Miscarriages of JusticeUK (MOJUK)
22 Berners St, Birmingham B19 2DR
Email: mojuk@mojuk.org.uk Web: www.mojuk.org.uk

MOJUK: Newsletter 'Inside Out' No 963 (09/08/2023) - Cost £1

Do Evidence Access Rules Hinder the Rectification of Miscarriages Of Justice

Law Commission: Views Sought on Criminal Appeals Process: A person who has been convicted of a criminal offence can seek to challenge either their conviction or sentence by way of an appeal. Appeals serve an important corrective function for individuals, whether this is to correct a miscarriage of justice, such as the conviction of someone who is factually innocent, or to correct a legal error such as imposing a harsher sentence than is legally permissible. They also serve important public functions, in ensuring that the criminal law is interpreted and applied consistently and predictably, and in the development of the common law.

In recent years several leading bodies and organisations – including the Justice Select Committee and Westminster Commission on Miscarriages of Justice – have argued that the law in relation to criminal appeals is in need of reform. Concerns have been expressed around requirements for new evidence and the tests used by the Court of Appeal and the Criminal Cases Review Commission (CCRC) – the body responsible for investigating potential miscarriages of justice. Some groups have claimed that the current system can make it difficult for wrongly convicted people to appeal where exculpatory evidence was available but not used at trial, and/or to obtain and analyse evidence which might suggest a person's innocence.

Our Review: In July 2022, the Government asked the Law Commission to review the law relating to criminal appeals in criminal cases, with a view to ensuring that courts have powers that enable the effective, efficient and appropriate resolution of appeals. We have published an issues paper which explains the law concerning appeals in criminal cases, and are now seeking views from those with experience of the appeals system, including lawyers; academics; groups with an interest in miscarriages of justice; and those who have personally sought to appeal their conviction or sentence – whether successfully or unsuccessfully – and their families (although we are unable to become involved in individual cases).

In the issues paper, we consider: the routes of appeal for challenging findings in magistrates' courts; the tests applied by the Court of Appeal when considering appeals against conviction or sentence; the test used by the Criminal Cases Review Commission when deciding whether to refer a conviction or sentence for an appeal; the "substantial injustice" test applied to appeals brought on the basis of a change in the law; and laws regarding the retention and disclosure of evidence and records of proceedings. We are seeking identify any areas of the law where reform is required to enable the correction of miscarriages of justice and to ensure that appeals can be dealt with efficiently, effectively, appropriately and fairly. We are also undertaking pre-consultation engagement with stakeholders to identify a number of technical reforms to improve the way in which appeals are dealt with. We plan to publish a consultation paper in 2024, which will lay out the areas where we have identified a need for reform, and will include provisional proposals for change.

The Law Commission was set up by section 1 of the Law Commissions Act 1965 for the purpose of promoting the reform of the law. The Law Commissioners are: The Rt Hon Lord Justice Green, Chair, Professor Sarah Green, Professor Nicholas Hopkins, Professor Penney Lewis, and Nicholas Paines KC. The Chief Executives are Joanna Otterburn and Stephanie Hack.

Anthony Entwistle - Court of Public Opinion and Scrutiny, Criminal Division

Here is my update; I had the Oral Parole Hearing, headed by Judge Beddoe. They kept it internal, i.e. not in public, as I had requested. As it was to be headed by a Judge, I foolishly considered that transparency and fairness would be the order of the day — how wrong was I. The Judge started the proceedings by saying how everyone would get their slot and that I would get my say at the end. All the conditions that were agreed upon were totally ignored, and everyone stuck to the false information!! Moreover, after four hours of bullshit, the judge jumped in and claimed that time was up! I didn't get to have my say! Inevitably, the result of this farrago was a negative decision.

I followed the instructions to challenge this decision that came with the decision itself. But, rather than send the appropriate forms etc, the instructions referred me. to their Website links which I cannot access from prison! ! It took more than two weeks to get a copy of the relevant forms, formulate my challenge and send it in by Recorded Delivery. As this was on the day before the cut—off date, I also put a copy to the Parole Clerk to be sent by Email.

Consequently, I received a reply after three weeks claiming that my reconsideration paperwork arrived out of time and they therefore rejected my submission. It appears from the wording of the refusal that the Recorded Delivery took 6 days to reach them, but there was no mention of the Email paperwork I sent through the prison, which would have reached them the day before the cut—off date! Either it got lost in transit from the Wing to the Parole Clerk, or it wasn't sent at all! Considering that all previous reconsiderations I created and sent through these proceedings, all missing initially, and I had to provide them again, I am not at all surprised.

Yet again there is another opportunity to request a motion to 'Set—aside this decision if I can challenge it on the basis of a matter of Law or Factual inaccuracy! Both of these apply here. I had to obtain the information and forms from another website. This involved another two-week wait for the authorities to get them, which again leaves me with just over a week to create and send in these submissions. I am about to send them in, but I am just going through the requirement of exhausting all domestic avenues of complaint before legal action by way of Judicial Review.

It was my intention to request the judge to refer my case to this new Court of Appeal — (The Court of Public Opinion and Scrutiny, Criminal Division —Appeal Section). This is a new court of appeal which is held by three anonymous retired High Court Judges, and cases can only be referred to them by a Judge. This court was established in 2003 by retired Judges of the High Court and Crown Court to review the cases of those "referred" to the Court by a member Judge. The rules of the Court are in accordance with the same rules of the Court of Appeal and the Judges take the pseudonyms of Lord Datta, Lord Dayadhvam, Lord Damyata and their identities remain secret. One of the retired High Court Judges said, "we do this to protect the integrity of the judiciary, but it is correct to say that some of the cases we have all participated in have left us disturbed enough to carry a weight on our conscience." The information about this new Court came to light through the Giovanni Di Stefano case. Which is well worth reading. He found out he had false convictions on criminal records and the authorities did their level best to stop him from ever getting this to a court of law! His case mirrors my situation in practically all respects. He wrote to his Trial Judge, who referred his case to the new court.

My trial judge is more than likely deceased by now. I was hoping to explain to the Judge in the Parole Board the parallels and request he refer my case to the same Court of Public Opinion and Scrutiny, but in the event, I never got the chance to have my say. I have no doubt that there will be a further rejection, which means further legal action by way of Judicial Review, or Habeas Corpus. I have nothing to lose and everything to gain from this course of

action now. I will inform you of the result I anticipate will come, and what I intend to do then. I would just point out that: "I am supposed to be able to think like the people responsible for deciding whether I am fit to be released or not". People who cannot comprehend that prisoners do not have access to the internet. It would seem to me that when delivering a negative decision and suggesting a possible challenge that requires particular forms and procedures, they would have the common sense to also send the required paperwork with the rejection decision I cannot dumb down that far.

Anthony Entwistle A5364AC HMP Full Sutton Moor Lane, Full Sutton, York YO41 1PS

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Not Guilty After Six-Week Firearms Conspiracy Trial at The Old Bailey

MH who was unanimously acquitted after a six-week trial at the Central Criminal Court. MH was charged on allegations of conspiracy to transfer a firearm and ammunition. During the conspiracy period, MH was in custody at HMP Wandsworth. The prosecution alleged that MH had facilitated the sale of a loaded firearm from his prison cell, using an illegal burner phone. The prosecution alleged the loaded handgun was sold on to two separate suspects who did not feature in the trial, and were known to have an interest in amassing weapons for the purpose of committing murder. The prosecution had previously alleged the firearms transfer was linked to contract killings. The Defence case involved comprehensive analysis of call data records, including patterns and sequencing, disclosure on prison material and intelligence, and a detailed examination of the prison regime at HMP Wandsworth. The jury returned Not Guilty verdicts after two days of deliberation.

Serious Failings Contributed to Death of Baby in Bronzefield Prison Cell

A coroner has today 28/-7/2023 concluded that the death of an 18-year-old Black woman's full-term baby in a prison cell in Surrey was contributed to by serious operational and systemic failings. Baby Aisha Cleary was born and died in HMP Bronzefield during the night of 26 September 2019, and was not found until the following morning. Concluding the month-long inquest into Aisha's death the Senior Coroner for Surrey, Richard Travers, stated that Aisha "arrived into the world in the most harrowing of circumstances" given that her mother, Rianna Cleary – a vulnerable teenage care leaver in prison – was left to give birth alone in a prison cell without any care or assistance. There were 196 pregnant women in prison during the 12-month period from April 2022 to March 2023. Campaigners are calling for an end to the imprisonment of pregnant women.

Rianna Cleary was excluded from mainstream education and taken into care as a young teenager. She moved frequently and lived in placements across London and in Wales. Rianna presented to Camden Social Services in October 2018, but was not accepted to be a former relevant child by London Borough of Camden until the end of July 2019, which only happened after a solicitor helped her and threatened legal action against the council. Being a former looked after child is a status which entitles a person to specific services and support, such as a Personal Advisor when you are over the age of 18.

In evidence to the inquest, Camden's Head of Safeguarding and Quality Assurance accepted that Camden had become involved in a debate with Haringey as to who was responsible for her. They said Rianna, "as a very vulnerable young woman, was not central to decision making" between the two boroughs' Social Services departments "which will have left her feeling unwanted and uncared for". The London Borough of Camden also accepted that the delay in agreeing to support Rianna as a former relevant child "took too long" and "presented her with further rejection, a lack of hope in the system and a further difficult battle – just to have her basic needs met". Rianna did not have support from a Personal Adviser until after

Aisha's death, which the coroner concluded contributed to the failure to help her engage in care. The coroner stated Rianna had been "let down" by Camden Social Services.

Rianna realised she was pregnant after being arrested whilst living in a supported hostel in Camden. On 14 August 2019, she was remanded to HMP Bronzefield, the largest women's prison in Europe. Rianna arrived with a Prison Escort Record stating that she was six months pregnant. On 19 August, at a meeting in HMP Bronzefield's Mother and Baby Unit, she was told by Camden Social Services that they would be seeking a court order to remove her child at birth. Rianna was given a letter, written in legal jargon, confirming this – which the coroner stated was unnecessarily judgmental and negative about Rianna, and further contributed to her difficulties in engaging with social services.

In her evidence to the inquest, Rianna stated that prison staff told her that she would only get minutes with her baby before the police would take the baby away. Rianna became so distressed at the prospect of her baby being removed that, on 25 September, she told prison officers she would kill herself if that happened. Despite this, no care plan for prisoners at risk of suicide or self-harm (known as an ACCT) was put in place for her by prison or healthcare staff – which the coroner concluded was a "significant missed opportunity" to engage with and monitor Rianna. Realising she was not going to get the help she needed in prison, Rianna tried to apply for bail, but her Offender Manager at the prison, Carleigh Marshall, refused to help her get a bail hostel address to go to. During the inquest, and in her evidence to the Prison and Probation Ombudsman, the Offender Manager referred to Rianna as a "gangster". In her evidence to the inquest, Rianna asked why her concerns and health needs were ignored and why the prison failed to respond to warning signs and adequately monitor her. She said that she, "wondered at that time if I was being treated differently from [other women in prison] because of my race, because I was young, or because of my past."

The coroner was strongly critical of the midwifery care provided to Rianna by Ashford & St Peter's Hospital Trust while she was a prisoner in HMP Bronzefield. He found that the approach of the Lead Safeguarding Midwife, Sarah Legg, was "highly inappropriate and unprofessional; and "probably made matters worse" in terms of Rianna's engagement. He noted that no effective plan was put in place for Rianna for some three weeks in September 2019, despite the obvious risks. After concerns were raised about the risks related to Rianna's pregnancy, a decision was eventually made by Prison Healthcare staff on the morning of 26 September to place her under extended clinical observations. No such observations were ever carried out – despite there being a 24-hour nursing station on Rianna's wing in the prison, and observations being carried out on other prisoners during that night.

During the inquest, the prison's Clinical Team Leader, who was supposed to be responsible for Rianna's clinical observations, accepted that the failure to carry these out were "a total and unacceptable failure in care" to Rianna and baby Aisha. During the evening of 26 September, Rianna went into labour. At around 8.07pm she used the intercom in her cell to urgently request a nurse or an ambulance. The call was answered by Prison Officer Mark Johnson, who is currently still under disciplinary investigation and suspended from prisoner-facing duties. No nurse or ambulance were called by Mr Johnson, nor by any other officer on duty, and no-one checked on her in response to her emergency call.

The coroner described this as a "complete disregard for the duties of a prison officer" and found Mr Johnson to be a dishonest and unreliable witness. The coroner concluded that if Mr Johnson had checked Rianna's cell after her urgent request for assistance, her labour would have been discovered and she would have been transferred to hospital immediately.

Despite being barely able to walk across her cell in labour, Rianna again pressed her emergency cell bell at around 8.32pm. This call was not answered, and the inquest heard evidence that it was simply disconnected in the prison communications room at 8.45pm. The prison officer in the Central Control Room could offer no explanation for this failure, and the coroner was unable to conclude on the evidence why this failure occurred.

The prison's Deputy Director, Vicky Robinson, admitted in her evidence at the inquest that the prison's response to Rianna calling for help by her cell bell was "wholly and completely inadequate." At around 9.27pm and 4.19am, Rianna's cell was checked extremely briefly by prison officers, who shone a torch through the hatch as part of a routine roll count. Each check lasted 1- 2 seconds before the officers moved on to the next cell. The officers who did undertake these checks told the inquest that they did not notice anything untoward in Rianna's cell.

Rianna subsequently gave birth alone in her cell, which she told the inquest was a harrowing experience. Rianna did not understand that she was in labour, just that she was in extreme pain; she lost blood and passed out in the early hours of the morning. At around 8.15am, a prison officer unlocked Rianna's cell. He did not enter the cell or address Rianna and told the inquest that he did not notice the blood on the walls and floor of the cell.

Rianna was eventually woken by the sound of her cell being unlocked. She discovered baby Aisha on the bed, who appeared purple and did not seem to be breathing. Rianna felt compelled to bite through her baby's umbilical cord as she had no medical or other help, and placed her placenta in the bin as she did not know what else to do.

Over 12 hours since she first rang the cell bell, and a few minutes after her cell was unlocked, at 8.21am, two other prisoners had to alert prison staff to the fact that Rianna needed assistance. Following this, a prison officer attended and discovered that Rianna had given birth alone during the night. Nurses attended and attempted to resuscitate Aisha (without access to a paediatric resuscitation equipment), and called an ambulance. At 9.03am, paramedics confirmed that baby Aisha had died. Ruth Mason, the expert Consultant Obstetrician and Gynaecologist instructed by the coroner, said that if a midwife had been present during Rianna's labour and if Aisha was alive when it started, it is more than likely that Aisha would have survived. The coroner agreed with this conclusion. As part of the inquest, the coroner considered whether Aisha was stillborn or took an independent breath before she died. While the coroner found that Aisha had air in her lungs, he found the evidence was not sufficient to confirm whether or not it was a stillbirth – concluding that it was possible Aisha had been born alive.

In what is understood to be the first time a coroner has deliberated on coronial powers and duties where it is unclear whether a baby was stillborn, the coroner agreed with Rianna's legal team's submissions – despite opposition from all the State interested persons – that Article 2 of the European Convention on Human Rights was engaged where it was possible that Aisha had been born alive, and where there was "ample evidence that serious systemic failures" had contributed to her death. The coroner also rejected an argument made by Sodexo, the Ministry of Justice and Ashford & St Peter's NHS Foundation Trust, that Aisha's death should be treated as a stillbirth, and that the coroner had no jurisdiction to make the critical conclusions he went on to do.

The coroner concluded as follows: By early September 2019 there was a recognised risk Rianna could give birth alone in her cell if her labour was not recognised and she was transferred to hospital in a timely manner; Despite those risks, the obstetrics and midwifery services in HMP Bronzefield failed to give any guidance to the prison, to undertake joint working with prison healthcare, to arrange a multidisciplinary meeting, or to ensure that there was an effective joint plan to ensure that Rianna's labour was identified and that she was transferred to hospital to

give birth; The prison failed to put in place a plan to monitor Rianna; to open an ACCT when she spoke of suicide and self-harm in the context of her pregnancy on 25 September; to implement extended observations on Rianna; to respond to Rianna's requests for medical assistance at 20:07 hours on 26 September (at which time she was already in labour); or to answer second call at 20:32 hours at all; and If Rianna's labour had been identified and she had been transferred to hospital, there was an opportunity to take effective steps to ensure Aisha's survival.

Following the coroner's conclusions, Rianna Cleary said: "Nothing can change the nightmare I went through or bring Aisha back. However, I am grateful that the coroner has recognised that London Borough of Camden let me down and that the prison as a whole failed me in so many ways. This includes the conclusions that the safeguarding midwife in prison was 'inappropriate and unprofessional', that prison healthcare let me down, and that the prison officer Mark Johnson who ignored my request for medical assistance when I rang my cell bell is a dishonest witness who showed 'complete disregard for his duties as a prison officer'. I really cannot believe Officer Johnson still has not been disciplined and is still employed by the prison. I feel so sad knowing that Aisha may have survived if they had helped me. Only one prison officer (Lewis Kirby) who didn't even do anything wrong said sorry to me directly. The Deputy Director of Bronzefield wrote one line to me saying sorry you gave birth alone just before the inquest started. If it wasn't for this inquest, they would still be blaming me for giving birth alone."

Deborah Coles, Director at INQUEST, said: "These conclusions are a shocking and damning inditement of the utter failure to keep Aisha and her mother safe, both long before and during her deeply traumatic time in prison. Aisha's mother was a young woman with a history of trauma. She deserved care and support from public services. The fundamental question is why so many agencies failed her, and why was she sent to prison in the first place, not least when pregnant? Inquest evidence has shown that as a vulnerable 18-year-old Black woman, narratives around gangs informed the way she was treated in the community and in prison. She was viewed not as someone in need of care and compassion but as a discipline and control problem. Her calls for help went unanswered, and her pain was ignored. The death of a baby in a prison cell is unconscionable and it is an indictment of the society we live in that a young woman can be failed so catastrophically by so many services. Prison is a disproportionate, inappropriate, and dangerous response to women in conflict with the law, let alone those who are pregnant. For too long we have ignored recommendations from inquests and reviews. We need to dismantle prisons and redirect resources to holistic, gender responsive community services. Only then can we end the deaths of women and their babies in prison."

Elaine Macdonald of Broudie Jackson Canter, said: "The evidence heard in this inquest about the treatment of such a young and vulnerable pregnant woman has been both distressing and heart-breaking. My client has shown incredible strength and courage to attend every single day of this inquest. She has seen the men who failed to respond to her on the night that Aisha was born and heard their inadequate explanations. Only one of them has apologised to her. The evidence heard confirms that prison is a completely inappropriate and dangerous environment for pregnant women. Sodexo and Ashford and St Peters NHS Trust have failed in significant and multiple ways in this case to provide safe and compassionate care to a young pregnant woman who needed support. There was no adequate plan for Aisha's birth and there was no basic emergency response to my client's calls for help. What happened here is utterly unacceptable and there must be changes to how we treat pregnant women in custody."

Janey Starling, Co-Director of Level Up, said: "Prison will never be a safe place to be pregnant and it's long overdue for courts to stop sending pregnant women there. There are plenty of other

countries that do not send pregnant women to prison, including Italy, Brazil and Mexico, yet the UK lags behind. Since the death of Baby Aisha in 2019, a coalition of mothers, midwives and medical experts have joined forces to demand an end to the imprisonment of pregnant women. It's time for the government to listen to the experts and end the imprisonment of pregnant women. When a mother is supported in her community, she is able to tackle the issues that swept her up into crime in the first place and get the support to give her child the best start in life, and herself the best future."

Naomi Delap, Director of Birth Companions, said: "It's not enough to promise improvements in care that we all know will be impossible to deliver. The government can, and must, end the imprisonment of pregnant women and mothers of infants. This is far from a radical position. In the vast majority of cases the imprisonment of pregnant and postnatal women is unnecessary and avoidable. It is a choice made by the legal system in this country. This tragic case also highlights the urgent work needed to improve the way local authorities support girls in their care, and women whose unborn babies and infants are subject to care proceedings. It is clear that support for Rianna was not well managed as she moved from child to adult services. Care was fragmented when she became pregnant and attention shifted to her baby, and support was further compromised when she entered the prison system. This picture is all-too common. If the government ends the use of custody for pregnant women and mothers of infants; if it prioritises services that address the root causes of offending; and delivers better support for girls and women in local authority care; it will break intergenerational cycles of disadvantage and deliver huge benefits for women, their families and society."

Second HMP Bristol Urgent Notification

I have issued an Urgent Notification for the following reasons: • Bristol remained one of the most unsafe prisons in the country The levels of recorded violence including serious assaults on both staff and prisoners were higher than most other adult prisons. • There had been 8 self-inflicted deaths since our last inspection and another suicide immediately after the inspection. This means that 6 prisoners have taken their lives in the last 10 months. One man had also recently been charged with murdering his cellmate. • In our survey, 46% of prisoners said it was easy to get drugs in the prison, and it was clear to see the physical effects of long-term drug misuse in the population. • The strategies employed to reduce these high levels of violence, self-harm and drug misuse had not been effective. leaders had failed to set high enough standards of behaviour, sanctions were ineffective, and prisoners were not being motivated to behave. Low-level poor behaviour often went unchallenged. • The prison was overcrowded, with almost half the prisoners living in double cells designed for one man. A significant minority were in single cells with no internal sanitation. Despite this, the capacity of the prison had been increased on several occasions since the last inspection. • The majority of prisoners were locked up for almost 22 hours a day. The proportion of men allocated to education, skills and work was too low and attendance was poor. • The health provision was not sufficient to meet the needs of prisoners many of whom were struggling with mental health problems. There were long delays in transferring the most unwell prisoners to secure hospitals and some of these acutely unwell men were being managed in segregated conditions. • There was no key work, and busy officers struggled to forge good relationships with prisoners to motivate them to make progress. Emergency cell bells were often left unanswered, a significant risk in a prison with so many self-inflicted deaths. • Leaders had neglected work to reduce reoffending or planning for future release. Work to support family ties had also deteriorated since the last inspection, and a quarter of prisoners left homeless on the day of release.

• Many of the senior team were new to post which continued a pattern of instability in key roles. Leaders at all levels had consistently overestimated performance and did not have a firm grip of the many challenges facing the prison.

Commenting on the announcement 28th July, that HM Chief Inspector of Prisons has issued a second Urgent Notification to HMP Bristol, Pia Sinha, chief executive of the Prison Reform Trust, said: "The appalling state of HMP Bristol is indicative of the wider chronically overburdened system. Prisons are experiencing a perfect storm which is pushing them past breaking point. The government must stop trying to incarcerate themselves out of this mess. Instead, they must urgently look to diversion, alternatives to ineffective short sentences, and to vastly reducing the remand population."

Retired Met Police Officers Jailed Over Plot to Share Child Sex Abuse Images

Two retired Metropolitan Police officers have been jailed over a three-year plot to share child sexual abuse images. Jack Addis, 63, and Jeremy Laxton, 62, had posted hard drives to one another containing indecent images and videos of children, and had concealed them in hidden spaces in their homes. The two former officers pleaded guilty at Southwark Crown Court to a charge of conspiring with Richard Watkinson, 49, to distribute or show indecent images. Mr Justice Wall jailed Addis for three years and nine months and Laxton for five years and nine months. Watkinson, who was a serving Met chief inspector for neighbourhood policing at the West Area Command Unit, was found dead at his home in Buckinghamshire on 12 January. The court heard he took his own life. He had been suspended from duty following his arrest in July 2021 and was due to be charged with conspiracy, as well as three counts of making indecent photos of a child, voyeurism and two counts of misconduct in public office.

INQUEST Responds to Sharp Increase in Deaths Involving Police

In the year that saw the high-profile deaths of Chris Kaba and Oladeji Omishore at the hands of the police, official statistics published today reveal the highest number of deaths recorded for five years and an increase of almost double the previous year. The latest annual data from the Independent Office for Police Conduct (IOPC) covering 2022/3 shows 23 deaths in or following police custody. This is an increase of 12 from the previous year. All but one were men. Eleven of these 23 people had some use of force against them by the police before their deaths. Three of these included Taser discharge. All but two of the deaths featured links to drugs and/or alcohol and over half (13) of those who died had mental health concerns. Four had been detained under the mental health act.

In addition to the custody deaths, there were: three fatal police shootings, including the death of Chris Kaba. 28 fatalities from police-related road traffic incidents, 18 of which were police pursuit-related incidents. 52 apparent suicides following police custody. The IOPC also investigated 90 other deaths following contact with the police in a wide range of circumstances. Six of these 'other deaths' involved restraint or use of force by police, one of which included use of Taser. Around two thirds of these 90 cases involved intoxication with drugs or alcohol, and a similar proportion involved mental health concerns.

Behind the data are stories of those who have died, and the families left fighting for truth and justice. Most deaths are subject to continued investigations and inquests. These include: Oladeji Omishore, a 41-year-old Black man who fell into the River Thames after being subjected to multiple Taser discharges by a Metropolitan Police Officer and died on 4 June 2022. He was experiencing a mental health crisis. Kaine Fletcher, a 26-year-old mixed-race man, who was subject to restraint by Nottinghamshire police during a mental health crisis and died on

3 July 2022. Godrick Osei, a 35-year-old Black man, who was subject to Devon & Cornwall police restraint during a mental health crisis and died on 3 July 2022. Donald Burgess, a 93-year-old White man with dementia and one leg in a care home, who was Tasered and sprayed with PAVA (pepper spray) and died three weeks later on 13 July 2022. Liam Allen, a 23-year-old White man, who drowned following contact with the Metropolitan police on 27 August 2022. Chris Kaba, a 24-year-old Black man, who was fatally shot by the Metropolitan police on 5 September 2022. Since the end of the reporting period for 2022/3, INQUEST is aware of 11 other deaths during or following police contact (including five road traffic or pursuit incidents).

Lucy Mckay, spokesperson for INQUEST, said: "No one should by dying at the hands of police. Yet once again we are seeing an increasing number of deaths. Too often these deaths involve mental illness or intoxication, and dangerous use of force and restraint by police. We know from our work with bereaved families that so many of these deaths are preventable, both at the point of death and long before things reached a crisis point. Inquests and investigations uncover issues of institutional racism, disproportionate use of force, and neglect of people in need of care not custody. Ultimately to prevent further deaths and harm, we must look beyond policing and redirect resources into community, health, welfare and specialist services."

INQUEST Unlocking the Truth, https://tinyurl.com/4j8n5863

John Stanley Remand Prisoner Died as a Result of Causative Failings By Prison Staff

Doughty Street Chambers: Stewart died on the 13 July 2020 at the Royal, Devon and Exeter Hospital, after having been found suspended in his cell by ligature at HMP Exeter in the early hours the day before. Following a two-week inquest, the jury found that the risk that Stewart might take his own life had not been properly appreciated, and that HMP Exeter's processes, which were designed to reduce the risk of a prisoner taking their own life, had not worked appropriately in Stewart's case. The jury concluded that both of these failures were probably causative of Stewart's death. Stewart was remanded to HMP Exeter on 23 June 2020, where an Assessment, Care in Custody and Teamwork ('ACCT') plan was opened, due to low mood, anxiety and a previous suicide attempt by hanging. That plan was closed the next day. On 4 July 2020, Stewart was assaulted by another prisoner whilst in the shower. Three days later, Stewart was moved to the same Wing as the suspected perpetrator.

On 9 July 2020, Stewart attempted to ligature in his cell, after expressing concerns to his family about his safety. A second ACCT was opened and Stewart was deemed to be 'high risk' and placed on to constant supervision in an anti-ligature cell, meaning a Prison Officer was to observe him at all times. Whilst on constant supervision, Stewart was noted by staff to be paranoid and erratic, and maintained that he was under threat from other prisoners. On 11 July 2020, following an ACCT review in the morning where it was decided that Stewart's risk had not changed and he needed to remain on constant supervision, a decision was taken to remove Stewart from his anti-ligature cell, to stop constant supervision and to place him onto 30 minute observations. The decision was made without input from healthcare staff in the prison, contrary to HMP Exeter's policy. The jury found that this decision, to exclude those best qualified to appreciate Stewart's risk to himself, probably led to his death. Less than 10 hours later, Stewart was found by staff, having ligatured in his cell.

The jury heard evidence from Stewart's family – who had contacted the prison on several occasions to express their concern about his safety and wellbeing – that he was a caring and loving person, and that they did not wish another family to go through what they had following Stewart's death. At the conclusion of the inquest, the Coroner paid tribute to Stewart and his family for their support of the organ donation process.

Judge Wrong to Let 14-Year-Old Boy Instruct Solicitor

Nick Hilborne, Legal Futures: A family court judge was wrong to order that a 14-year-old boy be allowed to instruct his own solicitor in care proceedings, the Court of Appeal has ruled. Lord Justice Peter Jackson said Her Honour Judge McKinnell "made her own assessment" of the boy's ability to instruct after meeting him, describing him as "very mature and very insightful" when the evidence from two psychiatrists was that he was "emotionally immature and lacking insight". He said the judge was "distracted by general observations about exercising caution before depriving intelligent older children of their own representation", which led her to "overlook how extreme and effective" his father's abuse had been. The lord justice said this was not a case where the boy, A, had his own solicitor in the previous proceedings, nor was it a case where a child had formed an unwise view of their own. "Instead, these children have been the victim of severe alienation of a kind that should have led the judge to firmly reject the application for A to be allowed to instruct a solicitor directly, for all the reasons she gave when making these care orders."

The court heard in C (Child: Ability to Instruct Solicitor) [2023] EWCA Civ 889, that the order allowing the boy to instruct his own solicitor arose in the context of proceedings brought by his parents to discharge care orders in respect of A and his sister B, who is 13. "The care orders were made to protect the children from parental conflict and from behaviour by their father that had severely alienated them from their mother." The parents married in 2006 and separated in 2019 before divorcing. "Communications further deteriorated after the separation and private law proceedings began, eventually involving the mother obtaining a non-molestation order in early 2020 and reducing the father's contact. "On several occasions the children ran away from their mother to their father, including for a month in March 2020, and the mother then stopped contact with their father altogether for a period." An interim care order was made in November 2021 and the children were put in foster care, where they have remained.

The father was arrested and charged with breaching the non-molestation order preventing contact with his children in June 2022, spending two weeks in custody on remand. At the same time, it was discovered that a 250-page e-book had been published in A's name on Amazon Kindle. "The book, entitled Monstrous, Corrupt and Criminal Family Court, with its Social and Health Services, contained significant personal information about the children, the case and professionals including foster-carers. Injunctions were granted by the High Court and Amazon removed the book from sale." During the discharge proceedings, HHJ McKinnell met the children separately in March 2023 in the presence of their joint solicitor and foster carers. The solicitor applied for an order for separate representation for A in May. Later that month, HHJ McKinnell gave an ex tempore judgment allowing A to instruct his own solicitor. The mother, supported by the local authority, appealed.

Peter Jackson LJ said that it was "the judge's role to adjudicate, not to assess" but "she made her own assessment of A's ability to instruct in a manner that went well beyond the permissible use" of the meeting. "The problem was compounded by the judge not expressly disclosing to the parties the reliance she was planning to place on her own view, so that they were deprived of the opportunity to alert her to how questionable that would be."

The reasons given by the judge for her assessment were "not sustainable". Peter Jackson LJ said that both father and son were "under the same delusion about the cause of the problems and the opportunity for A to instruct his own solicitor gives him a powerful extra dimension within which to perpetuate this damaging narrative, oblivious to the harm that he might be causing himself". The judge allowed the appeal and discharged the order permitting A to instruct his own solicitor. However, he said there was no reason why HHJ McKinnell should not continue to have conduct of the proceedings. Lady Justice Elisabeth Laing and Lord Justice William Davis agreed with his judgment.

End Living Cost Charge for Wrongfully Convicted

Marie Jackson, BBC News: In 1997, convictions against cousins Vincent and Michael Hickey for the murder of Carl Bridgewater at a farm near Stourbridge in 1978 were found to be fundamentally flawed. Michael Hickey was subsequently awarded £1.02m and Vincent Hickey £550,000 but, in each case, a 25% deduction was made from the part of their compensation that reflected loss of earnings while in prison. This was because of living expenses they did not have to pay while in prison. A senior Conservative MP has urged ministers to change prison compensation rules after it emerged Andy Malkinson who wrongly spent 17 years in jail may have money deducted from his payout. Under existing rules, savings made on living costs while in prison can be deducted from compensation. Sir Bob Neill said: "Any fair-minded person thinks this is just wrong." The government has no plans for any changes but keeps all laws under review. The rules date back to a decision made in 2007 by the House of Lords. It said that money could be deducted from compensation for "saved living expenses". This refers to costs the prisoner would have incurred if they had not been locked up, such as food and accommodation, according to a House of Commons briefing paper. Sir Bob, who is chairman of the Justice Select Committee, said that at the time the decision was made, it was thought that taxpayers would be offended at paying money to someone who was freed on a technicality. "It's clearly not right that somebody who was deprived of their liberty, because of the failures of the state and its institutions for a number of years, then should pay the state or be obliged to give some money back to the state, for the privilege of having been wrongly incarcerated. That surely offends any any kind of sense of justice".

Rap and Drill Music: A Song Should Not Land the Young in Jail

The use of lyrics, music videos and audio recordings in court to prosecute people raises issues of prejudice and free expression!

Gardian, Opinion: In the past three years, the courtroom fate of more than 240 people in the UK – almost all young black men – has been decided, partly, by their taste in music, namely the genres of rap, grime and drill. This trend raises troubling questions of freedom of expression, racial prejudice and the place of art in court. The data was uncovered by the University of Manchester's Prosecuting Rap project, which has identified more than 70 trials since 2020 in which rap evidence including lyrics, music videos and audio recordings has been used to build prosecution cases. This was five times the rate recorded in the previous 15 years of rap music being introduced to secure convictions, apparently without much unease over the conflation of fiction with real-life crime.

While the music and videos may not be the only evidence, there is often alarmingly little other evidence against some defendants. Rap, grime and drill artists regularly win critical acclaim and top the charts. Yet Crown Prosecution Service guidelines state that "gangs are increasingly using drill music and social media to promote gang culture, glamorise the gang lifestyle and the use of weapons". The research reveals a pattern in which police officers are put forward by prosecutors to act as rap "experts" in court, advising juries what the rapper "really" means in lyrics, what hand gestures signify and what denotes gang membership. The human rights charity Justice has with very good reason described this as "no more than the prosecution calling itself to give evidence".

The University of Manchester's work reveals that the cases where rap is used in evidence involve young men (almost half of the trials featured defendants yet to turn 18); prosecutors relying on a gang narrative to shape their case, an approach often involving controversial joint enterprise laws; and instances of "bad character application", when prosecutors introduce evidence of previous offences or, more vaguely, of a "disposition towards misconduct".

Keir Monteith KC argued in the academic journal Popular Music that rap and drill lyrics should be banned in the courtroom. He asked: how can first-person lyrics be taken for confessions? If a person appears in a video glorifying a gang, why does that make them members of it? If rapping about guns and gangs is evidence of a violent disposition, what can one say about Mick Jagger singing in Midnight Rambler that "I'll stick my knife right down your throat, baby, and it hurts"? It is hard to disagree with the silk's assessment that rap, drill and grime lyrics and videos are used against young, black defendants to build a narrative that reinforces racist stereotypes of black criminality.

There needs to be serious consideration about the way in which gang evidence, including music videos, is scrutinised. Surely juries ought to be given an indication of the degree of caution required when considering flimsy assertions about rap music? Abenaa Owusu-Bempah of the London School of Economics examined 38 cases where lyrics or participation in music videos had been used as evidence against a defendant or treated as an aggravating factor at sentencing – and found only one instance where this had been successfully challenged. Clearly the courts need a more rigorous and informed approach. The current use of musical preferences to infer criminality opens the door to miscarriages of justice.

Fix 'Endemic' Problems in Youth Custody, Urges Prisons Watchdog

Diane Taylor, Guardian: A prisons watchdog has warned that poor conditions are "endemic" at four young offender institutions in England and urged ministers to take urgent action to improve them. In her new role as the national chair of the Independent Monitoring Boards (IMBs), Elisabeth Davies has taken the unusual step of writing a letter to the prisons minister, Damian Hinds, to raise serious concerns about the welfare of children in YOIs in England. While concerns have previously been expressed, Davies wrote in her letter to Hinds: "These concerns have now considerably heightened and appear to be endemic across all YOIs in England."

Davies outlined a series of concerns in her letter to the minister, including the use of "keep aparts" to prevent children and young people who are in conflict with each other, either due to rival gang affiliations or a range of other issues, from mingling freely. Children reported feeling scared for their safety in YOIs and some resorted to carrying homemade weapons. Some were locked in their rooms for up to 23 hours a day due to staff shortages and keep aparts, although the duration of such confinement varied at different times and in different YOIs. At times, children were denied access to education or "purposeful activity" due to staff shortages. At Wetherby YOI in Yorkshire, children were out of their rooms for three to five hours a day, but this was reduced to two to three hours for the whole weekend period. The practice of keeping some children in their rooms for very long periods each day was described as "positively inhumane".

Children with complex needs, such as those with histories of trauma or those who are neurodiverse, are not accessing the support they need, according to Davies' letter to the minister. "A notable proportion of children and young people felt constantly afraid and unsafe and unprotected," the letter states. Children and young people said they felt the establishment they were in was out of control and they needed to protect themselves either by self-isolating or carrying weapons because they feared attack."