RESPONSE TO CONSULTATION PAPER ON ATTORNEY GENERAL'S REVIEW OF THE ROLE AND PRACTICES OF THE CPS IN CASES OF DEATHS IN CUSTODY

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INQUEST

Liberty

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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. We provide specialist advice to lawyers, advice agencies, policy makers, the media and the general public on all related issues. Working in partnership with members of the INQUEST lawyers group, we aim to provide high quality legal advice and representation for bereaved families attending inquests following deaths in custody. INQUEST aims to raise public awareness about contentious deaths and campaigns for the necessary changes to improve the investigative process, increase accountability of state officials and avert future deaths. INQUEST works closely with independent monitoring groups, black community organisations and human rights and penal reform organisations. In the ten years from January 1992 to December 2001, INQUEST has worked with the families of over 2,100 people who have died in circumstances requiring an inquest, which 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%). INQUEST has worked closely with a small team of lawyers on all of the deaths in custody cases that have raised concern in relation to the decision making function of the CPS.

LIBERTY is the UK's largest and most well-known human rights organisation. Liberty aims are to protect civil liberties and to promote human rights and pursues these objectives by lobbying, campaigning and media work; by providing legal advice and representing individuals in the courts and by research and policy development. Liberty has been concerned about deaths in custody for many years. Recently we have given evidence on this subject to the Committee on the Elimination of All Forms of Racial Discrimination and the UN's Human Rights Committee. Liberty has acted recently for the families of those that have died in proceedings in the domestic courts (Wright v the Home Office) and in the European Court of Human Rights (Edwards v UK). Currently Liberty (with the help of INQUEST) is engaged in a research project on deaths in custody which will report at the end of this year."

BHATT MURPHY is a niche human rights practice specialising in the protection of the civil liberties of those touched by or caught up within the criminal justice system and analogous detaining authorities such as immigration detention centres or mental health units. Our work has focused on the concerns of those alleging abuse of authority or neglect of duty within the criminal justice system, particularly on behalf of the families of those who had died in custody. We have sought to reflect these concerns in the context of a general engagement with the various avenues available to members of the public to hold the relevant authorities to account. To that end, our endeavours have inevitably invoked the formal complaints process as well as the investigative, prosecutorial and disciplinary machinery pertaining to police and prison officers, and, where necessary, private law and public law actions with the aim of bringing the conduct of the relevant authorities under the scrutiny of the courts. We have represented the families involved in many of the most significant and controversial restraint related death in custody cases over the last two decades, including Winston Rose (unlawful killing, 1981, Metropolitan Police), Clinton McCurbin (accidental death, 1987, West Midlands Police), Germaine Alexander (death by misadventure/neglect, 1989, Brixton Prison), Oliver Pryce (unlawful killing, 1991, Cleveland Police), Richard O'Brien (unlawful killing, 1994, Metropolitan Police), Shiji Lapite (unlawful killing, 1994, Metropolitan Police), Dennis Stevens (death by misadventure, 1995, Dartmoor Prison), Kenneth Severin (open verdict, 1995, Belmarsh Prison), Alton Manning (unlawful killing, 1995, Blakenhurst Prison) and Ibrahima Sey (unlawful killing, 1996, Metropolitan Police).

1. Introduction

1.1. This short response to the Attorney General's consultation paper on the role of the CPS in deaths in custody is to be read in the context of our general comments at the consultation seminar on 21 May 2002. Due to the constraints of time we have not been able to do more than outline our concerns. We would have liked to elaborate on those concerns in more detail, and we would welcome an opportunity to do so. We are also anxious that the lessons from the current trial in relation to the death of Christopher Alder are not yet available for consideration by the Attorney General, since that trial has not yet concluded and neither the family nor their lawyers have had the opportunity to contribute to this consultation.

1.2. It is extremely rare for there to be a prosecution after a death in custody, even where an inquest jury has returned a verdict of unlawful killing. This has been and remains one of the most contentious issues in relation to the approach of the criminal justice system to deaths in all forms of custody.

1.3. Since 1990 there have been eight deaths in custody (see appendix) where inquests have returned unlawful killing verdicts, all of which 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 four of these cases (O'Brien, Lapite, Manning and Alder), two of which eventually resulted in prosecutions (O'Brien and Alder). The only other prosecutions we have seen involve the use of police firearms in two cases (Erwin and Ashley) and the use of gagging by immigration officers in one (Gardner). There remain a number of other cases which have not resulted in unlawful killing verdicts or prosecutions, but which nevertheless raise serious and significant concerns about potential criminal conduct on the part of law enforcement officers (Brian Douglas, Wayne Douglas, Dennis Stevens, Kenneth Severin, Glenn Howard and Howard Wilkinson amongst others). The theme running through all these cases – which are a small minority of the total numbers of deaths in custody – relates to the use of excessive force by functionaries of the state[1].

1.4. Whilst we accept that the purpose of this review is to focus on the fundamental approach and practices of the CPS rather than to reopen decisions in individual cases, it is difficult to see how a detailed examination of the handling of the cases identified above can be avoided if there is going to be a real attempt take on board the crucial lessons to be learnt from those cases. The submissions below draw on those lessons as identified by us, and we shall be happy to provide detailed

[1] We are also concerned about deaths resulting from negligence by state officials, in particular those cases involving medical neglect of people in custody, which have lead to a small number of prosecutions of doctors, but again those prosecutions are the exceptions which prove the rule - see *Medication errors that have led to manslaughter charges,* R E Ferner, BMJ 2000; 321: 1212 – 1216 (11November).

references to the relevant case papers, by chapter and verse if that is considered to be necessary or helpful.

1.5. Similarly, we accept that the stated scope of the review is by definition confined to the handling of deaths in custody. However, what is common to the cases identified above is precisely the fact that each case involves allegations of serious criminality amongst police or prison officers acting in purported execution of duty. It must follow, in consequence, that the flaws in the process and quality of decision making as revealed in relation to these cases may well be symptomatic of the way in which other cases involving such allegations of serious criminality against police or prison officers are being handled within the CPS. We therefore trust that the scope of the review will be interpreted in a manner which allows a proper consideration of that possibility.

2. Accountability to the rule of law

2.1. The bereaved families in cases of deaths in custody have drawn an analogy between their experience and that of Mr and Mrs Lawrence, following the murder of their son Stephen. Speaking after the Court of Appeal had failed to grant a fresh inquest into the death of Wayne Douglas his sister said:

> `*My family believes we have been denied justice. We are particularly upset by the judge's remarks about the expense of holding a further inquest. A proper verdict on my brother's death is far more important than money. We feel, like the Lawrence family, that we have been excluded from British justice.'* (Guardian 31.07.98)

2.2. Brian Douglas' brother Donald commented after the inquest into his brother's death:

> *'I fear that the numbers killed in police custody over recent years without redress may have helped to shape the attitude that informed those officers when they brought down that baton on my brother's skull*'. (Independent 21.08.96)

2.3. In fact, the position in which bereaved families find themselves in these cases is somewhat worse than that of the Lawrence family: there, at least, neither the police nor the CPS sought to dispute that the death amounted to a homicide, and the failures lay in the conduct of the subsequent investigation into that homicide. In contrast, in these cases of deaths in custody, the approach of the police investigation and the CPS alike from the outset is to treat the death as anything other than a potential homicide, and that is the first issue with which bereaved families have to struggle. In other words, what we find in the handling of these cases is a familiar malaise: an institutionalised unwillingness and reluctance to approach these deaths as potential homicides which infects the entire process, from the investigation conducted by the police

into these deaths through to the deliberations of the CPS on the outcome of those investigation. From the outside, it appears that this malaise serves only to encourage a culture of impunity, to send a clear message to police and prison officers: that deaths can occur as a result of their acts or omissions and they will not be called to account. The perception is created that the police and prison officers are 'above the law'.

3. The role of the CPS

3.1. The cases where there has been an opportunity for scrutiny of the conduct and decision making within the CPS – such as Lapite and O'Brien under the pre-Butler arrangements, or Manning and Alder under the post-Butler arrangements, or, more recently, Sylvester under the post-Manning policy of providing reasoned explanations for decisions not to prosecute – appear to confirm a long standing but continuing inadequate independence and objectivity in the handling of such cases within the CPS. So, it appears, the steer given by those involved in the police investigation is allowed to shape the approach of and the decisions subsequently made by the CPS, without any recognition of the flaws that may pervade that investigation or the implications of such flaws. Instead, the fruits of that police investigation come to be swallowed and digested by the CPS without the benefit of the independent review or 'health check' which must be an essential part of its role in such cases.

3.2. This is not to say that the CPS fails to carry out any review or examination of the case. On the contrary, what we see is a detailed analysis, but more often than not one which appears geared from the outset, inadvertently or otherwise, to lead to a conclusion not to prosecute. As HH Butler commented at the consultation seminar, one is left with the impression that the case for a prosecution is analysed away through an exercise in over-analysis. Indeed, such an exercise in over-analysis would be possible in any case of homicide, with the result that none would ever be prosecuted.

3.3. What we would like to see is a relationship of sceptical scrutiny between the CPS and the police investigation: a willingness on the part of the CPS to search for and recognise any flaws in the police investigation, so that, where possible, steps are taken to remedy such flaws at the earliest opportunity to safeguard the quality of the evidence that may eventually support a prosecution, and, where appropriate, any first impression of weaknesses in the available evidence may be understood by reference to such flaws.

3.4. Subject to such a relationship of sceptical scrutiny, the CPS has an important role to play in providing an independent check or review of the police investigation in these cases, and an early and pro-active involvement on its part at the investigation stage should serve to ensure

that the investigation is as thorough and proper as possible. The purpose, it should be understood, is not to supervise or conduct the investigation, but to advise on its conduct precisely with a view to safeguarding the prospect of a prosecution that might otherwise be eroded. If that is understood clearly, and subject to the professionalism that one is entitled to expect of the CPS, we do not see this proposal as any compromise on the important principle of the separation of the investigation process from prosecution decision making.

3.5. We would suggest that there is no reason why such involvement on the part of the CPS should not commence from the outset following a death, since the potential flaws in police investigations are often founded in those first few crucial minutes and hours (such as the all to common failure to collect all relevant evidence at the scene of the death or to sequester potential suspects before they are interviewed under caution or, indeed, to carry out such interviews promptly or at all). Since the role envisaged for the CPS is not mere supervision of the police investigation, its interaction with those who may be responsible for such supervision (such as the PCA or its forthcoming successor body in the case of deaths in police custody) can only be constructive: the CPS should be able to focus on its specific interest in safeguarding the prospect of a prosecution. Moreover, in our view, the rationale for such CPS involvement should continue to hold good even if the investigation itself comes to be conducted, not by the police, but by the PCA's successor body in relevant cases of deaths in police custody. Any potential for conflict or confusion between the various roles could easily be ironed out by means of an appropriate protocol to be drawn up between the CPS, ACPO and the PCA/IPCC or Prison Service.

4. The inquest and the verdict of unlawful killing

4.1. For the purposes of the CPS, an inquest verdict of unlawful killing is and should be no more and no less than it is: it cannot be binding in any way, but it provides the best indication of the way in which any conflicts in the available evidence are likely to be resolved at a criminal trial, and therefore it provides the best guide available to the prosecutor engaged in the predictive exercise of determining whether there is a realistic prospect of conviction for homicide on the available evidence. Of course, the differences in the rules governing the conduct of and admissibility of evidence at inquests and criminal trials are relevant in this context, but the key feature of the explanations we have seen in support of decisions not to prosecute – conflicts in factual or scientific evidence and the credibility or reliability of relevant witnesses – will usually have been resolved to the satisfaction of the inquest jury in such cases.

5. The evidential test and assessing the prospects of conviction

5.1. It is not our submission that the evidential test to be applied by the CPS in these cases of deaths in custody should be any different from that applied to all other cases. Indeed, the demand of bereaved families in these cases is not for some special or privileged treatment for themselves, but rather for an end to the special or privileged treatment that appears to be reserved for police or prison officers. They, like us, see the CPS explaining away decisions not to prosecute by reference to conflicts in factual or scientific evidence, or questions about the credibility or reliability of relevant witnesses, even in those cases where such conflicts or questions have not prevented an inquest jury from returning an unlawful killing verdict.

5.2. It is of course understandable that, as law enforcement officers in their own right, prosecutors at the CPS find it difficult to believe witnesses who question the credibility and reliability of other law enforcement officers such as police or prison officers, especially when such witnesses in a case of death in custody – like the deceased himself – will inevitably be suspected, accused or convicted of criminal offences. In other words, an inevitable camaraderie amongst law enforcement officers, and their equally inevitable common cause against those suspected, accused or convicted of criminal offences, appears to infect the handling of deaths in custody in general within the criminal justice system, but most particularly in the objective assessment of the available evidence that has to be carried out by the CPS when determining the prospects of conviction. In those circumstances, where very real subjective factors appear to impact upon the ability of the prosecutor to carry out an objective assessment of the case, it must be all the more imperative that due respect and regard should be shown to the subjectively unfettered conclusions that may have been reached by an inquest jury in returning a verdict of unlawful killing and the implications of those conclusions for any apparent questions about the credibility or reliability of relevant witnesses.

5.3. The same can be said in relation to apparent complexities, uncertainties or conflicts in scientific evidence, usually as to cause of death, which may well have been resolved to the satisfaction of an inquest jury, but which are nevertheless cited by the CPS to justify decisions not to prosecute in these cases of deaths in custody. What we see in this regard is often something akin to a search for certainty beyond reasonable doubt, sometimes explicitly so, in violation of the most elementary but fundamental principles of the law of causation: first, that an act may remain a substantial cause of death in law as long as it contributed more than minimally to the death, even if the prime factor in the death was some other act or event (*R –v– Hennigan* (1971) 55 Cr App R 262 CA; *R –v– Cato & Ors* (1976) 62 Cr App R 41 CA) – in other words, that causation is established if the act complained of caused or was a substantial cause of the death, in the sense that it was a contributing factor that was not minimal, and it is not necessary to

establish that the act complained of is either the sole cause or even the primary cause; and, secondly, that the issue of causation is not and cannot be determined by a requirement of scientific certainty or expert opinion alone, but a matter to be determined by the tribunal of fact on the whole of the evidence including all of the factual evidence (*R –v – Cato & Ors* (1976) 62 Cr App r 41 CA; *R –v– Bracewell* (1979) 68 Cr App R 44 CA; *R –v– Dawson & Ors* (1985) 81 Cr App R 150 CA) – in other words, that the fact that scientific opinion may not be able or willing to express a view with absolute certainty does not mean that the scientific evidence together with all the other circumstances of the case may not be enough to satisfy the tribunal of fact so as to make them feel sure as to causation.

5.4. Such apparent ignorance or wilful neglect of fundamental principles of law on the part of the relevant decision makers within the CPS is a cause for concern in itself, especially since it appears to prevail only in the context of deaths in custody. But even more disturbing is their apparent readiness to imagine lines of defence based on theses unsustainable on the available evidence in their apparent determination not to prosecute in cases such as Lapite and Manning. And when such a thesis comes to be exposed as unsustainable, an alternative has been put forward to maintain the decision not to prosecute, in an exercise which has all the hallmarks of goal posts being moved.

5.5. At the very least, then, echoing the remarks of the then Lord Chief Justice in the case of Manning, we would say that in cases of deaths in custody the CPS certainly appear to apply an evidential test higher than that laid down in the Code for Crown Prosecutors, whether inadvertently or otherwise. We repeat that what we seek is no more but no less than the performance of basic and fundamental prosecutorial functions in accordance with the existing Code in a manner in which the rule of law is seen to apply to all without fear or favour towards anyone. In our capacity as advocates or lawyers acting on behalf of bereaved families in death in custody cases, we recognise the importance of the principle of the fair and impartial prosecutor. In that light, we have not and would not seek to bring any improper pressure to bear upon the decision to prosecute. However, that is not to say that bereaved families should refrain from making any representations that they or those representing them consider appropriate and helpful to the decision maker within the CPS, whether before the decision is made or, more usually, after a decision is made which appears to sit uncomfortable against the backdrop of available evidence.

6. The decision maker within the CPS

6.1. The current Butler arrangements for the handling of deaths in custody within the CPS – involving the designation of a very limited number of SCS level members of the Casework Directorate as reviewing lawyers, and consultation with leading or senior treasury counsel where

appropriate – are clearly designed, at least in part, to promote the quality of decision making on these cases. Our experience of these arrangements is far from satisfactory.

6.2. It is significant that the errors in the decisions made in the case of Manning went undetected despite the involvement of a very senior case-lawyer as the decision maker within the CPS as well as consultation with leading counsel under the interim arrangements that were then in place pending the publication of the Butler report. Accordingly, one does have to question whether mere seniority of the decision maker or consultation with counsel can be sufficient to guarantee quality. Subsequent decisions made under the current arrangements – in the case of Manning after the original post-inquest decision came to be quashed, and in the cases of Alder and Sylvester – appear to warn similarly against any complacency.

6.3. Moreover, the very fact that the number of lawyers designated to handle such cases is very limited – four at present – may be responsible for unconscionable delays in the decision making process (ranging from several months to over one year). It is simply inconceivable that such delays could occur, or could be tolerated, in cases other than deaths in custody. The message that bereaved families are left with is simple but clear: that these cases do not receive the priority they deserve. The implications are equally clear: if there was to be a prosecution, time would be of the essence, so any delay signifies that the outcome of the process has been pre-judged from the outset, and the case-file is sitting in some office awaiting its turn until the decision maker finds time to put together the reasons for that pre-judged outcome.

6.4. In the circumstances, there appears to be a crying need for a substantial increase in the number of case-lawyers trained and designated to handle cases of deaths in custody, and all the more so if proposals for early and pro-active involvement of the CPS at the investigation stage are to be adopted. The question that then arises for consideration relates to the nature and quality of training that should be made available to the lawyers designated to handle such cases.

6.5. Such training has to address, of course, the relevant law – the errors we have seen in decision making in the past suggest that we cannot be complacent about the need for the decision makers to understand and apply correctly the most fundamental and elementary principles of law. It should also address relevant current debates that go directly to the evidence potentially available in support of a prosecution, such as that in the field of pathology as to cause of death in cases involving restraint.

6.6. We would submit, however, that if the structural and institutionalised problems adverted to above are to be addressed, then the training should also be designed, from the outset, to challenge the institutionalised reluctance or unwillingness to approach these deaths as potential homicides that appears to have been prevalent in the process

as outlined above; to develop the relationship of sceptical scrutiny with the police investigation that we consider essential to the role of the CPS; and to understand the contextual issues surrounding deaths in custody, so that there is an ability and willingness to understand fully the significance of the material that emerges from the police investigation and the context from which it emerges.

6.7. As matters stand at present, there appears to be little or no real understanding within the CPS in relation to, for example, the reasons for prevalence of black or Irish men and/or mental illness amongst those who die in custody; the difficulties faced by their families in accessing practical and emotional support or adequate legal representation; the obstacles faced by potential witnesses as a result of fear, intimidation and, sometimes, illiteracy; the weaknesses and strengths of the arrangements for the training of police and prison officers in control and restraint techniques, suicide prevention or the handling of mentally ill detainees; the structural and institutionalised weaknesses in the investigative arrangements within the police service and the prison service alike; or the implications of the many profound weaknesses of the inquest system as a means of inquiry into these deaths.

6.8. The relevant knowledge base and expertise may not immediately or always be available within the CPS, but it must be willing to question whether it needs to seek it from elsewhere. So, for example, we would encourage the CPS to consult and work with INQUEST – the only organisation that specialises in advising and supporting families bereaved after deaths in custody – to address the perspective of such families and the significant differences between their experiences and those of families bereaved in other circumstances[2].

6.9. Identical concerns arise in relation to the identity and quality of counsel to be instructed to advise decision makers within the CPS, most of whom tend to compound rather than mitigate the structural and institutionalised weaknesses within the decision making within the CPS as outlined above. In this connection, we are aware of and welcome the initiative shown by the CPS in instructing an 'outsider' to advise on and conduct the ensuing prosecution relating to the death of Simon Jones – but it may be significant that the death in that case was one at a workplace rather than in custody, and the family of the deceased were white, middle class and articulate. We also aware of and welcome the initiative taken in the current prosecution relating to the death of Christopher Alder to consult the deceased's family on the choice of a second junior counsel who was then instructed with a particular brief to ensure the flow of communication with the family – but, again, it may be significant that the initiative came to be taken very late in the day, on the eve of the commencement of the trial, leaving very little opportunity for it to shape the conduct of the prosecution in any significant way.

[2] Families experiences of the Inquest system – Helen Shaw INQUEST (forthcoming Autumn 2002)

6.10. We would encourage a greater willingness on the part of the CPS to instruct counsel who have a track record in acting for bereaved families in cases of deaths in custody as well as survivors of abuse of authority or neglect of duty on the part of police or prison officers, and who are thereby able to mitigate as far as possible the weaknesses that otherwise lead to the current crisis of confidence in the decision making within the CPS.

7. Transparency

7.1. We welcome the current policy of the CPS – adopted belatedly, in the wake of the challenge in the case of Manning – to give reasons for decisions not to prosecute, which we have found to be working satisfactorily on the whole. We would suggest that disclosure of the review note reflecting the analysis and reasoning by which the decision maker reached his or her conclusions is the most preferable mechanism to achieve the stated objective of transparency.

7.2. The question of communications with bereaved families arises, of course, not only in relation to explanations for decisions not to prosecute, but also in relation to those cases where, rarely as it happens at present, a decision is made to prosecute. The imperative to ensure effective liaison with family members and their representatives becomes all the more pressing in this context, especially when the decision to prosecute follows a review of an earlier decision not to prosecute. Our experience suggests that in these circumstances the CPS tend to rely on the original police investigation team to provide prosecutorial support as well as family liaison. Where, as in the case of O'Brien, those officers come from the same police force as those being prosecuted, the resulting lack of independence between all concerned creates a uniquely difficult situation where the CPS cannot enjoy the confidence of the family. We would suggest that the CPS needs to take responsibility for its own arrangements for family liaison in these cases – the appropriate arrangements will vary from case to case but should be the subject of consultation and discussion at the outset.

8. Conclusion

8.1. We close these brief comments by making it clear that public concern surrounding deaths in custody is not going away – the inquest into the death of Roger Sylvester takes place in October 2002, and all the present indications suggest that it will present the same challenge to the CPS as previous similar cases, mirroring the same pattern of flawed investigations and other weaknesses in the process that have been identified before. The task for the CPS in this and other cases of deaths in custody remains simple: to do its job, no more and no less, so that the rule of law is seen to be upheld and applied equally to all citizens including those in the uniform of the police or prison service.

Appendix

UNLAWFUL KILLING VERDICTS AND/OR PROSECUTIONS FOLLOWING DEATHS IN CUSTODY SINCE 1990

	Name	***Ethnicity***	***Date***	***Custody***	***Prosecution***	***Inquest***	***Verdict***
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*
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 – hung jury	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 – pending	Yes	Unlawful killing

* Misadventure contributed to by neglect at fresh inquest