Death and the State: the importance of human rights in inquests and public inquiries

> ***"…but until that moment I had never realized what it means to destroy a healthy, conscious man. When I saw the prisoner step aside to avoid the puddle, I saw the mystery, the unspeakable wrongness, of cutting a life short when it is in full tide."***
> **Eric Blair (aka George Orwell) (A Hanging from a collection of essays)**

When I started 26 years ago, I knew little about human rights. Yes, we had the ECHR but it didn't come into the law we practiced.

I had studied civil liberties at university but soon came to the realization that it was a difficult concept mainly because we had no written constitution, and with our judge made law and our system of precedent, our rights could be evasive, fluid and constantly changing. Our rights were very much dependent upon the whim of judges with their interpretation only subject to a Wednesbury test of reasonableness.

It was all so difficult.

Eight hundred years ago was a monumental time in the history of the world. Fundamental changes came into force on a small, cold, wet and rather windy set of islands which would impact on our lives some eight centuries later.

'The Great Charter' or the Magna Carta established the principle that everyone, including the king of the time, was subject to the law.

This is a much used phrase and you will hear many variations repeated in your lifetime:

- No one is above the law
- Everyone is subject to the law
- The law applies equally to all

A medieval 'semi French king had his back against the wall and had lost his inherited lands in France to the then French King. He was broke. He was substantially weakened in England. He was trying to raise taxes. The powerful Barons of the land were fighting back and saying enough is enough. They brought their list of complaints to the King and signed a 'peace treaty' at Runnymede near Windsor, that peace treaty was the Magna Carta.

Why does it matter today?

Simply, the Magna Carta is the cornerstone of all modern written constitutions and the basis of many of our human rights and freedoms we enjoy today.

The most famous clauses in the Magna Carta are 39 and 40:

"*No free man shall be seized or imprisoned, or stripped of his rights or possessions, or outlawed or exiled, or deprived of his standing in any other way, nor shall we proceed with force against him, or send others to do so, except by the lawful judgment of his equals or by the law of the land.*
To no one will we sell, to no one deny or delay right or justice"

This is all great rhetoric. It is the foundation of civil liberties, human rights and the stuff of great speeches but it is more important than that- it is concrete and it is real:

- no one should be seized or imprisoned;
- no one should be stripped of rights or possessions;

- people have a right to a fair trial;
- an entitlement to due process; and
- no one shall be denied or delayed justice.

The Great Charter has acquired special status. Despite the fact that the vast majority of its clauses have now been repealed or superseded by other legislation, it has enormous symbolic power as an ancient defence against arbitrary and tyrannical State power and a guarantor of our individual freedoms and liberties.

The Right to Life

Arguably the most important and fundament right that we have is that of life. Without life we have nothing.

The legal framework

Article 2 of European Convention on Human Rights

> *"Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."*

Briefly Article 2 involves the following duties:

- the "negative obligation" on States to refrain from the unlawful taking of life;
- the "positive obligation" on States to take appropriate steps to safeguard the lives of those within its jurisdiction (systemic and operational); and
- the "investigative obligation" to investigate when life has been taken.

There are general duties on the state to put in place:

- a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably and practicably, protect life; and
- training, instructions, regulations, systems, equipment reasonably adapted to the risk, for a state's agents who are faced with situations where the deprivation of life may take place under their auspices and control.[1]

[1] *Kakoulli v Turkey* Fourth Section ECHR 22/2/06at para 110; *McCann v UK* (A/324) (1996) 21 EHRR 97

These duties arise irrespective of whether there is a real and immediate risk to life. For example, it is appropriate to fully investigate the adequacy of guidance for police restraint, or the system for investigation of complaints against a GP,[2] even where the acts of individuals surrounding the death may be entirely blameless.

The "operational" positive obligation

There is a distinct and additional 'operational' duty, which arises in certain well-defined situations. The duty is to take all reasonable steps to avoid a real and immediate risk to life of which the state knew or ought to have known.[3]

Where this duty applies, Article 2 may be invoked where "*although there has been no systemic failure, a real and immediate risk to life has been demonstrated, and individual agents of the state have reprehensibly failed to exercise the powers available to them for the purpose of protecting life*".[4]

A clear theme emerging from the case law is that whether the operational duty arises depends on factors such as:

1. the vulnerability of the person who is at risk;
2. the control exercised by the state over that person; and
3. whether the state can be said to have assumed responsibility for that individual.[5]

The Article 2 investigative duty

The investigative duty was established by the European Court of Human Rights (ECtHR) in *McCann v. UK*,[6] based on the need to make the substantive Article 2 protections effective in practice. The duty has been developed by the ECtHR in *Jordan*[7], and was established in domestic law by the House of Lords in *R (on the application of Middleton) v. HM Coroner for West Somerset.*[8]

[2] *Moss v HM Coroner for Durham* [2008] EWHC 2940 (Admin).
[3] *Osman v UK*
[4] Van Colle, para 31.
[5] *Savage* at 27 and 39; *Mitchell v Glasgow*at para 66; and *Menson v UK* (2003) 37 EHRR CD 220 where the Court explained *Edwards v United Kingdom* on the basis that the state had assumed responsibility for his welfare.
[6] *McCann v UK* (A/324) (1996) 21 EHRR 97
[7] *Jordan v United Kingdom* (2003) 37 EHRR 2
[8] [2004] 2 AC 182

Minimum standards

The ECtHR 'has laid down minimum standards which must be met, whatever form the investigation takes'.[9] Those minimum standards are:[10]

- the investigation must be independent;
- the investigation must be effective;
- the next of kin must be involved to an appropriate extent;
- the investigation must be reasonably prompt;
- there must be a sufficient element of public scrutiny; and
- the state must act of its own motion and cannot leave it to the next of kin to take conduct of any part of the investigation.

What does effective mean?

1. The purposes of the Article 2 procedural duty include[11:]
   a. ensuring that the full facts are brought to light;
   b. that culpable and discreditable conduct is exposed and brought to public notice, and those responsible are identified and brought to account;
   c. that suspicion of deliberate wrongdoing (if unjustified) is allayed;
   d. identifying and rectifying dangerous practices and procedures;
   e. ensuring that lessons are learned that may save the lives of others[12]; and
   f. safeguarding the lives of the public, and reducing the risk of future breaches of Article 2.

My early years practice

When I did my first inquest in 1990, I quite frankly didn't have a clue. I was told that the hearing would be a short matter. I was very junior counsel then, just out of training and the Coroner's Court was where junior, inexperienced counsel were sent to learn their trade. It was a time when it was generally thought by many in the profession that inquests weren't important cases. They certainly weren't lucrative if one was representing the interest of the

[9] *R (on the application of Amin) v. Secretary of State for the Home Department* [2004] 1 AC 653at para 32
[10] *R (on the application of D) v. Secretary of State for the Home Department* [2006] All ER 946 at para 9(iii)
[11] *R (on the application of Amin) v. Secretary of State for the Home Department* [2004] 1 AC 653at 31, 20(5), 41 and 62; *R on the application of Wright v Home Secretary* [2002] HRLR 1at para 43(2).
[12] *R (JL) v Secretary of State* [2009] 1 AC 588, para 29.

family since their was no legal aid. I would do my first case pro bono and I believed this was the reason why such work was readily available for junior members of the bar.

I attended my first hearing thinking it would be a short, simple affair. It was not. Yet I had no papers apart from a back sheet from the solicitors and a witness statement from the mother of the deceased. Her son had died whilst being restrained by police. He was drug addict and had been on cocaine. He had been arrested, struggled with several police officers, had gone limp and had died. I had no post-mortem report as that evidence would only be provided at the inquest. This was a time where there were no disclosure witness statements or evidence so I did not know what the police officers would be saying. I had a couple of days to prepare for the hearing and I didn't know where to start. I asked various members of my Chambers and I was pointed to the leading text books on the subject. There were two at the time and they were not practical. They talked about treasure, the great history of the Coroner's Court and the law but they did not tell me what to do or what I should expect. The language was complicated, the books were full of legal theory and case law. The only advice and assistance I received were tips from some of my colleagues.

When I attended the hearing, I was shocked. This was no small or quick hearing. It was intense and complicated. I was handling a grieving mother with no idea of how to cope with grief. There were several police officers to give evidence and they were represented by very senior counsel. The Chief Constable was separately represented. I noted that both counsel for the police interest, although they had different clients, sat together, conferred together and colluded together. I was excluded from all their discussions. It was definitely us against them. Despite the fact that I had read in the learned books that the inquest was not a trial and there were no parties - it certainly felt that way. The hearing started and I felt heavily outnumbered. The Coroner was cold and hostile. I asked him for his witness list which he reluctantly gave me: "*If you must Mr. thomas*". I could see that there were a number of witnesses that were just being read. Most of them were independent witnesses and bystanders. I enquired why they were not being called. The Coroner said he had reviewed the papers and their witness statements and there was not much they could add to the evidence. I hadn't seen their witness statements and asked if I could do so. Again, reluctantly, he said "*if you must Mr. Thomas*." The jury was sworn, the witnesses were called and I heard the evidence for the first time. I noticed that everyone else in the room had their witness statements. I was the only one who had no papers. I was hurried by the Coroner when I asked questions. I enquired whether I could see the statements or the notebooks and the other Barristers objected. The Coroner upheld their objections:"*Do get on with it Mr.*

Thomas." On hearing the evidence, it was clear there were contradictions between what was being said. The pathology evidence was equivocal. He, the pathologist, was unsure as to the cause of death. He thought the drugs had played a part but also the struggle. He did not consider or comment on the restraint and I knew nothing in those early days about the concept of positional asphyxia. At the close of the evidence, I asked about my right to address the jury and was told I had none. I could only address the Coroner on the law and the verdicts. I sat down with not much to say. The jury returned an open verdict.

It was an experience I will never forget and I was determined one that would never happen again.

The Journey

Positional asphyxia: *this is a mode of death, where the individual is held or restrained in a deleterious position, which inhibits the mechanics of breathing.*

How did I learn about positional asphyxia?

• Wayne Douglas 1997 – Wayne committed a house hold armed burglary, escaped and was running through the streets of Brixton. He was seen by police, apprehended and restrained. During the course of the restraint, Wayne died from positional asphyxia. His death sparked the 1995 Brixton riots and was a controversial case. Representing Wayne's sister was my first big case. Back then the concept of positional asphyxia was relatively new and still not fully accepted. I remember the pathologist in Douglas, Dr Freddie Patel, in answer to my questioning said that positional asphyxia was a myth. The jury rejected his medical testimony.

Although the verdict was accidental death and not exactly what we wanted, the jury did find that the death was contributed to by restraint and positional asphyxia. The verdict was nevertheless an accident.

More importantly, despite the fact that the Coroner had misdirected the jury by mixing and merging gross negligence manslaughter with unlawful act manslaughter in his summing up on unlawful killing, the court of appeal didn't overturn the verdict to remit the matter back for a fresh inquest.

This taught me an important lesson, even where the law is clear cut; the decisions of judges are not. This was certainly a low point.

• Ibrahim Sey 1999 – This case involved a man clearly suffering from mental health problems. His wife called the police in the hope of him receiving the medical assistance he required. Instead he was restrained, sprayed at close range with CS spray and died in custody. Sey was interesting for a number of reasons. Firstly, it was the first death after the introduction of CS spray in this country. Secondly, back then there was no legal aid for these cases so I spent 6 weeks doing this case pro bono while those representing the state were paid by tax payer's money. It begs these fundamental questions: if someone dies at the hands of the State why should their family fund their investigation? Should there be this inequality of arms?

This was a long and difficult case but a success and certainly one of my high points. The jury returned a verdict of (Unlawful killing) gross negligence, finding that Mr. Sey died from positional asphyxia and restraint.

The low point was that despite the jury's finding, the Crown Prosecution Service (CPS), being obligated to reconsider whether they should take any action, decided that there would be no prosecution.

• Christopher Alder 2000 - This is the case which has had one of the biggest negative impacts on me both personally and professionally. Christopher was an ex-paratrooper who got into a fight in a club one night. He received a blow to the head and was taken to the local hospital. He was difficult in the hospital, probably because of post-concussional syndrome, and the police were called. He was arrested and taken to Hull police station where the police officers dragged him into the police station. He had unexplained injuries, other than the blow he received in the nightclub, and his trousers were down his legs. He was exposed, not in a decent state and put on the floor of the police station. With five police officers standing around the custody suite and talking amongst themselves, Christopher Alder died. It was captured on CCTV.

There were no less than nine interested persons representing various State agents against only me. Things hadn't changed that much since the very first case I told you about: the colluding, conferring and discussing. I felt very isolated.This was the first case that I had done where upon seeing the CCTV, the jury cried at the inhumanity of man towards man.

Alder was an interesting case because it was the first death in police custody just before the introduction of the Human Rights Act 1998 which was introduced in October 2000. All the human rights arguments about the investigation and the right to life were explored. In the end, the court left a verdict of unlawful killing which the jury returned.

• Sean Rigg 2012 – Sean died on camera in Brixton police station. This case raised very similar issues to that in Alder.

Police Shootings

• James Brady 1999 - Representing the family of James Brady led to another landmark case in my professional life. James was one of a group of burglars who had broken into premises and were apprehended by the police (working on intelligence) upon exiting the premises. James was shot in controversial circumstances and there was a real issue as to whether the shooting was reasonable and proportionate. Interestingly, officers first successfully applied for anonymity in this case. A high point because despite the fact that the police maintained that the deliberate shooting of James was justified, this was rejected by the jury who returned an open verdict.

• Fosta Thompson 2004 – This case involved another young man who was shot by police in Bristol, again in reasonably controversial circumstances. It was suggested that Fosta was involved in an armed robbery, was running from the police and, as he was running, turned to shoot the police; therefore, the police shot him in self-defence. There was one problem with the police account: Foster was shot in the centre of his back. Undoubtedly a low point as the jury found that Fosta was turning when in the process of being shot, thus, the shooting was lawful and justified on this basis.

• Andrew Markland and Christopher Nunes 2011 – This involved a double shooting by the police of two men who were actively involved in an armed robbery in Winchester. The shooting of both men was captured on CCTV. This inquest raised issues regarding Article 2 right to life and real problems about the use of secret evidence in inquests. In this cases, the secret evidence was kept from the families of the deceased, and myself, so we didn't have the full picture in relation to the intelligence that the police had at the time they were conducting their undercover surveillance of the deceased.

• Azelle Rodney 2005 – Involved a man being shot 6 times by a police officer in North London. Azelle was with a group of men driving across North London to do a drug rip-off

from a group of Colombian drug dealers. The police had intelligence of this rip-off making the big question throughout the inquiry being whether the police could have intervened earlier. The report of the chairman Sir Christopher Holland was published in July 2013. He found that Azelle had been unlawfully killed and the use of force was excessive. That police officer, Anthony Long, is now facing a criminal trial for murder.

• Mark Duggan 2011- This case involved the shooting of a young man by the police which sparked widespread rioting across major cities in England. Again, a case that raises very similar issue to Azelle Rodney in terms of whether the police should have acted on intelligence earlier. It was found this shooting was justified despite our arguments to the contrary. The case has been widely reported nationally and internationally.

<u>The failure of the State towards vulnerable women and children</u>

• Mandy Pearson 2006 - Death of a woman with well documented mental health and self-harm issues at HMP Newhall in 2004. This was a critical verdict from the jury.

Mandy was found hanging in a dormitory cell in the Health Care Centre at HMP New Hall on 11 October 2004. Mandy had a long history of serious self -harm and mental health difficulties but despite persistent and regular threats of suicide and self- harm, she was never placed on the suicide or self -harm monitoring procedure in the weeks before her death. In their narrative verdict, the jury stated that prison "was not the best option for Mandy or for others in a similar position…there appears to be a dearth of effective alternatives which means they are imprisoned within the justice system."

The jury highlighted shortcomings in the prison's management of Mandy's risk of self- harm stating "Mandy was seen by a number of staff who made an assumption that she was under 2052 action [suicide watch]. This highlighted clear inadequacies in the communication systems between healthcare staff and staff of other agencies within New Hall".

They went on to state that "there was a lack of appropriate training and inadequate support of the staff responsible at the time as well as confusion over the interpretation of local instructions [prison's internal procedures]."

• Petra Blanksby 2005 - Death in HMP New Hall of a young woman following numerous acts of self-harm. Narrative verdict including comment that prison was not a suitable place for

Petra and that the sexual and emotional abuse she suffered while in the care of social services had contributed to her fragile mental state.

Quote from the Guardian:

"*The inquest heard how Petra's problems started when she was five and her parents divorced. She and her identical twin sister were beaten by their mother; sometimes they were locked in a cupboard with dogs at their home in Buxton, Derbyshire. When they turned nine, social services were called in. The twins were sent to live with different foster carers because they fought so much.*

The pair were reunited a few months later when they were placed in the care of a foster family. But the inquest heard evidence that Petra was sexually abused while in care, triggering episodes of self-harm that would become a pattern in her life. Petra was moved to a children's home where, at 14, she was raped. Her self-harming episodes increased dramatically. At the home Petra became pregnant by a teenage boy who refused to have anything to do with their son. She was moved by social services into a halfway house for young mothers.

The inquest heard that Petra struggled to bring up her son as she continued to self-harm. She asked social services whether they could find him a nursery place for two or three days a week to give her some respite, but her request was rejected.

In December 2002, Petra suffered a breakdown and tried to commit suicide. She was sectioned and her son was taken into temporary foster care. Several times while in the psychiatric unit she said she wanted her son adopted. On other occasions she asked to keep him. Three months after being admitted to Thameside, Petra was released. She was judged to have a 'borderline personality disorder' which, according to the hospital, was not treatable under the Mental Health Act. Instead it was decided she was to be treated as an outpatient. Eight months later she was dead.

Just after 4pm on 7 July, 2003, Petra phoned Derbyshire's community psychiatric team. She told them she had cut her wrists by smashing her hands through the window of her flat. When the team arrived, they found Petra had tried to gas herself. But no one reassessed her mental state. One team member told the inquest the team had known her condition was considered untreatable, so there was no point. 'It beggars belief that a cry for help that loud was ignored.'

Petra was left on her own in a seriously disturbed state. Three hours later she set fire to her mattress. Alarmed by her actions, she phoned the fire brigade.

This was another cry for help. But the local magistrate saw things differently. Petra was charged with arson to endanger life. Inquest, the group that campaigns on behalf of those who have died in custody, has questioned why the magistrate jailed Petra, but the decision could not be investigated by the coroner because it was considered outside of his remit, which is chiefly to establish the cause of death.

After being charged, Petra was transferred to New Hall prison in 2003 where, over the next 130 days while awaiting trial, she was involved in at least 90 incidents of self-harm, many requiring hospital admission. It is questionable as to whether New Hall is suitable for holding vulnerable women. "

So that is a snapshot of the work I do.

I want to finish with a poem by Edgar Albert Guest

Things are difficult when you do this work and this poem is a good reminder to keep going.

It Couldn't Be Done

BY EDGAR ALBERT GUEST

Somebody said that it couldn't be done
But he with a chuckle replied
That "maybe it couldn't," but he would be one
Who wouldn't say so till he'd tried.
So he buckled right in with the trace of a grin
On his face. If he worried he hid it.
He started to sing as he tackled the thing
That couldn't be done, and he did it!

Somebody scoffed: "Oh, you'll never do that;
At least no one ever has done it;"
But he took off his coat and he took off his hat
And the first thing we knew he'd begun it.
With a lift of his chin and a bit of a grin,
Without any doubting or quiddit,
He started to sing as he tackled the thing
That couldn't be done, and he did it.

There are thousands to tell you it cannot be done,
There are thousands to prophesy failure,
There are thousands to point out to you one by one,
The dangers that wait to assail you.
But just buckle in with a bit of a grin,
Just take off your coat and go to it;

Just start in to sing as you tackle the thing
That “cannot be done,” and you’ll do it.

Leslie Thomas QC

14 March 2015