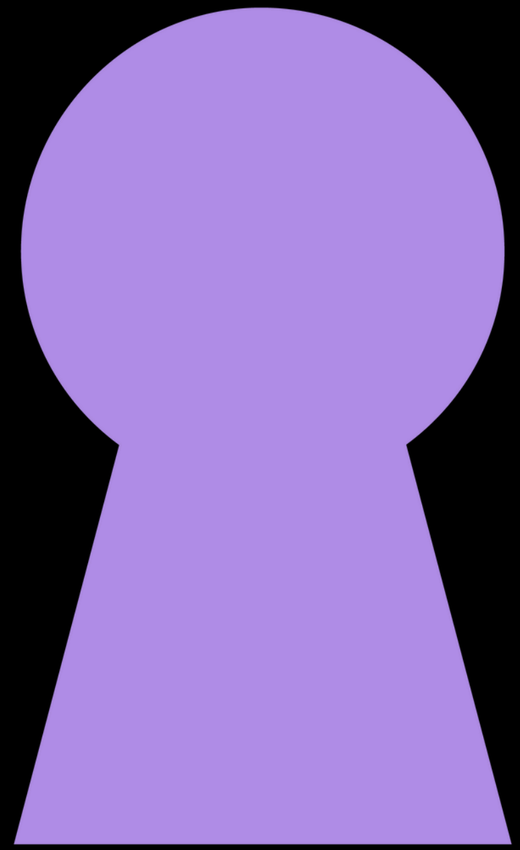
INQUEST

Truth Justice Accountability

‘Working with communities through judicial review and public law’

Jodie Anderson, Senior Caseworker



Our key areas

- Police custody
- Prison and immigration detention
- Mental health settings
- Hillsborough disaster
- Grenfell Tower fire

INQUEST

- Free specialist casework service
- Evidence-based policy & research work
- Family Reference & INQUEST Lawyers Groups
- Publish briefings & press releases
- Statistical monitoring

Family engagement

INQUEST's Judicial Review Timeline

MIDDLETON INQUESTS
2004

RABONE
2012

'N' (HARRIS REVIEW)
2014

MAUGHAN
2019

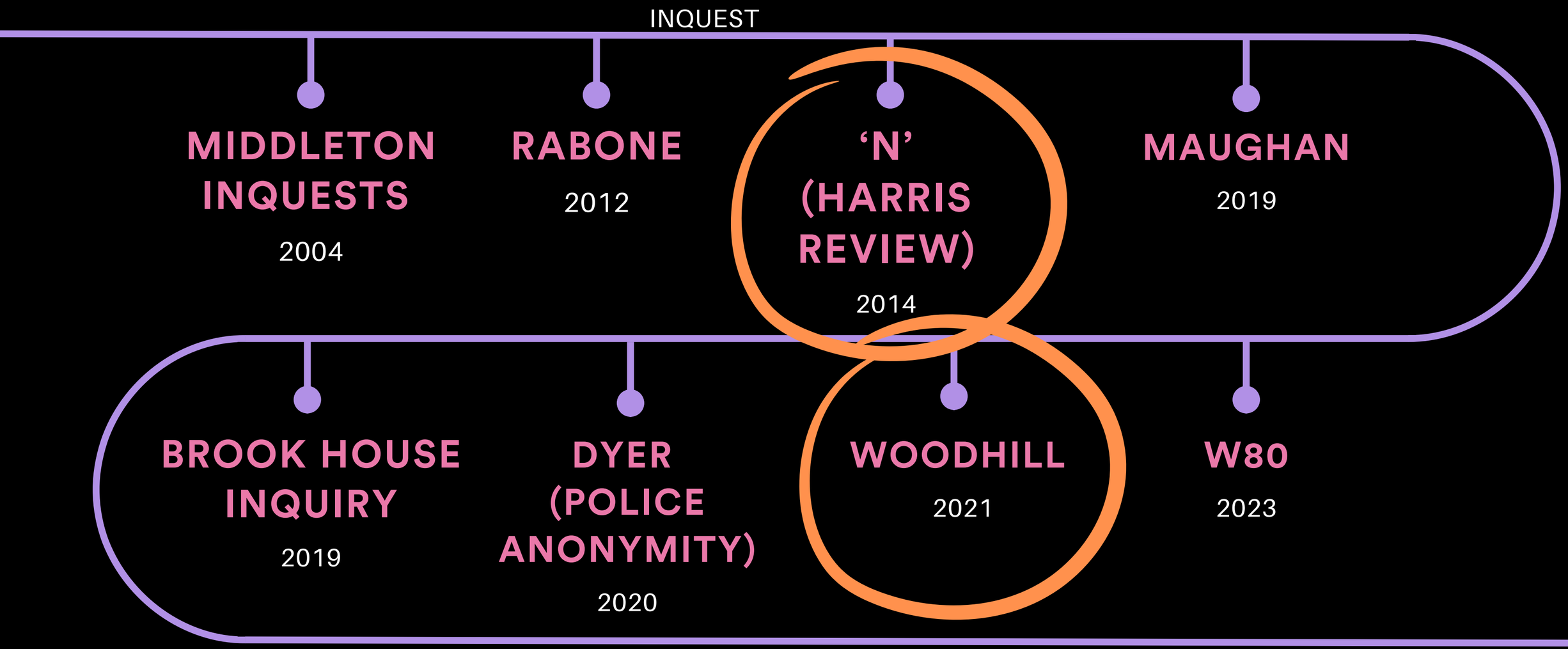
BROOK HOUSE INQUIRY
2019

DYER (POLICE ANONYMITY)
2020

WOODHILL
2021

W80
2023

INQUEST's Judicial Review Timeline



‘N’ and the Harris Review

- Inquest into the self inflicted death of a vulnerable 19 year old ‘N’ at Aylesbury YOI in 2011.
- Neglect conclusion at the inquest.
- Family demanded a public inquiry into the deaths of children and young people in custody.

‘N’ - Fatally Flawed Report

‘Fatally Flawed’, PRT and INQUEST, 2012

13. An Independent Review should be established, with the proper involvement of families, to examine the wider systemic and policy issues underlying the deaths of children and young people in prison. As a starting point the Ministerial Council on Deaths in Custody should commission a new working group of the Independent Advisory Panel to draw together the specific learning from recent deaths of children and young people and identify issues for an Independent Review to consider.

The Harris Review, 2015

‘N’ and the Harris Review

- The Secretary of State for Justice commissioned an independent review into the deaths of 18-24 year olds in prison, led by Lord Toby Harris.

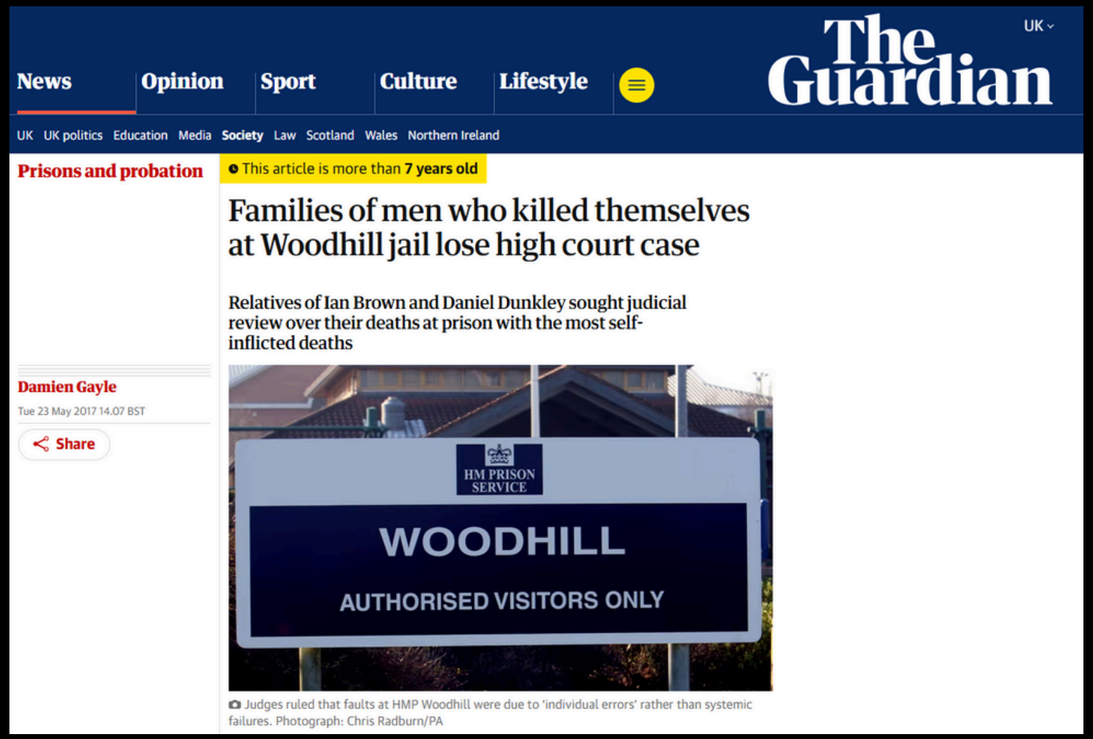
- Recommendations included:
  - Reform the Purpose of Prison
  - Enhance Leadership and Accountability
  - Addressing Vulnerability and Mental Health
  - Improve Prison Conditions and Staffing
  - Divert Vulnerable Individuals from
  - Strengthen Oversight and Transparency

Woodhill prison

- Woodhill Prison had the highest number of self-inflicted deaths in prison in 2016. One every 45 days.
- Same legal team working on all cases which enabled us to identify repeat failures.
- 2017: JR proceedings instigated by the families of two men who had taken their lives at the prison.

Woodhill prison

- The JR was destined to fail but provided a springboard for the family campaign.



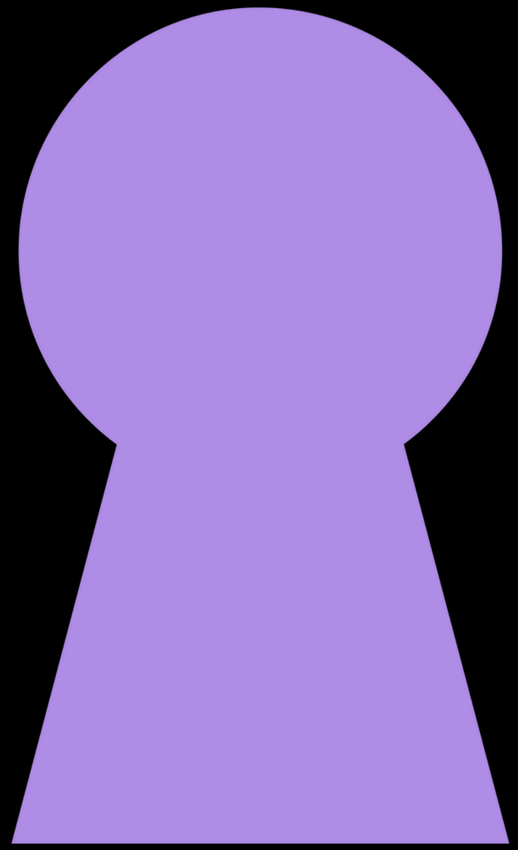
Woodhill prison

- MOJ commissioned PPO Steven Shaw to investigate the 20 deaths.
- He found that difficulties in recruiting and keeping staff had led to a “completely unacceptable situation”.
- 1 in 10 of the prison’s 800 inmates were on a form of suicide watch, a ratio far higher than most prisons.
- This led to re-categorisation from a local prison to a category B training establishment.
- Zero deaths over the next 12 months!

Observations

- Importance of public law claims in upholding procedural rights of bereaved people: coronial bias, delays, insufficient inquiry
- Importance of situating deaths in their broader social and political context.
- ‘W80' and the Sheku Bayoh Inquiry allowed INQUEST to admit evidence of race and disproportionality which would otherwise be absent from the process.

Concluding thoughts...



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