circumstances' will not do. Devolved responsibility does not mean the right to behave irresponsibly or illogically or without regard to fairness.

I began by quoting a BoV and I am sorry that a Board of Visitors should apparently mock the Prison Service for making its regulations and procedures available to prisoners. The law matters, especially Human Rights law. And procedural fairness and legitimacy matter a great deal too.

My limited international experience suggests that the Prison Service in England and Wales is far ahead of most prison administrations in terms of the quantity and quality of information it publishes and disseminates. I celebrate that fact, and the absence of cynicism in most governors' commitment to the Prison Service's values. No-one who has seen Martin Narey's brave and moving video on Decency could doubt the strength of his personal commitment to the highest international standards of conduct.

In any case, what is so wrong if information is freely available but rarely referred to? I have a dictionary, thesaurus and guide to English usage on my bookshelves. But wordsmith that I am, there's nuffink I need to look up. Just like some prison staff and Boards of Visitors in their attitude to Prison Rules eh?

The Prisons and Probation Ombudsman for England and Wales can be contacted through its website: www.ppo.gov.uk

Investigations into Deaths in Prison Custody

Steven Bramley, *Legal Adviser to HM Prison Service.*

Last year, 72 prisoners died an unnatural death in prison custody. The vast majority of these took their own lives. Comparing this statistic with figures for recent years, this was a relatively encouraging result. No prisoners were killed by other prisoners. Each of these unnatural deaths is likely to have taken place while the prisoner was alone, unattended by prison officers, doctors or nurses, and far from his (occasionally her) family. What needs to be done is to discover how and why the death occurred.

This article explores these questions by running through the varied forms of inquiry that may or must take place. It then discusses the most recent, and still unfolding, legal developments before summarising the substantial changes that have taken place in law and practice over the past five years or so.

Prison Service investigation

All unnatural deaths in prison custody are investigated by a senior investigating officer from another prison establishment. This officer will be commissioned by the area manager responsible for the prison where the death occurred to produce a thorough, comprehensive and prompt report into how the prisoner died. Prison officers interviewed during the course of the investigation are required to offer all reasonable co-operation. The family of the deceased is given the opportunity to be kept informed with the progress of the inquiry. Once it has been concluded, it will be disclosed to the family. This however is subject to the views of the coroner.

Inquest

A coroner will always be involved. Section 8 of the Coroners Act 1988 requires that there must always be an inquest when there is a death in a prison. And in such a case the inquest must always be held with a jury. The coroner might sometimes object to disclosure to the family of the internal Prison Service investigation into the death. He might feel that the conduct of the inquest would somehow be compromised if the family were to see the investigation report before the inquest has taken place. But this is rare, and is becoming more unusual.

The jury's verdict is certified in writing by the coroner and those jurors who agree with the verdict (some might dissent from it). This certificate is known as an inquisition. It sets out, so far as has been proved in the inquest, who the dead person was and how, when and where he came by his death. It does not identify any person as bearing responsibility for the death. There is currently a review of the coronial system, conducted for the Home Office and expected to conclude around early next year.

Criminal proceedings

Aside from the Prison Service investigation and the inquest, there will sometimes be criminal proceedings arising from a death in custody. This is

very rare because killings of prisoners are very rare. But in March 2000, Zahid Mubarek was killed by his cellmate Robert Stewart in Feltham Young Offender Institution. Stewart was tried and convicted of murder on 1 November that year. The inquest into the death was formally opened and then adjourned on the same day until the conclusion of the criminal proceedings, so as not to hear evidence before it had been given at Stewart's trial. After the conviction, the coroner had the discretion to reopen the adjourned inquest. She considered this would serve no useful purpose and did not exercise this discretion.

Unusually in that case, there was also a police investigation into the Prison Service's responsibility for the death in custody. If it can be shown that individual staff, with a responsibility to care for the prisoner, were grossly negligent so as to cause the death, then they may be guilty of manslaughter. There is gross negligence where, having regard to the risk of death involved, the conduct of the member of staff was so bad in all the circumstances as to satisfy a jury that it was criminal. This carries with it a maximum of life imprisonment. Alternatively there may be evidence of a serious offence under section 3 of the Health and Safety at Work Act 1974. The police concluded that there was insufficient evidence of either offence at Feltham.

Non-statutory inquiry

There are other ways to investigate deaths in prison custody. In November 1994, Christopher Edwards was stamped and kicked to death by Richard Linford in the cell they shared at Chelmsford Prison. Linford pleaded guilty to manslaughter and an inquest was adjourned and then closed in the light of the conviction. The Prison Service, Essex County Council and the Local Health Authority set up an inquiry. This sat in private and heard evidence for 56 days. Those who established the inquiry did so voluntarily, rather than under any specific power in or under an Act of Parliament. Those who gave evidence to the inquiry did so because they were asked to. They could not be required to give evidence. Two prison officers decided not to give evidence, and one of these may have been able to make a significant contribution to the inquiry.

Statutory inquiries

Under section 5A of the Prison Act 1952, the Chief Inspector of Prisons can be directed by the Home Secretary to inquire into and report on specific matters connected with prisons or prisoners. There seems no reason why this power could not be exercised in relation to deaths in prison custody. But the power has not been used in this way. As with a non-statutory inquiry, the Chief Inspector could not compel a prison officer to co-operate. This is not the position in other areas, such as inquiries under section 49 of the Police Act 1996.

In relation to the murder of Zahid Mubarek, there is another type of statutory inquiry. At the time of writing, this has still not been published. In late 2000, the Commission for Racial Equality was required to investigate racism in the Prison Service. Its terms of reference include general considerations but also grounds for belief that it is necessary to inquire into some specific issues in particular prisons. One of these is the murder at Feltham. In certain closely defined circumstances, there is a power under the Race Relations Act 1976 to require a person to disclose information to such an investigation. That power has not been used in relation to this inquiry.

Civil proceedings

Not all deaths in prison custody are self-inflicted and killings are thankfully extremely rare. But prisoners die of other causes. In 1996, Paul Wright died in Leeds Prison after a severe asthma attack. There was no question of criminal liability. An inquest was held which indicated that there was no unnatural element to the death.

All the investigations looked at so far have been established by 'the authorities'. Whether it is the Prison Service, the coroner, the police or local authorities, some body with public responsibility has initiated the inquiry into how a prisoner came by his death while being detained by the Prison Service on behalf of the State. In Paul Wright's case, which occurred before the introduction of regular internal investigations into deaths in custody, none of the authorities indicated anything irregular in the circumstances of his death.

The case of Paul Wright

When Paul Wright died, his mother was chronically ill. She depended upon him to look after her when he was at liberty. Because of this dependency, she was able to bring civil proceedings against the Prison Service. She said that Leeds Prison had been negligent in their care of her son. Consequently, he had died and she had suffered financial loss. This was because of the expense in obtaining care facilities which her son, had he remained alive, could have discharged for nothing. She initiated these proceedings together with Paul Wright's aunt.

The Prison Service investigated the circumstances of the death thoroughly. It concluded that the better course was to compensate Paul Wright's mother and his aunt. A substantial payment was made which had the effect of concluding the civil proceedings and no hearing took place. As a result, there was no public airing of the issues raised by the claim. So the claim was revived as a challenge to the Prison Service's failure to disclose an account of its internal investigation and to convene a public inquiry into the death.

This revived claim was decided in summer 2001. By the time it came to court, the Prison Service had disclosed the investigation report to Paul Wright's mother and aunt. At the hearing it was accepted that this disclosure was sufficient for the claimants' purposes. But they still sought a public inquiry which could effectively, independently and (some years after the death) promptly investigate how Paul Wright had died. The court decided such an inquiry should take place. This was the first time an English court had had to consider whether there was a human right to have an unnatural death in custody publicly investigated in an inquiry. The significance of this will be explored later.

As with Christopher Edwards, there was no relevant statutory power to establish an inquiry into the death of Paul Wright. In both cases, the inquest had been, or turned out to be, inconclusive. But the court nevertheless required the Home Secretary to set up a public investigation into the death of Paul Wright, and issues surrounding the quality of his health care at Leeds Prison.

This has been done. Dr Jon Davies was appointed to conduct the inquiry and a two-day hearing took place in Leeds towards the end of last year. No witnesses were, or could have been, compelled to attend by Dr Davies. However, all Prison Service witnesses who were asked to attend, did so.

European Court of Human Rights and the case of Mark Keenan

Mark Keenan killed himself in the segregation unit of Exeter Prison in May 1993. He was 28 and had been on anti-psychotic medication for the past seven years. When close to the point of release, he was found in an adjudication to have assaulted a prison officer. Cellular confinement was ordered and 28 days were added to his sentence, delaying his imminent release. The next day he hanged himself.

His mother could not bring civil proceedings against the Prison Service in relation to its treatment of Mark Keenan. Since he was aged over 18 and she was not financially dependent upon him, the Fatal Accidents Act 1976 effectively prevented her bringing proceedings in England and having her concerns about the death independently examined. So Susan Keenan brought proceedings against the UK in Strasbourg under the European Convention on Human Rights. There were essentially three claims. The first was the most serious of all claims that can be made under the Convention, article 2.

Article 2.1 provides that:

> *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 penalty is provided by law.* [The death penalty for treason and mutiny in the UK has relatively recently been abolished. Capital punishment for murder was repealed in 1965.]

This right goes further than the duty not to take life unlawfully, as was alleged in the case of *McCann v UK* — this was the case involving three IRA members shot dead by the British Army in Gibraltar in 1988, the so-called 'Death on the Rock' case. The article 2 right extends to the duty to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another, as in cases involving allegations of RUC collision with Loyalist paramilitaries and police taking insufficiently seriously threats to kill made by a deranged individual.

The European Court of Human Rights considered the application of article 2 in the Keenan case. They concluded not that it could not apply to suicide cases, but that on the facts it had not been breached because Mark Keenan had not been at immediate risk of suicide throughout his detention. The implication was that, if he had been, then there might have been a breach of article 2 because of Exeter prison's decision that he was fit to undergo disciplinary proceedings and to be given cellular confinement.

The next claim brought by Susan Keenan was a breach of article 3, another extremely serious issue. Article 3 provides, simply:

> *No one shall be subjected to torture or to inhuman or degrading treatment or punishment.*

The court found that this article had been breached in the standard of care with which Mark Keenan had been treated in the days before his death. It considered that there had been a lack of effective monitoring of his condition and a lack of informed psychiatric input into his assessment and treatment. In the light of this, the imposition on Mark Keenan, nine days before his expected date of release, of seven days in segregation unit and 28 days added to the time he had to serve in custody constituted inhuman and degrading treatment.

The final issue in this case arose under article 13. This article is the most important right in the European Convention which is not incorporated into English law by the Human Rights Act 1998. This means that no complaint of a breach of article 13 can be entertained in our domestic courts. It provides:

> *Everyone whose rights and freedoms as set forth in this Convention [such as articles 2 and 3] are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.*

The court found a breach of article 13. It considered that the article requires, not only the payment of compensation where appropriate, but also a thorough and effective investigation. Without this, the court held that the right to an effective remedy could not be satisfied, whether in relation to an alleged breach of the right to life or the right not to be subjected to inhuman or degrading treatment.

Any case in Strasbourg brought against the UK is heard by a chamber of judges which must include a British judge. In Keenan's case, Lord Justice Sedley held that what was required to provide an effective remedy was a 'proper and effective inquiry into responsibility for the death'. The inquest that had taken place and the fact that no effective civil proceedings could be brought meant that article 13 had been violated. This decision was delivered in April 2001. Susan Keenan was awarded a sum of compensation to reflect the court's findings that her rights under articles 3 and 13 had been breached.

Judicial review

Judicial review is the means by which many sorts of administrative action or inaction can be legally challenged on the grounds that they are unlawful, procedurally unfair or wholly unreasonable. So it has long been possible to challenge the conduct of an inquest and thus the inquisition on the basis that the coroner has erred in some way in the evidence he has admitted or the view he has taken of the relevant law.

On 2 October 2000, the Human Rights Act 1998 came fully into force. This makes it unlawful for any public authority, including a court or a coroner, to act in a way that is not compatible with 'the Convention Rights'. These are the majority of the human rights set out in the European Convention on Human Rights which the UK has accepted the European Court of Human Rights can apply in cases brought against this country since 1966. We have seen that the Convention rights do not, however, include the right to an effective remedy under article 13. They do include the right to life (article 2) and article 3 which concerns the right not to be tortured or treated in a degrading or inhuman way.

The case of Colin Middleton

Colin Middleton hanged himself in January 1999 while in custody in Bristol Prison. He was aged 30. An inquest held that May was later quashed as being an inadequate investigation. A second inquest was held in October 2000. It examined the death very thoroughly and, unusually for inquests at that time, the family, as well as the Prison Service, was represented by a barrister. It was clear that this was a suicide. A note had been left by Colin Middleton in his cell. The family was however concerned that there were sufficient warning signs for a 'self-harm at risk form' to be raised before he died. One had been opened, but later closed, and despite some evidence that the prisoner was still at risk, a fresh form had not been opened.

The coroner ruled that the issue of whether the death had been contributed to by 'neglect' could not be considered by the inquest jury. But he told them that if they wished they could give him a note regarding any specific areas of evidence about which they were concerned. The coroner undertook to consider this when deciding whether to make any recommendations. Where the coroner believes that action should be taken to prevent the recurrence of similar deaths, he may recommend such action to the authority which has power to take it. The coroner further told the jury that any such note would not be published.

The jury did produce a note, but the coroner did not publish it — though he showed it to the lawyers acting for the family and for the Prison Service. He refused to publish the note when asked by the family and they consequently brought judicial review proceedings.

The requirement to investigate effectively

The family's case was that article 2 required not simply that the State must put in place adequate safeguards to protect the life of those in its custody. It also required an effective investigation into the circumstances of the death. This is a critical point. If article 2 does require such an investigation, and it applies to a coroner, then because the article is now part of English law the standards laid down in cases in Strasbourg can affect the way English courts require coroners to conduct inquests into deaths in custody. The fact that cases decided by English courts before the introduction of the Human Rights Act strictly limit the role of the inquest and the range of possible verdicts will not hamper a coroner if the Convention rights require him to conduct a fuller investigation into the circumstances of a death.

The European Court decided in the McCann case that there was a duty to investigate deaths which resulted from the use of force by the State, under article 2. There had been an inquest in Gibraltar following the killings of the three IRA members. The families had been afforded full legal representation and the court decided that article 2 had been satisfied. As the case law on the extent of article 2 developed to include the use of force by non-State bodies, with or without State collusion, the corresponding duty to investigate such deaths extended alongside. The English court which heard the Colin Middleton case decided that article 2 did extend to suicide in prison custody (as the Keenan case had shown), and (which Keenan had not decided) that there was a corresponding duty under that article to investigate such deaths.

The court held that in order for the inquest to be sufficiently effective so as to satisfy article 2 it was

necessary for the jury's findings to be made public. The court rectified what it saw as this omission by making two parts of the note public. These expressed their concern at the closing of Colin Middleton's self-harm at risk form and their belief that sufficient information existed to warrant a fresh form being opened.

In this way the judicial review proceedings themselves contributed to the completion of the investigation into Colin Middleton's death.

Legal developments in 2002

We have seen, particularly in the last two or three years, a very substantial range of ways that unnatural deaths in custody can be investigated in whole or in part. These include:

- Internal Prison Service investigations
- Inquests
- Prosecutions
- Inquiries, whether statutory or not
- Civil proceedings
- Applications to the European Court of Human Rights
- Judicial reviews

How best to make sense of this variety? Are some investigations only suitable for some sorts of death? Is there a choice between different types of inquiry? These and other issues came to a head before the Court of Appeal in February this year. The court was considering two appeals brought by the Home Secretary.

The first concerned the death of Zahid Mubarek and a judicial review case brought by his uncle Imtiaz Amin. He had successfully challenged the current Home Secretary's refusal (following his predecessor's refusal) to hold a public inquiry into that death. The court at first instance did not consider that the internal Prison Service investigation, the trial of Robert Stewart, the police investigation into the Prison Service and the CRE inquiry to have discharged the State's duty to investigate under article 2, whether individually or cumulatively.

The second appeal concerned Colin Middleton. The Home Secretary originally argued that article 2 did not require a investigation into the circumstances of a death in prison custody that did not involve any use of force by any officers, or indeed any suggestion of involvement or collusion in the death. This argument was discarded after the decision of the European Court of Human Rights in the Christopher Edwards case. It was held that there had been a duty to investigate that killing and that the inquiry had been inadequate because of the inability to compel to give evidence a witness who might have a significant contribution to the investigation, and because of the limited involvement of Christopher Edwards' family.

It was further argued by the Home Secretary in the appeals that it was not necessary for there to be a satisfactory investigation into an unnatural death in custody for the issue of neglect or other fault to be determined or otherwise made public by the coroner, the jury or the inquisition. What was necessary under article 2 was a thorough examination and marshalling of the facts. It might be that these would enable a criminal prosecution to take place, but that would be a separate matter. It might also enable the family, in the case of a death after October 2000, to bring civil proceedings relying on the Human Rights Act and arguing that there had been a breach of article 2 or 3. This again would be a separate matter, to do with remedies.

The Court of Appeal decided, in relation to Imtiaz Amin's case, that the nature of an investigation into an unnatural death in custody would depend on the facts of each case. The law did not lay down a rigid set of rules to be followed slavishly. It might be appropriate to hold an inquiry in public in some cases. In others it could be sufficient for the family of the deceased prisoner to participate in private.

In relation to the death of Zahid Mubarek, the investigations that had taken place and still underway, taken together, were sufficient to discharge the legal requirements. This was not least because of the Director General's straightforward acceptance of responsibility. He had written to the parents straight after the death:

> *You had a right to expect us to look after Zahid safely and we have failed. I am very, very sorry. What I am determined to do now is to ensure we are completely open with you. If mistakes have been made we shall not conceal them from you.*

The Service had not pretended it was not to blame and the formalistic requirement that investigations should be independent did not prevent the subsequent internal investigation by senior investigating officer Ted Butt (praised by the court) from contributing to the overall inquiry into the death. It is not clear at the time of writing whether Imtiaz Amin will bring any appeal against this decision.

In relation to Colin Middleton, the Court of Appeal did not rule any of the English law on coroners to be incompatible with the European Convention. Nor did they strike down any part of the Coroners Rules, as they had the power to do. But they did reinterpret that law. They held that, where the coroner knows that he is the means by which the duty to investigate under article 2 is being carried out, and he considers that there was a systemic failure on the part of the Service as opposed to human error by an individual, then he must allow the jury to reach such a finding. This is in order to prevent the recurrence of similar deaths.

There is currently a petition before the House of

Lords to appeal this part of the judgement, lodged by the Home Secretary. In the meantime at least, it should be noted that the judgment represents the law of the land.

Some reflections

Law and practice surrounding the investigation of unnatural deaths in custody have developed considerably since, say, the death of Paul Wright in Leeds Prison.

- Internal investigations by Senior Investigating Officers from outside the prison are now carried out routinely. They have expert help when they need it.
- Family participation into these inquiries is regarded as important and the investigation report is usually disclosed to them before the inquest.
- The family is, since the end of last year, more likely to be afforded legal representation at the inquest.
- If the Service has been at fault in the systems it uses to minimise self-harm, the jury can say so.
- If the inquisition finds unlawful killing, then there is an expectation that the CPS will consider criminal proceedings (this follows the death of Alton Manning at Blakenhurst prison).
- In cases where the deceased prisoner is an adult and his family is not financially dependent on him, they may nevertheless be able to bring proceedings against the Prison Service under the Human Rights Act, though this has yet to be tested.

It appears likely that, in most cases, the contribution of the availability the internal investigation, the inquest and possible criminal proceedings will be sufficient to discharge the requirement to establish and conduct an effective investigation promptly.

S-21 The Heart of the Cambodian Nightmare

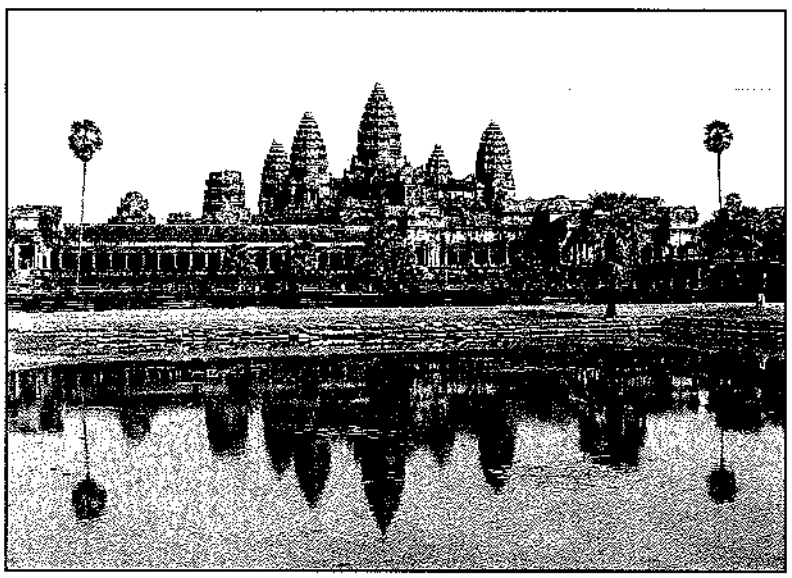
Jamie Bennett, *Head of HMP Whitemoor's Dangerous, Severe Personality Disorder (DSPD) Unit.*

In the UK, the second half of the 1970s saw Callaghan as Prime Minister, Margaret Thatcher as Leader of the Opposition, the Rhodesian declaration of independence, the discovery of North Sea oil, the punk phenomenon and the Queen's Silver Jubilee. In the rest of the world, figures such as Idi Amin, Jimmy Carter and Anwar Sadat made headlines, whilst critical events included the death of Mao, the Iranian Revolution and the murder of Steve Biko.

This period also brought Cambodia, or as it was then known, Kampuchea, into the public consciousness as it descended into a nightmare from which it is only now beginning to awake. The rule of Pol Pot and the Khmer Rouge, 1975 to 1979, resulted in the deaths of 1.7 million people, one in five of the population, and left a generation scarred. This horrific legacy stands alongside the Holocaust, the Russian purges and the apartheid regime in its barbarity. The acts of this regime have been termed 'autogenocide' reflecting the sense of a country indiscriminately destroying itself.

Cambodia was previously famous for the glorious Angkorian empire, the most powerful in South-east Asia between the ninth and sixteenth centuries. The spectacular remains of this empire are a major attraction to both archaeologists and tourists. These remains cover an area of 60km^2 and include Angkor Wat, the largest religious site in the world. Prior to and since the Khmer Rouge this has been the symbol of the glorious Cambodian culture.

The huge scale of destruction between 1975 and 1979 has been directly attributed to the policies of the



Below: Angkor Wat, the largest religious site in the world and the symbol of the ancient and modern Cambodia.