all 16** of these verdicts raised issues relating to self-harm, while **7 (28%)** made reference to cell design and/or health and safety concerns.

Of the 25 narrative verdicts relating to deaths in prison:

- 24 (96%) were critical narrative verdicts; and following 14 (58%) of those verdicts no rule 43 report was made.
- 1 (4%) was a descriptive narrative verdict, following which no rule 43 report was made.

## **B. DEATHS IN POLICE CUSTODY**

### **Rule 43 reports**

Eight of the fifty (16%) rule 43 reports in our sample relate to deaths in police custody. Of these,

- 7 (88%) refer to men;
- 1 (12%) concern women;
- 2 (25%) were from BAME communities.

The issues raised by the reports include the following:

- 1 (13%) communications;
- 3 (38%) office training;
- 2 (25%) staff record-keeping;
- 1 (13%) drugs as a factor in the detainee's death;
- 1 (13%) the use of restraint by police officers;
- 1 (13%) involved health care;
- 1 (13%) mental health care issues.

The sample of rule 43 recommendations following deaths in police custody includes 3 (38%) self-inflicted deaths.

### **Narrative Verdicts**

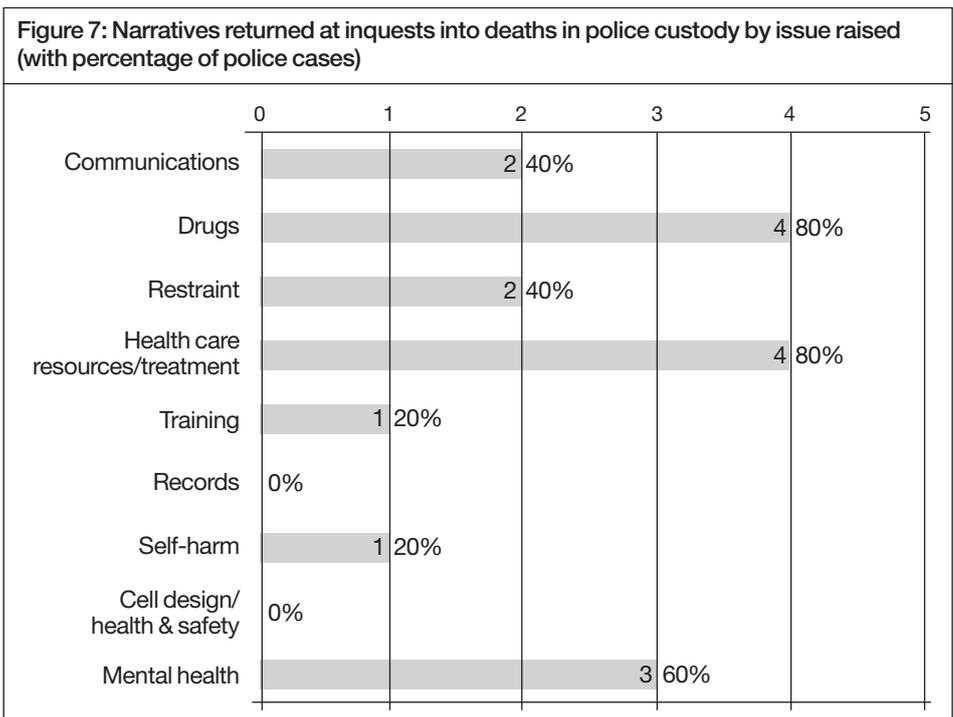
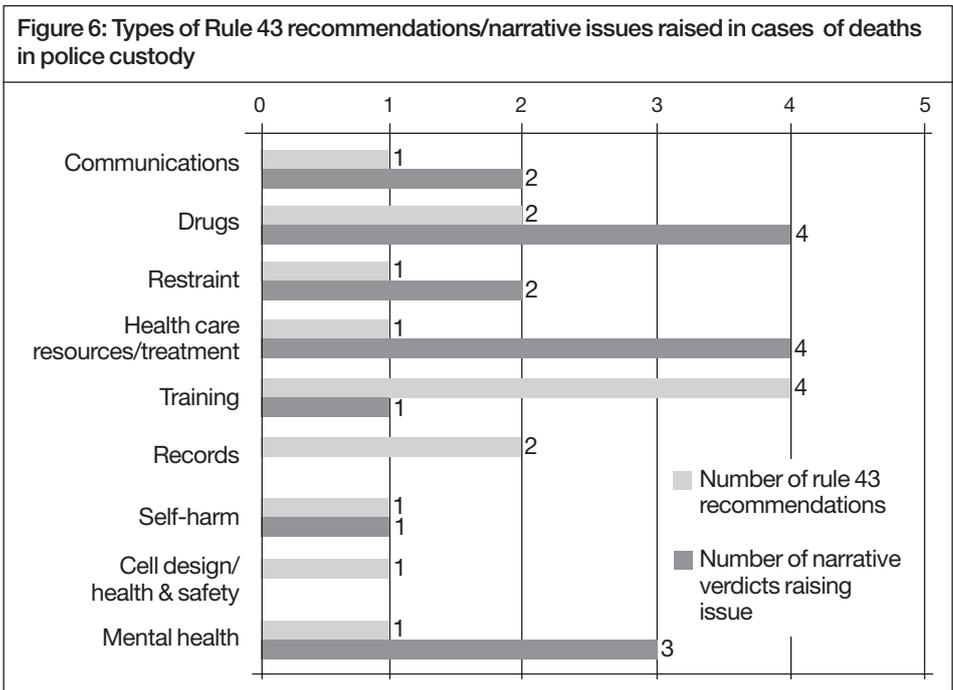
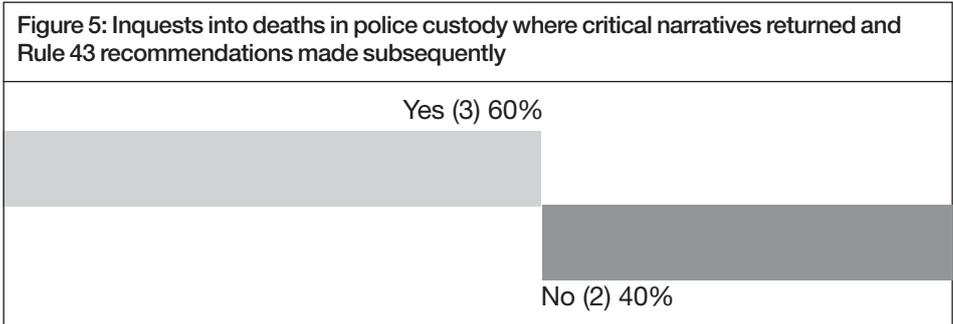
5/30 (17%) of the critical narrative verdicts in the sample relate to deaths in police custody. Of these:

- All 5 (100%) were men;
- 2 (40%) were from BAME communities.

The issues raised in the verdict included the following:

- 2 (40%) communications;
- 1 (20%) training;
- 4 (80%) drugs as a factor in the detainee's death;
- 2 (40%) the use of restraint by police officers;
- 4 (80%) inadequate health care;
- 3 (60%) mental health care;
- 1 (20%) raised issues relating to self-harm,

None of the verdicts in this sample made reference to cell design and/or health and safety concerns, nor did any raise issues about record-keeping.



## Appendix 3 – Coroners Rule 43

### From the Coroners Rules 1984:

#### 43. Prevention of similar fatalities

A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly.

### As amended by The Coroners (Amendment) Rules 2008 (S.I. 1984/552)<sup>32</sup>

32. See [bit.ly/CRle2008](http://bit.ly/CRle2008).

(1) Where—

- (a) a coroner is holding an inquest into a person's death;
- (b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and
- (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner may report the circumstances to a person who the coroner believes may have power to take such action.

(2) A report under paragraph (1) may not be made until all the evidence has been heard except where a coroner, having adjourned an inquest under section 16 or 17A of the 1988 Act, does not resume it.

(3) A coroner who intends to make a report under paragraph (1) must announce this intention before the end of the inquest, but failure to do so will not prevent a report being made.

(4) The coroner making the report under paragraph (1)—

(a) must send a copy of the report to—

- (i) the Lord Chancellor; and
  - (ii) any person who has been served with a notice under rule 19;
- and

(b) may send a copy of the report to any person who the coroner believes may find it useful or of interest.

(5) On receipt of a report under paragraph (4)(a)(i), the Lord Chancellor may—

- (a) publish a copy of the report, or a summary of it, in such manner as the Lord Chancellor thinks fit; and
- (b) send a copy of the report to any person who the Lord Chancellor believes may find it useful or of interest (other than a person who has been sent a copy of the report under paragraph (4)(b)).

### Response to report under rule 43

43A.(1) A person to whom a coroner sends a report under rule 43(1) must give the coroner a written response to the report containing—

(a) details of any action that has been taken or which it is proposed will be taken whether in response to the report or otherwise; or

(b) an explanation as to why no action is proposed

within the period of 56 days beginning with the day on which the report is sent.

(2) On receipt of a response under paragraph (1), the coroner—

(a) must send a copy of the response to—

(i) the Lord Chancellor; and

(ii) except where paragraph (6) applies, any person who has been served with a notice under rule 19; and

(b) except where paragraph (6) applies, may send a copy of the response to any person who the coroner believes may find it useful or of interest.

(3) Except where paragraph (6) applies, on receipt of a response under paragraph (2)(a)(i), the Lord Chancellor may—

(a) publish a copy of the response, or a summary of it, in such manner as the Lord Chancellor thinks fit; and

(b) send a copy of the response to any person who the Lord Chancellor believes may find it useful or of interest (other than a person who has been sent a copy of the report under paragraph (2)(b)).

(4) A person giving a response under paragraph (1) may make written representations to the coroner about—

(a) the release, under paragraphs (2)(a)(ii) or (b) or (3)(b), of a copy of the response; or

(b) the publication, under paragraph (3)(a), of the response.

(5) Representations under paragraph (4) must be made to the coroner no later than the time when the response is given under paragraph (1).

(6) On receipt of representations under paragraph (4), the coroner may decide that the response should not—

(a) be released in full under paragraphs (2)(a)(ii) or (b) or (3)(b); or

(b) be published in full under paragraph (3)(a).

(7) If paragraph (6) applies—

(a) the coroner must prepare a summary of the response; and

(b) paragraphs (2) and (3) apply to the summary of the response

prepared by the coroner as they apply to the response received under paragraph (1).

## Appendix 4 – Coroners and Justice Act 2009

### Schedule 5

#### *Action to prevent other deaths*

##### 7 (1) Where—

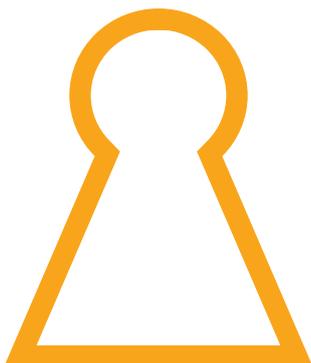
- (a) a senior coroner has been conducting an investigation under this Part into a person's death,
  - (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
  - (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.
- (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.
- (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

## Appendix 5 – About INQUEST

INQUEST is the only charity in England and Wales that provides expertise on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. INQUEST provides a general telephone advice, support and information service to any bereaved person facing an inquest and *The Inquest Handbook*<sup>33</sup> is available to any bereaved person free of charge. INQUEST also runs a free, in-depth specialist or complex casework service on deaths in custody, in state detention or involving state agents and works on other cases that also engage article 2 (the right to life) of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability.

INQUEST's policy and parliamentary work is informed by its casework and we work to ensure that the collective experiences of bereaved people underpin that work. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; ensures accountability and disseminates the lessons learned from the investigation process in order to prevent further deaths occurring.

33. Available via handbook.  
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