Tony Francis, Mark Samuels and Peter Gibbs were fitted up by the infamous West Midlands Serious Crime Squad for the murder of Police constable Tony Salt on Sunday 17 April 1989. The three were forced to confess to a murder that never happened. At the time Salt was totally intoxicated and the cause of his own death. Pc Salt left his secret observation post to go drinking at a pub with colleague Pc Mark Berry before he died. After drinking more than eight pints he tried to get into the illicit club he was supposed to be keeping watch over, to get even more booze – but was turned away by doorman Mr Francis. As he staggered back to his hide-out Pc Salt slipped and smashed his head and neck on a JCB which builders had left parked overnight on the road.

Fast forward to February 2013, Tony Salt's name is emblazoned on a memorial plaque to West Midlands police officers who died in the line of duty. The plaque features the names of 89 officers who have been killed while on duty since 1822. It was commissioned and paid for the by the West Midlands Police Federation.

According to the Birmingham mail, friends of the three have condemned the inclusion of Salt's name on the plaque as has former West Midlands Police Authority member and Wolverhampton Councillor, Milkinder Jaspa.

If the West Midlands Police Federation are remembering police officers who died in the the line of duty by a memorial plaque.

Surely it is beholden on them to put up a plaque with all the names of those who were fitted up by West Midlands Serious Crime Squad?

MP Chris Mullin on West Midlands Serious Crime Squad circa 1991

False imprisonment of Francis, Samuels and Gibbs: The case demonstrates that, despite the safeguards provided by the Police and Criminal Evidence Act 1984, West Midlands police officers are still able to persuade people to confess to crimes that they did not commit and even to tape-record those false confessions. It demonstrates that all the bland assurances—we may hear more of them later—that everything has been fine since PACE are nonsense.

The case also shows that, even when West Midlands police officers have been caught fabricating confessions and attempting to pervert the course of justice, they can rely on their superiors, up to the chief constable himself, to make sure that the truth is covered up. They can rely on the Crown prosecution service to connive in the disappearance of inconvenient evidence. They can rely on the silence of the police authority to whom the chief constable is supposed to account. Finally, they can rely on the Home Office to block any inquiries from inquisitive Members of Parliament. Hansard HC Deb 12 December 1991 vol 200 cc1221-8

Francis, Mark Samuels and Peter Gibbs, all from Birmingham, were eventually cleared of all charges and awarded compensation in an out-of-court settlement with the force.

Hostages: Darren Waterhouse, David Norris, Brendan McConville, John Paul Wooton, John Keelan, Mohammed Niaz Khan, Abid Ashiq Hussain, Sharaz Yaqub, David Ferguson, Anthony Parsons, James Cullinene, Stephen Marsh, Graham Coutts, Royston Moore, Duane King, Leon Chapman, Tony Marshall, Anthony Jackson, David Kent, Norman Grant, Ricardo Morrison, Alex Silva,Terry Smith, Hyrone Hart, Glen Cameron,Warren Slaney, Melvyn 'Adie' McLellan, Lyndon Coles, Robert Bradley, Sam Hallam, John Twomey, Thomas G. Bourke, David E. Ferguson, Lee Mockble, George Romero Coleman, Neil Hurley, Jaslyn Ricardo Smith, James Dowsett, Kevan Thakrar, Miran Thakrar,Jordan Towers, Patrick Docherty, Brendan Dixon, Paul Bush, Frank Wilkinson, Alex Black, Nicholas Rose, Kevin Nunn, Peter Carine, Simon Hall, Paul Higginson, Thomas Petch, Vincent and Sean Bradish, John Allen, Jeremy Bamber, Kevin Lane, Michael Brown, Robert Knapp, William Kenealy, Glyn Razzell, Willie Gage, Kate Keaveney, Michael Stone, Michael Attwooll, John Roden, Nick Tucker, Karl Watson, Terry Allen, Richard Southern, Jamil Chowdhary, Jake Mawhinney, Peter Hannigan, Ihsan Ulhaque, Richard Roy Allan, Sam Cole, Carl Kenute Gowe, Eddie Hampton, Tony Hyland, Ray Gilbert, Ishtiaq Ahmed.

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Sexual Abuse in Prisons - Learning Lessons

This Learning Lessons Bulletin is a revised version of a paper that I presented to the Howard League's Commission on Sex in Prison in November 2012 entitled - for good reason - "A Hidden Issue in a Hidden World". Sexual activity is an inherent part of our humanity and its existence in prison is inevitable. Sexual activity covers a broad range of behaviours both consensual and coercive but, in so far as the issue reaches my office at all, it is allegations of abusive behaviours with which my investigations into complaints and deaths in custody are most usually concerned.

As a result of the infrequency of the issue coming to my office, we have rarely sought to distil relevant lessons to be learned, although the issue of intimate relationships among women prisoners was explored in our thematic study2 on links between bullying and deaths in custody. Even once raised, issues relating to sex in prison can be difficult to investigate, usually being secretive and hampered by a lack of persuasive evidence. This bulletin takes a tentative look at both our complaints and fatal incident case load to see if there are lessons to learn in the custodial context about this most fundamental aspect of human nature. Nigel Newcomen CBE

1. Complaints made to the Prisons and Probation Ombudsman

Complaints of a sexual nature made up less than half a percent of the total complaint caseload from 2007- 2012. Of the 108 sexual complaints received, 47 (44%) were found to be eligible for investigation (a similar eligibility rate for all complaints in the period).

The majority of complaints of a sexual nature were allegations of sexually abusive behaviour towards prisoners by either a member of staff or a fellow prisoner. Of all these complaints, 45 were allegations of abusive behaviours by staff, 27 were about abusive behaviours by other prisoners, 18 were about prison rules and policies, 10 were about discrimination on the grounds of gender identity and 8 were about discrimination on grounds of sexuality.

1.1 Complaints of homophobic bullying by prisoners and staff

Homophobia is still an issue found in prisons but there is little data available on the experiences of lesbian, gay and bisexual prisoners. The Prison Service is required to challenge homophobia and ensure equal treatment of all prisoners.

Case Study 1: Mr A complained to the Ombudsman in 2010 that he had experienced homophobic bullying by prisoners and staff, and that the prison had failed to respond to his complaints. Mr A was assaulted in the shower by another prisoner who was subsequently convicted of assault causing grievous bodily harm.

The Ombudsman upheld Mr N.s complaint about his overall experience as a gay prisoner. He found that the prison was not sufficiently supportive of gay prisoners and a culture existed in which prisoners felt unable to confide in staff. The Ombudsman also agreed that is was probable that Mr A was subjected to homophobic bullying by other prisoners. The Ombudsman did not agree that the prison had failed to sufficiently respond to Mr N.s concerns and did not uphold this part of the complaint.

The Ombudsman found that, although a new diversity policy had been developed since Mr A had been at the prison, staff were not entirely at ease with the language used to discuss sexual orientation. Other prisoners would not generally accept a prisoner being openly gay.

The Ombudsman's recommendations supported those previously made by Her Majesty's Chief Inspector of Prisons. These were for the prison to review their sexual orientation policy; take action to challenge homophobic language and attitudes; display information which affirmed equality of respect for sexual orientation; and provide details for sources of support and assistance. Two specific recommendations were made to the prison by the Ombudsman.

First, to rewrite their diversity policy to remove the reference to displays of sexual orientation being in contravention of good order and discipline.

Second, to develop further support and guidance for gay prisoners. The Ombudsman also made a national recommendation that research should be carried out into the experience of lesbian, gay and bisexual prisoners, given the lack of knowledge in this area.

1.2 Complaints of Sexual Assault by Prisoners and Staff

A number of complaints made to the Ombudsman concerned allegations of a sexual assault taking place during searches. Not infrequently, the Ombudsman found that the perceived sexual assault was an inherent and lawful aspect of the search. Indeed, prison governors sometimes assert that it is effective, thorough staff who most frequently face allegations of sexual assault when searching. Nevertheless, the highly intrusive nature, particularly of full searches, means that the humiliation of the prisoner must be minimised (as stated in Prison Service Instruction 07/2011) - However, that is not always the case and this has been highlighted by the Ombudsman.

Case Study 2: In 2009, Mr B complained that an officer in his high security prison sexually assaulted him during a search. Mr B was subject to a routine rub down search when he was due to go to a visit. After Mr B had complained that he didn't like the pressure being used to search him, he alleged that the prison officer told him he would 'touch him how he liked' and that he would take him round the corner where there were not any cameras. Mr B asked for the complaint to be referred to the police.

Complaint was partially upheld. On the evidence available, the Ombudsman was satisfied that staff conducted the search appropriately and did not intend Mr B to feel aggrieved by it. However, it was of concern that the Police Intelligence Officers (PIOs) could not demonstrate that they had dealt with Mr B's complaint even though he had requested their involvement. As a result of the investigation, managers undertook to remind PIOs to keep proper records of any complaint referred to them.

Sexual abuse rarely takes place in front of witnesses and allegations often come down to one person's word against another's. It is therefore essential that internal investigations are rigorous and consider whether there is any other corroborating evidence, including intelligence and circumstantial evidence. This might enable a conclusion to be drawn, appropriate action taken and future safety of prisoners improved.

Case Study 3: In 2011, Ms C complained that a male officer had had a sexual relationship with another female prisoner (Ms D) in return for bringing contraband in for her.

Ms D had told Ms C that she had been having a sexual relationship with the officer, and that she had put in several complaints about the officer, but the prison had not investigated them and had moved her to another prison. The Ombudsman interviewed Ms D and she repeated the allegations made by Ms C, although she did not want to make a formal complaint herself. Ms D said that she was worried the officer would track her down once she had been released and said that the officer told her she would spend longer in jail if prison staff found out what they had been doing.

The Ombudsman discovered that similar allegations had been made about this officer over a period of years (although this does not necessarily mean they are true). The Ombudsman concluded that the prison's previous investigation into Ms D's allegations about this officer had been wholly

the mystery deepens because the results of this investigation have been sitting on a shelf somewhere in the Crown Prosecution Service offices since its conclusion last May. Trident is also the unit that led the operation in which Duggan was shot and killed. If local officers had followed up and arrested Hutchinson-Foster, the gun might never have reached Mark Duggan, if indeed it did; he would still be alive today; and Tottenham, London, and cities across the country would not have exploded in flames that summer. Given the devastating consequences for so many, the IPCC should have made public its report a long time ago. Instead it appears, along with the CPS, to be shielding the police from proper public scrutiny During the trial and retrial of Hutchinson-Foster we heard much about Mark Duggan yet there was nothing to suggest that the police could have avoided the entire incident. The IPCC says it deliberately held back the report until the conclusion of the Hutchinson-Foster trial, but to achieve true justice you need to look at the entire picture, and examine all relevant events before passing a meaningful judgment. And even now, four weeks after Hutchinson-Foster's conviction, the IPCC say they are "consulting with our community reference group and liaising with the Mark Duggan investigation team" and will give no date for publication of the report. Grieving families who rely on the independence and integrity of the IPCC can have little faith in the organisation as long as things remain as they are. Where is the independence to ensure the integrity of its investigation in all of this? The system, as it stands, is not designed to get at the truth, and cases like this reinforce the views of many, especially those who have long endured a poor relationship with the police, that the system is skewed against them.

HMCIP: Prisoners Should Be Given In-Cell Phones

Nick Hardwick said the illegal use of mobile phones was widespread in most prisons and installing phones in cells would enable more calls to be monitored. Making inmates wait to use a phone on the landing and then asking prison officers to control the scrum as prisoners battled for five minutes to talk was a waste of scarce resources, he added. A pilot scheme is being trialled at Rochester Young Offenders' Institution and around half of private prisons, including the new G4S-run Oakwood jail in Wolverhampton, which opened last year and Parc jail in Bridgend, Wales, already have phones installed in a limited number of cells.

John Anslow Prison Escape: Six Remanded In Custody

Six men accused of helping Midland murder suspect John Anslow escape from a prison van, Anslow, who has a a £10,000 reward on his head, is the first Category A prisoner to escape in 17 years. Luke Hazel, Robert Riddell, Paul Cadby, Moysha Shepherd, 23, Ryan Powell, and Brett Anslow, appeared before a district judge at Birmingham Magistrates' Court on Friday 1st March 2013. All six were remanded in custody by Recorder Mr Shamim Qureshi and committed straight to Birmingham Crown court for a preliminary hearing on March 15. None entered a plea to the charges and all spoke only to confirm their names and addresses in the short hearings.

Campaigners Unite Against Secret Courts

An alliance of more than 100 human rights groups, legal experts and free press campaigners has called on MPs to vote against government plans for "secret courts" – branding them "a charter for cover-ups" that will seriously undermine the principles of British justice. In a letter to the Observer, the group says it is "deeply concerned" at the effects that the justice and security bill will have on "open and accessible justice" and insists that it threatens the right to a fair trial and the rule of law.

tence as a form of punishment. Even less would it be appropriate to impose an IPP to protect the interests of the public when it seems to us that, given that the offence was caused by the medical disorder, there is no justification for detaining this appellant once - assuming it ever occurs - the medical authorities take the view that he can properly be returned to the community and the public safety is fully protected. This is a decision, in our view, that should be left to the medical authorities rather than to the Parole Board. That is not to say that Dr Swinton's evidence at the time of the hearing before the judge may not have been correct. We do not have to determine that issue. We are satisfied that in the light of the material now before us, with all three doctors saying that it is in principle the satisfactory outcome and the appropriate outcome, that that is what we should do. As Mr George QC put it to us, the evidence overwhelmingly shows that this appellant is someone who is ill and requires treatment. He is not a criminal who requires punishment.

37. In those circumstances, therefore, we do substitute an order under section 37 with a restriction under section 41 for the IPP imposed by the judge. It is not therefore necessary to go on to consider the alternative ground relating to the minimum term. In those circumstances the appeal succeeds.

Gun Conviction Only Raises More Questions Over Mark Duggan's Death

'Police had a golden opportunity to remove an identified gunman and a firearm off of the streets but somehow managed not to do so', An investigation into two Hackney police officers shelved: *Stafford Scott, guardian.co.uk, Wednesday 27 February 2013*

Kevin Hutchinson-Foster, the man who had been found guilty after a retrial of supplying the firearm found at the scene of Mark Duggan's killing, was sentenced on Tuesday to 11 years' imprisonment. Hutchinson-Foster, who is currently serving a sentence for drug offences, was sentenced to seven years for supplying the gun to Duggan on the day of his death, 4 August 2011; and a further four years for two offences that happened just a week before, on 29 July, where he pleaded guilty to using the same firearm to "pistol whip" a man in a hairdresser's salon in Hackney, east London.

Unsurprisingly, the media focused on Hutchinson-Foster's conviction for supplying the gun to Duggan. Publicity over the trial has helped to implant firmly in the public's mind that Duggan was armed and dangerous when shot in Tottenham, north London, by Metropolitan police officers. But some important facts have escaped scrutiny. For we now know that Peter Osadebay, Hutchinson-Foster's pistol-whipping victim, immediately informed Hackney police after he had been assaulted. His allegation was supported by CCTV footage, which clearly shows Hutchinson-Foster with a firearm intimidating and then assaulting Osadebay.

I first became aware of this in late 2011 as a member of the community reference group when I met the Independent Police Complaints Commission for an update on its investigation into Duggan's death. It was the IPCC that discovered the forensic evidence that led to Hutchinson-Foster, whose fingerprints were found on the gun, along with Osadebay's DNA.

So it is now clear that the police had a golden opportunity to remove an identified gunman and a firearm off of the streets but somehow managed not to do so. And this is all the more shocking because the police have a special unit, Trident, established specifically to deal with gun crime in the black community. Given that Hutchinson-Foster was a black man brandishing a gun in broad daylight in Hackney, a Trident "hotspot" borough with a long history of gun and gang activity, it's remarkable if Osadebay's assault claim was not followed up.

In November 2011 the IPCC announced an investigation into two Hackney police officers. Yet

inadequate and recommended that the prison commission a new investigation into the allegations, taking account of the historical allegations against the officer. The Cell Sharing Risk Assessment (CSRA) should be used to assess the suitability of prisoners for cell sharing and protect prisoners from being placed with an unsuitable cell mate. It is vital that prisons ensure their risk assessment paperwork is kept up to date in order to maintain the safety of prisoners.

Case Study 4: In 2011, Mr E complained that he had been sexually assaulted in his category C prison by his cellmate, Mr F. Mr E said this could have been avoided as Mr F was known to have sexually assaulted previous cellmates and had moved wings due to these incidents. Mr E was moved cells after the allegations and a police investigation was carried out. The investigation found there was intelligence on Mr F's behaviour towards other prisoners while in previous prisons and at the current prison. The CSRA carried out on Mr F when he moved to the current prison failed to mention the previous intelligence reports about his behaviour towards other prisoners, and said that he had never shown anti-social behaviour, for example bullying or assault. He was assessed as being a low risk of harm to others and deemed suitable for multi-cell location.

The Prison Service has a duty of care to ensure the safety of all prisoners. Any allegations that a prisoner has assaulted or sexually assaulted other prisoners should be taken into account when considering whether it is appropriate for them to share a cell. In this case, there were numerous relevant security intelligence reports. Although these related to allegations rather than proven behaviour, they were sufficiently serious to make it clear that Mr F was not suitable to share a cell.

The complaint was upheld and the Ombudsman recommended that a formal apology be made to Mr E for being made to share a cell with Mr F and for the way his complaint was handled. The governor was also asked to formally remind his staff to take into account security intelligence when completing CSRAs.

1.3 Complaints of Discrimination Against Transgender Prisoners

The Ombudsman has investigated a number of complaints about discrimination experienced by transgender prisoners. This is coming to light more frequently now that gender reassignment is a protected characteristic under the Equality Act 2010, supported by a service users' guide produced by the Equality and Human Rights Commission"

Case Study 5: In 2011, Ms G, a transgender prisoner in a male prison, complained that the prison was not treating the transgender population respectfully and that there was a lack of engagement between the various departments at the prison on the issue. Her complaint also extended to how the prison was managing her specifically as a transsexual prisoner.

The Ombudsman found that the prison had been attempting to protect Ms G - whose behaviour was sexually promiscuous - but that it was not adhering to Prison Service policy on the care and management of transsexual prisoners set out in Prison Service Instruction (PSI) 07/2011. The PSI included allowing the prisoner to live in their chosen gender, referring to them by their chosen gender identity and allowing them to purchase clothes for their chosen gender, as well as being able to wear them.

The Ombudsman upheld the complaint and recommended that training be developed for staff on the care and management of transgender prisoners.

2. PPO Fatal Incident Investigations

In the last five years the PPO investigated six fatal incidents where sexual issues were found to have contributed in some way to the prisoner's death. Although given the hidden nature of relationships and sexual issues in prison, this figure is probably an under-representation.

While this is a very small proportion of all cases investigated, five of these were deaths of women, meaning 20% of all self-inflicted female deaths from 2007-2012 involved this issue.

Some general themes emerged in all the cases regarding poor record keeping and information sharing which impacted on the safety of the individual. The more specific issue to emerge was the challenge posed in the prison context of intimate relationships among women prisoners which fail or involve abuse.

This subject was touched on in a PPO thematic review of deaths in custody related to bullying in October 20115. This identified that intimate relationships between female prisoners, which can obviously be a source of comfort, companionship and commitment, can also be a source of jealousy, abuse and bullying. The report recommended that staff should be more aware of, and if necessary, challenge abusive relationships between prisoners and ensure they record and report all incidents of violence.

2.1 Female Relationships

Of the six fatal incident investigations with sexual aspects, five were female prisoners who all experienced relationship problems with a fellow prisoner prior to their death. Issues of concern, including bullying and abuse, were found in the relationships, but prison staff were often unaware of the problem or did not share the information if they were aware or received it too late to act upon it.

Case Study 6 : The case involved the self-inflicted death of Ms H in 2007. Throughout her time in custody Ms H had had intimate relationships with other prisoners. These relationships seemed to have been a major element in Ms H's distress and she had threatened to take her life on a previous occasion as a result of a relationship problem with another prisoner.

The prison appeared to have had little or no written information about relationships between prisoners. According to other prisoners, the usual prison response on discovering intimate relationships was to separate the women from each other. Whether this perception was accurate or not, the inevitable effect was to discourage prisoners from being open about their relationships. As a result, when a relationship comes to an end, the impact may not be apparent to staff and they will not be in a position to offer help or support or be able to identify any related bullying.

Seven recommendations were made to the prison in relation to safer cells, mental health support and staff training. A national recommendation was made to provide training for violence reduction co-ordinators on how to identify and manage bullying caused as a result of relationships between prisoners.

2.2 Sexual murder

Although murder is very rare in prison, this case highlights the wider issues around information sharing and keeping records up to date. This is a vital task in the secure estate which ensures that prisoners are correctly risk assessed and the prison population is kept safe.

Case Study 7: In 2008, Mr I was murdered by his cell mate Mr J. Mr J had allegedly sexually assaulted prisoners on two previous occasions. He had been convicted of the rape of an adult male two years before Mr I's death. There were concerns that Mr J was 'grooming' other prisoners. He was the subject of three Violence Reduction Strategy documents, due to his inappropriate behaviour to other prisoners, the last of which was open at the time he murdered Mr I. Given the security information available in Mr J's files, he should have been considered a risk to other prisoners and not been sharing a cell. The lack of action on these indicators of risk meant that there was a failure to protect Mr I.

One national recommendation was made in relation to the appropriate use and regular

expressed the view that the appropriate order would not be a section 37 order at all, but one made under section 45A of the Mental Health Act. He gave evidence before us today and explained why he had come to that view. His objection was not based on the nature of the treatment, or the requirement for the treatment, but on the potential wider consequences if a section 37 order with restrictions were to be imposed.

29. As we understand the point, it is this. The appellant is an illegal immigrant. In order to be discharged from hospital he would have to undergo a period of controlled supervision. This would be in appropriate accommodation. Dr Swinton tells us that this is not an option open to an illegal immigrant like the appellant. Thus he cannot be discharged into the community because he cannot undertake the necessary conditioning which would satisfy the hospital that he was safe to be left in the community on his own. As a consequence he has to remain in hospital and he will take up a bed, apparently permanently. This is damaging to the wider public interest. If a section 45A order were made, then although the appellant would receive precisely the same treatment under a section 47 transfer as he currently does, a discharge can be effected by sending the appellant back to prison where the relevant supervision can be provided.

30. If Dr Swinton is right about this - and we have no reason to suppose he is not - it is indeed a most unhappy state of affairs and the authorities need to look at it very speedily. But it seems to us that we cannot properly allow such considerations to play a part in determining the proper disposal of this case. The questions we have to ask in the light of this new material are first, whether the evidence should be admitted as fresh evidence; and second, whether it ought to cause us to substitute a hospital order with restrictions.

31. Both the appellant and the prosecution agree that in the light of the evidence now before us, that would be the appropriate course to take. But of course, whatever the parties may think, it is ultimately for the court to be satisfied that it is a proper order to make.

32. We have in fact considered four cases which are, in some respects, analogous to this one. These are the cases of Beatty [2006], Hempston [2006],R v O [2011] and Teasdale [2012]. It is not necessary to go into the detail of those cases. Suffice it to say that a feature in all of them is that the sentencing judge, for one reason or another, never was in a position to impose a hospital order. The relevant material to enable that step to be taken was not available either because the issue was never addressed, or the reports had not been provided, or in one case, Teasdale, it was because the defendant by his own decision had not co-operated and therefore the reports could not be produced. In those cases it was in the interests of the defendant and the public alike that the fresh evidence be adduced from the experts and that a hospital order should be made.

33. If, however, a judge has made a determination not to make a hospital order when he was empowered to do so, it plainly is not legitimate for an appellant to obtain two further reports from two further expert medical witnesses and to seek to rely on those to secure a change in the sentencing outcome.

34. In this case, as we have indicated, the reason the judge did not make this order was that he was not empowered to do so because the conditions of section 37 were not met. In those circumstances the judge did not go further and express any view as to whether he would have made the order had two psychiatrists supported it.

35. We now have to consider whether it would be an appropriate order to make. It is material, in our view, that the appellant was, in effect, a man of good character. It is plain that he would not have committed this offence but for his mental disorder. Nobody has suggested otherwise.

36. We think that in those circumstances it would not be appropriate to impose a sen-

he found the report to be most unsatisfactory. Accordingly he concluded that he could not rely on that report and therefore the conditions for making the order were not present since there were not two doctors in favour.

22. In view of that, on 16 August 2011 the appellant was sentenced to a period of imprisonment for public protection under section 225 of the Criminal Justice Act 2003. The judge determined that the appropriate minimum term, without taking account of the guilty plea, was one of 12 years. He gave a reduction of one-sixth for the plea, reducing the period to ten years. From that it was necessary to deduct also the period spent in hospital and the period spent on remand which left a period of 5 years and 3 months.

23. Leave to appeal that sentence was granted by the single judge on the basis at that time that the minimum term was too high.

24. On 26 February 2012 the case was heard before this court, (Rix LJ and Griffith Williams and Haddon-Cave JJ) and the minimum term was reduced from five years and three months to one of three years and three months. The court considered that the starting point of 12 years was appropriate but the judge had wrongly given only one-sixth deduction for the guilty plea in the belief that a manslaughter of this kind had to be treated in the same way as murder, whereas he ought to have given the full one-third deduction.

25. At the hearing counsel had indicated to the court that he would in principle like to raise an additional ground, namely that the judge may have been wrong not to make a hospital order under section 37 with 41 of the Mental Health Act. The Court of Appeal recognised that it was not possible for it to deal with that argument. It only had one medical report before it in any event and have there have to be two before the order can be made. In the event, updated orders needed to be prepared. The appeal was adjourned to enable the appellant to get his tackle in order. The court made no formal order but give directions as to the service of fresh evidence. It later transpired that in fact the court has no power to determine any part of an appeal and adjourn the remainder.

26. No doubt one of the factors which caused counsel to consider mounting an appeal along these lines was that not long after the appellant's return to prison he was in fact transferred to hospital pursuant to section 47 of the Mental Health Act. It seems that the stress of prison life, coupled with the fact that he would not take his medicine, may have led to his deterioration. So it was that two doctors were instructed by the appellant. One, Dr Mendelson, in a report dated 28 June 2012, expressed the view that the appellant suffered from schizophrenia and that the illness was of such a nature and degree as to warrant his detention in hospital with restrictions under sections 37 and 41. It was his view that that was in fact the position at the time when the sentence was considered by the judge. Dr Easton reached the same conclusion in a report dated a month or so later. The appellant then lodged amended grounds of appeal submitting that the hospital order was the appropriate disposal of the case.

27. Dr Mendelson was under the impression that the treating doctor, Dr Swinton, was now in favour of a section 37 order combined with a 41 restriction. Dr Swinton was accordingly instructed by the Crown to provide evidence. In fact that is not quite his position. He produced a report in the form of a letter on 10 October 2012 where he indicated that although he did not resile from his previous view that a section 37 order was not appropriate at the time when the judge sentenced the appellant, nonetheless, he accepted that if the appellant were to be sentenced today then the conditions were satisfied.

28. In a later report, dated 30 November, he somewhat modified that position. He

review of CSRAs, to ensure they effectively identify prisoners' risks to others. Other recommendations were made in relation to improving information sharing, risk assessments, and keeping abreast of the police investigations at the two prisons involved.

Lessons to be Learned

1. Research should be carried out by the National Offender Management Service (NOMS) into the experience of gay, lesbian and bisexual prisoners.

The Ombudsman has found that there is a lack of information on the treatment of gay, lesbian and bisexual prisoners. In order to ensure that all prisoners are treated equally, the experiences of these groups should be collected.

2. Allegations of sexual abuse should be taken seriously, police investigations should be facilitated and internal prison investigations should be thorough and consider a wide range of evidence (as sexual abuse seldom takes place in front of witnesses).

The Ombudsman has found that some abusive sexual behaviours are not always taken sufficiently seriously and the quality of internal investigations is variable. These allegations may also raise serious criminal matters and the prison's PIO should be informed in a timely manner and a police investigation facilitated and, if necessary, encouraged.

3. Searches, particularly strip searching, should be carried out in line with National Security Framework requirements.

Strip searches, particularly full searches, can be highly intrusive and prison staff should ensure they follow NOMS policy to ensure humiliation of prisoners is minimised.

4. Prisons need to ensure they conform with the Equalities Act 2010, specifically in relation to transgender prisoners (as set out in PSI 07/2011).

The law is clear that in a single sex service environment, a transgender person should be treated according to the sex they identify with and be permitted to live permanently in their acquired gender, with access to appropriate clothes and risks to them properly managed. This poses significant challenges to prisons, but a challenge that needs to be met.

5. Staff should identify and challenge abusive intimate relationships, share appropriate information, proactively respond to bullying and support prisoners.

Intimate relationships, particularly among female prisoners, have been highlighted as a contributing factor in a number of fatal incident investigations. These illustrate the need for staff to be clear on when and how to challenge inappropriate relationships and to record and share relevant information. This stance should be reflected in the safer custody and prison decency policies.

Justice for the Craigavon Two

The Committee on the Administration of Justice (CAJ) met with a delegation from the Justice for the Craigavon Two campaign group recently regarding the convictions and pending appeals of Brendan McConville and John Paul Wootton. The Group set out its concerns regarding the original non jury trial, talking extensively about the evidence and witness testimony and why the group believe the case to be a miscarriage of justice.

The CAJ asked what role they could provide, The JFTC2 group then asked would CAJ be willing to provide independent oversight of the appeal process, following a briefing by both Brendan and John Paul's legal teams the CAJ agreed to send observers to the appeal which is scheduled to start on April 29th.

Brian Gormally the director of CAJ said the CAJ had been monitoring the case among others and had concerns, enough to engage our attention as a human rights organisation

although it would not pre-judge the outcome. He is quoted as saying "The first aspect is obviously it was a no jury trial we are always concerned about no jury trials. Another aspect was involvement of a clandestine military surveillance unit and we are not sure if it was covered by the terms of deployment of the British army here". CAJ is also concerned about issues arising from the use of a British army tracking device placed in John Paul Wootton's car. "it appears that was interfered with and wiped by the army,"

Justice for the Craigavon Two are pleased with the outcome of the meeting and the fact CAJ has committed to observing the trial, before Christmas Fianna Fail TD Eamon O'Cuiv also stated publicly that due to concerns he would be attending the appeal as an independent observer.

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Northern Ireland - The Policing You Don't See *Committee on the Administration of Justice*

Covert Policing And The Accountability Gap - Five years on from the transfer of 'national security' primacy to MI5. The Committee on the Administration of Justice has published a major report on covert policing after a research project lasting a year. The report develops a human rights based framework from international standards and the Patten Report and uses it to analyse past and present practice.

The research reflects on the evidence of the involvement of police informants in serious criminality uncovered in investigations into RUC Special Branch and the evidence that MI5 gave it strategic support. Such investigations and the Patten Report made recommendations to ensure covert policing became accountable and operated within the law. However, since primacy in 'national security' policing was given to MI5 five years ago (2007), the research finds that there is a growing "accountability gap" over a large part of policing. It reports that the UK level oversight of MI5 is plainly inadequate and that the local mechanisms that hold the PSNI to account are evaded by the Security Service. It argues that this situation falls woefully short of international standards and has the capacity to undermine confidence in policing as a whole.

Brian Gormally, Director of CAJ said: "There is overwhelming evidence from official inquiries that there were many abuses in covert policing in the past. These did immense damage to the rule of law and arguably prolonged the conflict. Since the peace agreement there have been huge reforms to the police service designed to prevent such abuses ever happening again.

"Unfortunately, the secret Security Service – implicated in past abuses – has not been so reformed and has been put in charge of a highly important area of mainstream policing. MI5 has primacy in covert 'national security' policing and gives 'strategic direction' to the PSNI in this area.

"The Patten report recommended the downsizing, deinstitutionalisation and integration of Special Branch within the PSNI and the oversight of the PSNI by an independent board rather than a government minister. However, since the St Andrews Agreement perhaps the most sensitive area of policing is being run by a parallel police force – 'a force outside a force' – answerable to 'direct rule' Ministers and subject to separate and ineffective oversight arrangements. If the Chief Constable's assertion at the time of St Andrews that MI5 would focus only on dissident republicans remains true, the practical impact of this is that two different covert policing regimes, in terms of operational techniques, standards and oversight, are now in place for republicans and loyalists.

"Our research shows that the UK level oversight of MI5 is ineffective. Limited additional accountably measures were promised in the St Andrews Agreement but some of the most significant commitments, to publish policy frameworks, have not been honoured. Related policy documents which have been released to CAJ under Freedom of Information rather than

Reference case provides an example of that. In those circumstances the court may make an order under section 45A of the 1983 Act the effect of which is to subject the defendant to both the custodial and the hospital order regimes. Section 45A(1) is as follows:

"This section applies where, in the case of a person convicted before the Crown Court of an offence the sentence for which is not fixed by law --

(a) the conditions mentioned in subsection (2) below are fulfilled; and

(b) the court considers making a hospital order in respect of him before deciding to impose a sentence of imprisonment ('the relevant sentence') in respect of the offence."

13. The conditions referred to in subsection (2) are precisely the same as those referred to in section 37(2)(a)(i).

14. Subsection 3 then provides:

15. "the court may give both of the following directions, namely-

(a) a direction that instead of being removed to or detained in a prison, the offender be removed to and detained such hospital as may be specified in the direction (in this Act referred to as a "hospital direction"); and (b) a direction that the offender be subject to the special restrictions set out in section 41 above (in this Act referred to as a "limitation direction").

16. The advantage of an order under this section, therefore, is that it provides the flexibility for the court both to impose a custodial sentence where it considers that such a sentence is necessary, whether determinate or indeterminate, and at same time to secure the necessary medical treatment without delay as if a section 37 order coupled with restrictions were being imposed. In the case of a dangerous offender he will not be released until he ceases to be a risk to the public both from crime and his mental illness.

17. We turn to the circumstances of the particular case. On 14 December 2004 the appellant, who was 19 years old at the time, killed Jeanette Hullah by means of strangulation in the presence of her baby. At the time of her death Mrs Hullah lived with her husband at an address in Cheetham Hill in Manchester and the appellant was their lodger. The appellant had been acting very strangely in the days before he killed the victim. He had been following her around and he was failing to go to work. He was an undiagnosed paranoid schizophrenic at the time. He said he believed that the deceased was having a sexual relationship with her 18-month old son.

18. When the matter was first listed for trial the appellant was unfit to plea. On 9 May 2008 a jury found that he had done the act that caused the death in this case. At that point he was sentenced to a hospital order under section 37 with a section 41 restriction.

19. He then spent three and a half years in a secure hospital after which he was considered by the responsible medical officer to have recovered sufficiently to be fit to plead. On 5 July 2011 he pleaded guilty to manslaughter by reason of diminished responsibility having in fact been indicted for murder.

20. On 11 August 2011 the learned judge, His Honour Judge Goldstone, heard evidence from three psychiatrists as to whether a hospital order was an option available to the court. They all considered that the appellant suffered from paranoid schizophrenia, but an issue arose whether, on the language of section 37, the conditions for making the order were satisfied.

21. We have only this afternoon, in fact during the course of this hearing, received the transcript of the observations of the judge. Suffice it to say that whereas one doctor was satisfied that the conditions were satisfied, another, Dr Mark Swinton, who was the doctor at the time treating the appellant, did not consider that the illness was of a nature or a degree to warrant a section 37 order. The judge considered the report of a third doctor. For various reasons

before the court before the restriction order can be imposed.

8. Sometimes a court may consider that having regard to the nature of the offence and the character and antecedents of the defendant, the section 37 order is not suitable even for somebody who is suffering from a mental disorder and even though the conditions are in principle applicable. It may be, for example, that the court considers that there is an element of culpability which requires punishment. A section 37 order would then be inappropriate because it could lead to a medical discharge at some point prior to the appropriate sentence having been served.

9. Alternatively, the court may take the view that there are concerns about the risks of serious harm to the public even if the defendant is successfully treated for his mental illness. An obvious example may be where a mental disorder does not arise until after the offence has been committed. We were referred to the case of Jenkin [2012] EWCA Crim 2557 which provides an example of such a case. In those circumstances the court may consider that it is necessary to pass an indeterminate sentence, be it life imprisonment or imprisonment for public protection, notwithstanding the mental disorder.

10. The distinctions between an IPP sentence and a section 37/41 hospital order regime were succinctly summarised by the Vice President, Hughes LJ, in the case of Attorney General's Reference No 54 of 2011 [2011] EWCA Crim 2276 where at paragraph 17 he said this: "17. It is true that the detention for public protection regime and the section 37/41 hospital order regime have features in common. Under both regimes discharge on release is discretionary and in the hands of the Secretary of State, that is to say the Ministry of Justice. In both cases regard is had in making the discretionary decision whether or not to release to danger. In neither case is there any absolute right to release. Secondly, release under both regimes is conditional and the defendant is subject to recall. That said, there is an absolutely crucial difference between the two forms of regime. Under an order for detention for public protection release is dependent upon the responsible authority being satisfied that the defendant is no longer a danger to the public for any reason and principally not at risk of relapsing into dangerous crime.

Under the hospital order regime release is dependent upon the responsible authority being satisfied that the defendant no longer presents any danger which arises from his medical condition. Similarly, and critically, release under the detention for public protection regime is on licence and the licence can be revoked if the defendant shows that he remains a danger to the public from crime. It is possible and indeed inevitable that the licence conditions will be designed, among other things, to prevent association with dangerous criminals. Under the hospital order regime, recall is available but only if the defendant's medical condition relapses. Simple crime does not trigger a recall under the hospital order regime."11. Where a custodial sentence is imposed on someone with a mental illness, it does not mean that the defendant will be without treatment. There is a power under section 47 of the 1983 Act for the Secretary of State by executive order to transfer the prisoner from prison to hospital so as to secure the necessary medical treatment. If and when he is discharged from hospital, however, he will then return to prison where that is necessary for him to complete the sentence.

12. A disadvantage with imposing a sentence of imprisonment and relying upon the exercise of executive discretion to transfer under section 47 is that there may be a time lag before that can be completed, and there will be circumstances where the delay in treatment could be detrimental both to the defendant and indeed the general public. The Attorney General

being safeguards actually appear designed to limit accountability. This includes an NIO held document which contains a list of types of information the Chief Constable should not tell the Policing Board, even in confidential sessions. The documents we have discovered show an obsession with keeping anything with the label 'national security' secret from our devolved institutions and a total indifference to accountability.

"Whilst the Prime Minister after St Andrews gave assurances that PSNI officers working with MI5 would be 'solely accountable' to the Chief Constable and Policing Board, this is contradicted by these documents which stipulate that PSNI officers, up to and including the Chief Constable, working on national security matters are not accountable to the Policing Board but rather to the NIO. MI5 – secret, unreformed and unaccountable – is now running one of the most sensitive areas of policing. This is a disaster waiting to happen to confidence in the rule of law and our peace settlement. CAJ wants a full, independent review with the aim of bringing covert policing here in line with human rights standards."

Prisons Must Conduct Adjudications Correctly

Prisons must ensure that adjudications are carried out correctly, otherwise prisoners who have broken the rules may go unpunished while other prisoners may be punished unfairly, said Nigel Newcomen, the Prisons and Probation Ombudsman (PPO). Publishing a report into complaints about adjudications, the internal disciplinary hearings conducted against prisoners.

Adjudication decisions can have substantial implications on the life of a prisoner: restrictions may be imposed, money or access to activities removed and release decisions affected. It is, therefore, important that adjudications are conducted correctly, that adjudicators hear sufficient evidence to find the charge proved beyond reasonable doubt, and that punishments imposed are fair and proportionate."

The PPO received 1042 complaints from prisoners about adjudications between April 2009 and March 2012; nearly three quarters were eligible for investigation. Eligible complaints were received from prisoners in 111 establishments. The five establishments with the highest rate of eligible adjudications complaints were all high security prisons, HMPs, Whitemoor, Full Sutton, Long Lartin, Frankland and Wakefield.

There was also a disproportionate representation of black prisoners, who constituted 29% of eligible adjudication complainants in comparison to 16% of national proven adjudications.

Between April 2011 and March 2012, 269 eligible adjudication complaints were received by the PPO. This was the second most common complaint type after property related complaints.

21% of eligible adjudication complaints were upheld. This was slightly less than for all complaints (25%) received by the PPO, but still constitutes a very large proportion of cases in which significant flaws were identified in the Prison Service's internal disciplinary system.

The report highlights steps adjudicators and establishments can take to deliver effective adjudications: - ensure that guilt is fully established through thorough investigation of the facts of the case. Even in cases where the prisoner pleads guilty, the onus remains on the adjudicator to prove the charge beyond a reasonable doubt; - ensure the correct charge is laid and, where the charge needs to be altered, that this is done promptly; - accurately record the details of the hearing; - comply with Prison Service Instruction (PSI) guidance around witnesses, ensuring they are called where relevant; - provide appropriate information and support to prisoners to access legal advice or representation when requested; and - ensure that punishments are fair, safe and proportionate to the charge.

A copy of the report can be found on http://www.ppo.gov.uk/

Sefton Youth Offending Team - Need a Kick up the Arse

An inspection led by HMI Probation: Youth offending work in Sefton still needed to improve, said Liz Calderbank, Chief Inspector of Probation, publishing the report of a recent joint inspection of the work of Sefton Youth Offending Team (YOT). This joint inspection of youth offending work in Sefton is one of a small number of full joint inspections undertaken by HM Inspectorate of Probation with colleagues from the criminal justice, social care, education and health inspectorates.

Inspectors focus on five key areas: reducing the likelihood of reoffending, protecting the public, protecting children and young people, ensuring that the sentence is served and governance arrangements. This inspection followed a critical Core Case Inspection of the YOT, undertaken by HMI Probation in 2009.

Inspectors were concerned to find that, overall:

- work to reduce reoffending was unsatisfactory, due largely to deficiencies in the assessment which looks at why a young person had committed an offence at a particular point in time. The delivery of interventions was a strength, but was undermined where the assessment had not identified the correct work to be done or where work was not undertaken in the right order;
- work to protect the public and both actual and potential victims was poor. This was mainly due to inadequate assessment and planning;
- work to protect children and young people and make them safer was unsatisfactory. Case managers knew details about children and the events in their lives but did not always recognise that these facts had a bearing on their vulnerability, ie, the risk that they may be harmed, either from others or from their own behaviour; and
- the governance arrangements were unsatisfactory. Safeguarding needed to be embedded through both strategic and operational management. Protocols and procedures were not sufficiently robust and the lack of specific training and experience was reflected in case management. However, the YOT Manager and previous and current Chairs of the Management Board were working hard to re-establish the Board, while operational managers were working hard to support staff and improve practice.

The new inspection programme of youth offending work, based on a risk-proportionate approach, was agreed by Ministers in December 2011. Under this programme, full joint inspections are targeted primarily on areas where there are significant concerns about the effectiveness of youth offending work, based primarily on the three national youth justice indicators, supplemented by other measures, such as recent inspections.

Occasional inspections are undertaken in areas that report high performance, in order to maintain a benchmark for good practice. In Sefton, performance had been declining on the national youth justice outcome custody measure. Inspectors also wished to establish if improved performance after Sefton's last inspection in 2009 had been sustained.

These inspections focus on issues not subject to other forms of external scrutiny: work to reduce the likelihood of offending and re-offending by young people; the management and minimisation of the risk of harm that a young person may pose to other people; safeguarding young people from harm (from their own actions and others); and work to ensure they serve their sentence.

The inspections are led by HMI Probation, with participation by HMI Prisons, Ofsted, CQC and HMI Constabulary (and in Wales by the corresponding Welsh inspectorates,

Healthcare Inspectorate Wales, Estyn and Care and Social Services Inspectorate Wales).

R v Ahmed (Imtiaz)

1. Lord Justice Elias: This is an appeal against sentence with the encouragement of this court in circumstances which we describe in a moment. The principal ground now being advanced is that in the light of evidence now available, it is clear that the appropriate way in which this appellant ought to have been sentenced was by way of a hospital order with restrictions under section 37 read with section 41 of the Mental Health Act 1983, whereas the sentencing judge imposed a sentence of imprisonment for public protection.

2. Before considering the detail of the case it is helpful in order to understand the arguments briefly to summarise the relevant principles.

3. In some cases where a defendant is convicted of a criminal offence other than one for which the sentence is fixed by law, the court may, instead of sending him to prison, authorise that he be detained in hospital for treatment. The power is conferred by section 37 of the Mental Health Act 1983. Section 37(1) is as follows:

"Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law, or is convicted by a magistrates' court of an offence punishable on summary conviction with imprisonment, and the conditions mentioned in subsection (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order or, as the case may be, place him under the guardianship of a local social services authority or of such other person approved by a local social services authority as may be so specified."

4. The conditions referred to in that subsection relevant to this appeal are specified in subsection 37(2)(a)(i) and 37(2)(b):"(2) The conditions referred to in subsection (1) above are that

(a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from a mental disorder and that either --

(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him;... and

(b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section."

5. Where it appears to the court, as it almost inevitably will, that the public may be at risk of serious harm if the defendant is released from hospital until the mental disorder is fully under control, a restriction order is combined with a section 37 order. The circumstances in which that order may be imposed is set out in section 41(1) which is as follows:"Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section;… and an order under this section shall be known as 'a restriction order'."6. The practical effect of this order is that the defendant will not be released until the relevant medical authorities are satisfied that he no longer presents a danger to the public from his medical condition.

7. Section 41(2) requires that at least one medical practitioner must give evidence orally