

Deaths in custody: State violence denied

Deborah Coles looks at what deaths in custody reveal about the nature of the criminal justice system.

Between 1995 and 2005, 2,120 men, women and children died in prison and police custody. Of these, 558 people died following contact with the police (excluding deaths involving road traffic accidents), and 1,562 died in prison. An unidentifiable number died in psychiatric and immigration detention. (There is no central collation or publication of figures about deaths of detained psychiatric patients; the same holds for deaths in immigration detention until April 2006). INQUEST has always viewed the deaths to be part of a continuum from negligence and neglect to intimidation and violence.

INQUEST's work since the early 1980s with families bereaved after deaths in custody revealed serious shortcomings in the mechanisms of legal and democratic accountability and led the organisation to develop a critical analysis of custodial deaths. Not all deaths in custody arouse public concern, lead to complaints or indeed are controversial – however there have been a significant number of high profile deaths in police, prison and psychiatric custody that have raised public and Parliamentary disquiet. In considering the question of State violence we need not just to consider individual acts that have contributed to a minority of deaths in custody but think more about the violence of the custodial experience. In this context acts of violence against the self can be considered in a different light. They mirror the violence of the prison environment documented in a series of recent Prison Inspectorate reports with prisoners describing feeling 'unsafe', experiencing racist abuse and violence by staff, alongside high levels of use of force and segregation (HM Chief Inspector of Prisons, 2005 and 2006; HM Inspectorate of Prisons, 2006).

People die in custody in a broad range of circumstances including:

- in police and prison cells as a result of medical neglect;
- self-inflicted deaths in prison and police cells;
- following the use of force by police and prison officers – CS spray, US style batons, firearms, body belts, 'neck holds' and other restraint techniques resulting in the inhibition of the respiratory system, asphyxia;
- homicide in prison.

Many of the deaths raise issues of:

- negligence;
- systemic failures to care for the vulnerable;

- institutional violence, racism, sexism and inhumane treatment;
- the unlawful use and abuse of force by custodians;
- abuse of rights;
- lack of state and corporate accountability.

Deaths in penal custody

Recent casework into prison deaths has revealed the sheer brutal and often incompetent nature of the system: impoverished regimes and conditions, inadequate care of the physically ill and prisoners with mental health and drug problems, bullying, endless lock up, endemic self harm and attempted suicides, incompetent or negligent medical care, dirty and unhealthy environments, managerial chaos and complacency, poor communication between staff, use of segregation, strip cell isolation, high levels of restraint and racism. All features of a penal system that continues to expand.

Bereaved families tell us that what they want is for the investigation and inquest to result in changes that help prevent similar fatalities and ensure another family does not have to go through the same distressing experience. Where there is misconduct or failings families want an admission, an apology and for those responsible to be brought to account.

Most bereaved families have negative experiences of post-death procedures at a time of great vulnerability. They have sought answers and tried to establish the truth but have found that the investigation and inquest system is flawed and inadequate. The inquest is the only public forum where the death is subject to public scrutiny and yet there is an inequality of power between state agencies and bereaved people in access to funding, disclosure, and resources. Following each death there is an individual investigation and inquest but these are subject to appalling delay, are limited in remit and each death is looked at in isolation. Investigations too often focus on the individual pathology and personal inadequacy of the deceased, often attempting to blame and demonise the deceased and their family for the death to deflect attention away from the responsibility of institutions and agents of the state. Inquests where families are legally represented can highlight practice and systemic problems and shed a spotlight on prison life and penal policy and provide a stark exposé and insight into the damaging nature of the penal system.

It is clear from INQUEST's monitoring and analysis that understanding why deaths in custody occur requires an examination of their broader social and political contexts. For example no discussion of deaths in prison could ignore the regimes and conditions operating in prisons, the overuse of custody and flawed sentencing policy and the institutional culture of violence and racism that exists.

While individual cases often provide the most stark and shocking evidence of systemic and individual failings, a single case is by definition unable to reveal trends or patterns among custody deaths. In terms of policy work, INQUEST's monitoring has enabled it to take a thematic view of a number of cases which highlight recurring issues. Examples of this include our in-depth work on deaths of children and young people in custody, on the high levels of deaths of women in prison (Coles and Sandler, forthcoming) and the disproportionate number of deaths following the use and abuse of force involving people from black and minority ethnic communities.

Casework on some of the deaths of 29 children in penal custody since 1990 has exposed the institutional and psychological violence inflicted by the State on children and young people (Goldson and Coles, 2005). In our evidence to the Parliamentary Joint Committee On Human Rights Inquiry we stated that "for many young people prison is inappropriate and ...their experience of imprisonment has *directly* contributed to their death" (Parliamentary Joint Committee on Human Rights, 2004c).

worrying aspects of the treatment of detainees within the criminal justice system. In uncovering these issues we come face to face with the secrecy and authoritarianism inherent in the system. INQUEST's monitoring has shown how the State uses the inquest rather than criminal prosecution and trial for the public examination of deaths in custody. It is extremely rare for there to be a prosecution after a death in custody even where there has been an inquest verdict of unlawful killing (INQUEST/Liberty/Bhatt Murphy, 2002). Despite a pattern of cases where inquest juries have found evidence of recklessness, negligent acts or omissions or unlawful killing, no police or prison officer or nurse has been held responsible either at an individual level or at a senior management level for the institutional and systemic failures to improve training and other policies. Recommendations made by inspection bodies regarding potential risks to the health and safety of people in custody are often not implemented.

Prisons should be democratically accountable and yet all institutions of detention are exempt from corporate manslaughter legislation. The number of custodial deaths is disturbingly high – particularly the number of self-inflicted deaths. Many of the cases reveal a horrendous catalogue of failings in the treatment and care of vulnerable people in custody or otherwise dependent on others for their care. They raise questions about excessive and inappropriate use of custody for some of the most vulnerable people in society, and highlight the State's failure in its duty to protect life – repeatedly inquests show the failure to implement existing

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This is highlighted by the deaths of children like Joseph Scholes, a 16 year old boy with known mental health problems incarcerated in brutal conditions that propelled him to acts of self harm and the ultimate act of despair when he hung himself from the bars of his cell; Gareth Myatt, a 15 year old boy who died after being restrained by three members of staff in a secure training centre; Adam Rickwood, at 14 the youngest child to die in custody, found hanging hours after being restrained by staff in a secure training centre. Sentencing policy and allocation remains outside the remit of most inquests and yet an examination of these are crucial in understanding the dramatic increase in incarceration rates in England and Wales. Officially sanctioned painful restraint methods, strip searching, strip cell isolation and segregation results in unacceptable levels of serious self harm, suicide and violent death of children, and yet there *has never been a public inquiry held into any of the child deaths.*

Deaths in custody and their investigation expose to scrutiny some of the most brutal and

guidelines on the care of 'at risk' detainees.

The Government has failed to address the wider policy questions that arise from the shocking death toll in our prisons and the need for a dramatic reduction in the prison population. Suicide prevention is incompatible with the current reality of many of our prisons with the overcrowded, poor conditions of impoverished regimes and a large number of men, women and children with mental health, drug and alcohol problems who should not be there.

Despite critical investigation and inspection reports and narrative verdicts returned at inquests highlighting systemic failings, there is no accountability or responsibility either individually or institutionally.

INQUEST's frustration with the failure of the State to learn lessons and the lack of public accountability for the relevant institutions resulted in our recommendation on the setting up of a

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capacity to think. Within such institutions there is a constant pressure on staff to respond to the primitive communications of those who are resident in unhealthy, distorted ways, just as we respond to the problem of violence collectively as a society. Institutional dynamics may come to mirror the societal impetus to deal in talion law. It is well established that there are high rates of mental disorder amongst inmates within our prisons (Singleton *et al* 1998). The consequence of grouping people with personality disturbances together is that the institution inevitably becomes infected by those who inhabit it, and a constellation of disturbed dynamics is set in motion.

Our gut response is to respond to violence in a thoughtless way, at best as a problem which needs to be eliminated and locked away. Clearly there are some people who have to be physically restrained. But by shifting our view and maintaining our capacity for thinking, violence provides useful data; seen from a different point of view, what at first appears to be a problem can be a source of information, a communication about the experience of shame, humiliation, vulnerability and fear, which the perpetrator cannot bear to experience and thus forcibly locates in someone else. Our wish as a society to forcibly relocate these experiences with the perpetrator once again can perpetuate rather than address the problem of violence in society. ■

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Standing Commission on Custodial Deaths to bring together the experiences from the separate investigation bodies as the most effective way to ensure that the lessons of past custodial deaths are learned in order to prevent or minimise future violations of Article 2 of the European Convention on Human Rights (Parliamentary Joint Committee on Human Rights, 2004c). An over-arching 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. The Standing Commission could play a key role in the promotion of a culture of human rights in regard to the protection of people in custody. It could provide a mechanism for an examination of broader thematic issues as well as issues of democratic accountability, democratic control and redress over systemic management failings that fall outside the scope of the inquest.

The continuing high toll of preventable deaths of vulnerable people in custody make it absolutely vital that this closed world is open to independent inspection and investigation and held to account when human rights abuses occur. ■

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