

### John Bowden 40 Years in Prison, 40 Years of Struggle

Connor Woodman, Novara Media: John Bowden, a long-time prison organiser and member of the Prisoner Solidarity Network, was recently released after 40 years of incarceration. While all those who were sent down with him were released after 20 years, Bowden was kept back as punishment for his anti-prison organising. Connor Woodman sat down with Bowden to discuss the prison system, including the dynamics of struggle between guards and prisoners, the role of gangs in today's prisons, and his involvement in an uprising in one of the most repressive segregation units in the UK.

*CW: Based on your 40 years in the UK prison system, what would you say the function and purpose of prison is?* JB: If there is a relationship between prisons and public protection, it's very much an inverse one. Prisons actually create and produce alienated and de-socialised individuals. We're dealing with people that already exist on the margins of society and have for most of their lives. To put them into a total institution, to disempower them, brutalise them if necessary – all that effectively does is further alienate and isolate them. That's why you have such a high rate of reoffending. People who spend long periods of time in prison encounter incredible difficulties trying to adapt to the society they then emerge into. Prison doesn't rehabilitate anybody in any sense; it further damages them. The fundamental purpose of prison is social control. The social composition of the prison population illustrates that perfectly: mostly poor, disproportionately young Black people. Those who really don't have a place in society are disappeared into the prison system.

*CW: You were a committed prison organiser. What were the core principles that guided your organising?* JB: I committed and devoted my life not just to the personal struggle against brutality but to a wider struggle against the prison system generally, and spent almost 40 years trying to organise and mobilise prisoners. Our aim was to collectively empower prisoners. By collectively empowering them we could shift the balance between us and those with the keys. You had to see where the balance of power lay, not just with the screws but between prisoners themselves, and try and change that incrementally by creating a common purpose or consciousness amongst as many prisoners as you could. You have to establish the roots of organisation amongst the prisoners before you can confront the system itself.

*CW: What were the key tactics of struggle you would use in prison?* JB: Once you had successfully created a structure of organisation and solidarity, there were many issues you could focus on: the brutalisation of particular prisoners, the maltreatment of prisoners in segregation, the behaviour of particular prison officers. The tactics we would deploy would include sit-down protests, refusal to lock-up, refusal to work, food strikes. Even in places like close supervision centres, where you're in virtual solitary confinement, if you're able to communicate with those around you – for example through the cell windows – you could organise collective protests. Organisation even in the most oppressive situations was possible.

*CW: What was the most successful prison uprising you were involved in?* JB: The one that gave me the greatest inspiration and faith in struggle occurred in probably the worst segregation unit in the UK: Wakefield segregation unit, or F-Wing. During the seventies they set up this control unit in Wakefield Prison, based on the principles of behaviour modification, Pavlovian methods. It was absolutely brutal. A lot of the lessons they learnt from that were

applied in Northern Ireland in the H-Blocks – it was very much an experiment in behaviour modification. They would use F-Wing as a national facility for the most 'difficult' or 'unmanageable' prisoners in the system. People were held in total and absolute isolation and were frequently brutalised by the staff. There was a high level of suicide, mental illness etc.

I took a prison governor hostage at Parkhurst Prison in the early eighties, and after that I was sent to Wakefield F-Wing. I was placed in a subterranean cage. It was an atmosphere of total and absolute control and terror. When I got there, they'd got so confident of being able to control and break so-called prison subversives that it was quite overpopulated by Irish Republican prisoners and others. I was able to open up lines of communication with them, and we started to withdraw our cooperation, engage in dirty protests, wreck the cells etc. And the whole place came together in absolute and total unity. For two days, we had more or less control of it. It was unprecedented, they shut F-Wing Wakefield for about two months and ghosted us all elsewhere. Despite the fact we were in individual cells, there was this great feeling of togetherness, that we had won. The inspiring thing about that was, even in a place of total repression, where the system appeared to have absolute control, we won. And if it could be achieved there, it could be achieved anywhere. That was the most inspiring experience of my life in prison. It gave me great hope and faith in the collective power, not just of prisoners, but of poor and oppressed people everywhere. They were capable of defeating the system, providing they saw their struggle as one.

*CW: How does the prison system try and prevent such uprisings?* JB: The 1990 Strangeways Uprising was incredibly positive. It really terrified the system, because they realised that prison organisation and collective rebellion was a possibility. In response they introduced the close supervision centre system, whereby those perceived to be trouble-makers and organisers are placed in total isolation. They introduced the incentives and enhanced privileges scheme, which is a kind of class system among the prisoners. If you refuse to work, you are basically locked up with nothing. If you agree to work and cooperate, your 'privilege' status is increased. State-hired psychiatrists were always used against prisoners, particularly from the fifties to the eighties. Psychiatrists would lend their blessing to the brutalisation of prisoners, usually in the form of the 'liquid cosh': the unlawful sedation of difficult prisoners. Later you had the growth of psychology in the prison system. In order for prisoners to achieve parole or release, they had to accept that they suffered from a personality disorder and accept that all the problems were within their own character. They had to do behaviour modification courses, and if they didn't, they wouldn't receive parole, and if they were life sentence prisoners they would die in prison.

*CW: How did the prison system relate to the emergence of prison gangs?* JB: I escaped from prison in 1992, and was eventually recaptured in Scotland. When I went back to Whitemoor Prison years later I was absolutely shocked by the changes in prisoner culture. Divisions among prisoners had grown, gang culture had really grown, drug culture had increased dramatically, and it was clear that the staff, the screws, were using that as a means of control. They'd almost subcontract out the discipline and control function to the most powerful gangs on the wing. When I went to Swaleside Prison, for example, there was a mentally ill prisoner next door to me. He was banging on his door all night and a gang of screws went in and badly beat him up. The next morning a group of us said to everybody else on the wing, 'we can't allow this. They can come in at any time day or night and physically assault people, we need to protest'. So we tried to organise a stay-out, to refuse to lock-up at the end of the day. Initially about 70-80% of the wing agreed with us, so there was a real feeling of solidarity. Then I noticed the screws approaching and talking to certain members of the gangs that were selling most of the drugs on the wing. And I then watched those gang members going around various cells talking to people, and by 9 o'clock that night, when they were trying to lock us up and

we were going to stand out, there were just five of us left.

*CW: Marshall "Eddie" Conway, a Black Panther and prison organiser who was imprisoned for about as long as you, writes that he managed to find a degree of mutual understanding and respect with the gangs within some prisons in the US. Did you ever manage something similar?*

JB: To some degree. When I was in Swaleside I interacted a lot with the young Black gangs and I tried to encourage them to see a common struggle and attempted to organise a Black prisoners representative group. But the screws became aware of what I was doing, and they would approach leading gang members in the wing and encourage them to instruct the younger Black prisoners to 'come out of my influence'. Sometimes it would even assume the form of blackmail with drug debts etc. So when trying to organise – although there's always a potential for organisation, particularly among young Black prisoners – you're not just up against the screws and the governors and the system, you're up against people I would describe as kapos, in the sense that the system is prepared to turn a blind eye to their drug dealing and so on provided they maintain order on the wing. And that was the hardest part of my time in prison.

*CW: A debate occasionally breaks out on the British left, most recently within the Corbyn project, over the role of prison guards in the labour movement. What do you think of the Prison Officers' Association (POA)?* JB: One of the things that really struck me during my imprisonment was how far more psychologically damaged prison officers are by prisons than prisoners. And the reason for this is that the system hands absolute power and control over prisoners to prison officers. Obviously this results in abuse, but something more disturbing and sinister happens. In order to save their consciences, most prison officers begin to see prisoners as almost subhuman. So brutalising them, beating them up, locking them up in solitary confinement is okay, because they're not really human beings. The prison officers themselves then become dehumanised.

I remember I was in a prison van approaching Wandsworth Prison – it was an awful place, they called it the 'hate factory' – and like a lot of jails then, it was controlled and run by the POA. As the van drew up, I was watching the prison officers come on duty. They were there, heads down, scurrying through the gates, and as these guys entered the prison a sort of metamorphosis overcame them. The swagger would start, like they were mini-dictators. Prison officers develop a real far-right, neo-Nazi culture. During the seventies and eighties, 70% of prison officers at Strangeways Prison – POA members – were active members of the National Front. I remember during the eighties they had to be ordered not to wear National Front uniform, so they just put on a little badge with the union jack. You can imagine the treatment of particularly ethnic minority and Black prisoners in those days. We need to look at the history of the prison officer movement, and how it has been used, for example, against imprisoned trade unionists. I was in prison in 1984 during the miners' strike. There were a lot of miners locked up and they were brutalised in some prisons, particularly jails like Manchester and Wakefield. Some prison officers would come in guided by pretty noble inspirations and aspirations. But they could be singled out after a while, and if they didn't jump in line, they were victimised and driven out. I saw terrible examples of that: some prison officers beaten up by their colleagues, some having their cars set on fire in the prison car park. It was expected that they would keep their mouths shut, even if they witnessed actual brutality or even murder, as happened in Wormwood Scrubs segregation unit during the eighties and nineties, where prisoners were being regularly murdered. When there was a police investigation into it, the police claimed they came up against a complete wall of silence from all prison staff, including prison doctors, psychologists, social workers and chaplains. And that is why the brutality and the

murder was allowed to continue for so long. I do not understand how the Labour party or the trade union movement would embrace them [the POA] as fellow workers or comrades.

*CW: Were there any groups on the British left who were supportive of your organising in prison?* JB: When I tried to make contact with Marxist-Leninist groups, I was met by complete disinterest, or even hostility. We in prison were received as the 'lumpen-proletariat', and they thought prisoners would have to exist regardless of what sort of society we were living under. The only exception to that was the Revolutionary Communist Group. I found that anarchist groups, the Anarchist Black Cross in particular, were far more understanding and knowledgeable about the prison struggle than traditional Marxists.

*CW: How important for you was solidarity from groups outside the prison?* JB: Very important. We organised a massive work strike in Whitemoor Prison in 1991. We were all totally locked down, and I managed to get word out to a friend involved in the Anarchist Black Cross. They organised pickets of the Home Office, Prison Department headquarters and Whitemoor Prison. Once the system became aware that we had the support of outside groups and organisations, that empowered us immeasurably.

*CW: My experience of the prison abolition groups over the past few years has been that there generally aren't that many prisoners or ex-prisoners involved in them. That is a problem in itself. It's critically important that prisoners have some central input. The thing to do is to try to build a network of support within the prison system itself. Open up lines of communication with prisoners. It is difficult. At the moment you've got this massive lockdown of prisons, and that isn't going to ease, regardless of what happens with this virus. The POA have made it clear that they want prisoners locked down permanently, and they've been campaigning for this lockdown for at least the last ten years. But solidarity can be achieved.*

*CW: What opportunities are there for prison organising today?* JB: I suspect that even if the lockdown continues they will ease it just to allow prisoners to work and to continue to exploit them. Because of the divisions within the prison populations in terms of race or gangs, the one area where organisation is potentially possible is in creating a loose trade union movement within prison workshops like they've done in parts of America. I think there's also incredible potential for groups like the Prisoner Solidarity Network along with Black Lives Matter to highlight the purpose of prisons, why they exist, what they're there to do, and how abolition is a reasonable alternative.

### **Paul Cleeland 47 year Fight to Clear His Name Continues**

The Home Office is reviewing its archives to see if any files exist on Paul Cleeland, who has been fighting to clear his name of murder for 47 years. Damian Collins MP sought answers from the Home Office after Cleeland raised questions about an archive from a 1990s inquiry by retired judge Sir John May. Cleeland, from Kent, served 26 years in prison for the murder of Terry Clarke in Hertfordshire in 1972. His long-running legal battle has been continuing in the Administration Court. The archive catalogue included a documentary given to Sir John by the BBC in 1992. The programme - Who Killed Terry Clarke? - was provided as part of the Royal Commission on Criminal Justice, which followed a series of high-profile wrongful convictions. The documentary stated that a copy of the film had been accepted by the inquiry but it is not yet known whether Sir John took any other evidence on Cleeland's case.

Cleeland's campaign has seen two failed appeals and ongoing proceedings against the Criminal Cases Review Commission - which has not commented. After Folkestone and Hythe MP Mr Collins submitted questions, Home Office Minister Kit Malthouse said: "A review of

any Home Office file holdings on this subject is currently being undertaken. It would not be appropriate to comment further while legal proceedings are ongoing." Mr Collins said: "I think it's important that Paul Cleeland is aware of any Home Office files that exist and which are relevant to his application to have this case referred back to the Court of Appeal. "I'm pleased that the Home Office are now conducting a review to see if they have any such files. "I hope that the results of this review will be made available to Paul Cleeland and his lawyers."

### **Judges "Most Likely to Discriminate" Against Black Barristers**

Nick Hilborne, Legal Futures: Black barristers are most likely to experience racial discrimination from judges or magistrates than other lawyers, a report has found. While a majority of barristers said their relationships with solicitors either had been or might have been "negatively affected by race", a much larger majority (86%) said this was true of their experiences before the bench. The report, by the Black Barristers' Network, was based on a survey of 100 self-employed Black barristers, split almost equally between those from African and those from Caribbean backgrounds. Nearly two-thirds (64%) of the respondents were women.

When asked whether they felt their experiences before judges, magistrates and panel members had been "negatively affected by race", more than half (56%) said yes – rising to 67% of those who have practising for up to seven years – 30% maybe and only 14% no. The most common types of inappropriate treatment cited were 'being patronised', mentioned by 58 barristers, followed by 'microaggression', 'being belittled' and 'being undermined'. 'Being silenced' was mentioned by 30 respondents, bullying by 27, and 'overt racism' by 12. A majority (54%) felt they had been treated inappropriately by opponents because of their race at some point, particularly for those of more than seven years' call.

Most barristers (61%) said their relationships with solicitors had been or could have been negatively affected by race. A very narrow majority (51%) said they felt respected by solicitors in terms of the fees they were willing to pay. A similar number (52%) said they did not believe their relationship with clerks was negatively affected by race, but less than half (47%) felt allocation of work within chambers was not negatively affected. Women were more likely than men to say their relationships with clerks were or could be negatively affected by race and much more likely to say that work allocation had been affected in that way. Almost as many respondents were not confident as were (43 v 45) that their clerks would challenge a solicitor or client who had been discriminatory in their instructions to counsel.

On the positive side, most barristers (54%) said they did not believe the fees quoted for their work were negatively affected by race. Male barristers were much more likely to believe this than female. When asked to rate how much encouragement they had received to promote themselves to solicitors, on a scale of one to 10, most Black barristers (63%) gave scores of at least seven. The majority felt their experiences in chambers could be improved by more Black barristers or more senior Black barristers.

Natasha Shotunde, chair of the BBN and a barrister based at Garden Court Chambers, said: "This survey shows that many Black barristers feel that their experiences at the Bar may be negatively affected by racism. "What is particularly striking is the differences in experiences by Black male and Black female barristers, with many more Black female barristers reporting negative treatment which may be due to their race. This highlights the intersectionality of their race and gender, and how that can result in negative treatment towards Black female barristers."

Other research published this month showed that female barristers and those from Black, Asian and minority ethnic backgrounds were likely to earn less than male and White counterparts by every measure, and that in all but two of 30 practice areas analysed, female barristers received a lower

proportion of the gross fee income than their representation in the field. Meanwhile, in a debate on race and the Bar yesterday at the start of the Bar Council's annual conference – taking place via Zoom over four days – Jo Sidhu QC, vice-chair of the Criminal Bar Association, said the inequalities in the profession were rooted in institutional racism. He expressed concern that there was too much talk in place of action, without which "I fear the energy which is behind the drive for diversity will eventually begin to dissipate", a view shared by Martin Forde QC.

### **Slow Pace of Urgent Change to Prevent Deaths in Police Custody**

*Sarah Uncles, Open Democracy:* Last week's report "Black people, racism and human rights" from the UK Parliament Joint Committee on Human Rights urged that: "recommendations from the Angiolini review of deaths in custody which reference institutional racism, race or discrimination must be acted upon as a matter of urgency." What progress has been made since Angiolini herself called for urgent change three years ago? On 30 October 2017, the landmark independent review by Dame Elish Angiolini into deaths and serious incidents in police custody in England and Wales was published. The first and only review of policing practices and the legal processes that follow police related deaths, its recommendations extend to the police service, health service and justice systems. It was seen as a blueprint for change that could save lives. Three years and one progress report later, the government seems to think its job here is done. But our work at INQUEST, a charity that works alongside families bereaved following state related deaths, tells a different story.

The starkest indicator as to the visible progress on Angiolini's recommendations is the number of deaths of people in police custody. The most recent statistics show that the numbers remain at the same level as 10 years ago. Since the Angiolini review was published, INQUEST's casework and monitoring indicates there has been 54 further deaths of people in police custody in England and Wales, of which 13 involved restraint. Black people are still more than twice as likely to die in police custody. Theresa May, then Home Secretary, commissioned the review after meeting the families of Olaseni Lewis and Sean Rigg, two Black men who died following restraint by police officers whilst suffering mental ill health in 2008 and 2010. Angiolini, the former Solicitor General and Lord Advocate in Scotland, was appointed to take on the review, with INQUEST Director Deborah Coles acting as Special Advisor.

Recommendations in the review sought to address the concerns raised in these cases, such as highlighting that all restraint can cause death and the heightened dangers when someone is in mental health crisis, and the need for police to understand institutional racism and its impact. But only five months after publication, Kevin Clarke, a 35 year old Black man in a mental health crisis died after prolonged and heavy restraint by multiple police officers. At the inquest into Kevin's death last month the jury concluded, among a series of damning failings, that the "officers' decision to use restraint was inappropriate because it was not based on a balanced assessment of the risks to Kevin, compared to the risks to the public and police". The police told the inquest that they were aware of the risks of restraint, so why was there no attempt at de-escalation and why was restraint used as a first, not a last resort?

"We want mental health services better funded so the first point of response is not just reliant on the police." The inquest once again demonstrated the urgent need for structural and cultural change in policing, mental health and healthcare services, one which ends the reliance on police to respond to public health issues, and confronts the reality of institutional racism in our public services. Speaking after the inquest into her son's death Kevin's mother Wendy Clarke said: "In his memory we want to see accountability, and real change, not just in training, but the perception and response to Black

people by the police and other services. We want mental health services better funded so the first point of response is not just reliant on the police.” The current processes following deaths continue to fail bereaved families, many of whom remain unable to access anything resembling justice or accountability following a death in police custody. In response to the Angiolini review in October 2017, the then Home Secretary Amber Rudd said the government was “continuing to overhaul the police complaints and disciplinary systems, seeking to ensure that, where misconduct is found, the systems provide a transparent and robust mechanism for holding police officers to account”.

Yet following every contentious death over the past few years, the police have continued a culture of defensiveness and denial, rather than adhering to the explicit duty of candour Angiolini recommended. Time and again misconduct hearings, the disciplinary mechanism for police officers, have been dropped or dismissed following tactics by the police and their representatives to delay or avoid cooperation with the investigation. Take the gross misconduct disciplinary process earlier this year for five Bedfordshire police officers following the restraint related death of Leon Briggs. The misconduct hearing was stopped before it had even started when Bedfordshire Police force said it would offer no evidence against the officers. Angiolini’s recommendations highlight the importance of accountability at both an individual and corporate level following restraint. “To be told that the officers will not face any public scrutiny is further denial of justice and accountability.”

Following the decision to withdraw misconduct proceedings, Leon’s mother Margaret Briggs said: “As a family we are devastated and outraged. It is over six years since my son’s death and to be told that the officers will not face any public scrutiny is further denial of justice and accountability for Leon.” In light of the abandoned misconduct process the focus now falls on the inquest in January 2021 to explore whether the restraint was used in an unnecessary, disproportionate or excessive way. In the case of Sean Rigg, the misconduct panel dismissed all charges against five officers, despite an inquest jury concluding seven years previously that the level of force was unsuitable, and the restraint was unnecessary and inappropriate. This followed a series of attempts by one police officer, PC Andrew Birks, to appeal his suspension in order to retire and avoid disciplinary proceedings altogether. Such delays only add insult to the already painful and prolonged aftershock of losing a loved one in such traumatic circumstances. Angiolini had proposed a series of recommendations to remedy such delays.

“My question remains, if the police acted as they were required, why is my brother dead? Nothing will tell me that this is justice,” said Marcia Rigg following the decision to dismiss all gross misconduct charges against the officers involved in Sean’s death. And consider the judicial review brought by the police officer who fatally shot Jermaine Baker. The officer, known as W80, challenged the decision by the Independent Office of Police Conduct (IOPC) to direct the Metropolitan Police to bring misconduct proceedings. The officer’s challenge, which the Court of Appeal rejected, is just one example of police resistance to scrutiny after the use of lethal force. “What is important now is that W80 is held to account for his actions,” said Margaret Smith, Jermaine’s mother after the Court of Appeal handed down its judgement. “The Metropolitan Police Service have fought hard to avoid taking any action against him.”

These cases point to police impunity and a process which frustrates the prevention of abuse of power and ill treatment. They are just a few of many examples over the past few years. Others include those relating to the deaths of Olaseni Lewis, Rashan Charles, Adrian McDonald, Thomas Orchard and Duncan Tomlin. The government and state agencies clearly have much work to do before they can claim a “transparent and robust mechanism for holding police officers to account”, but where is the evidence that this work is being done? Time and again, after deaths and a plethora of recommendations from investigations, inquests, inquiries and reviews,

promises are made by the authorities responsible, that learning and action will follow. For the families, each new death exposes the lie in this promise and causes new pain. Indeed, Angiolini said one of the key themes to emerge from the review is the failure to learn lessons.

For this reason, the Angiolini review recommended the government establishes a national “Office for Article 2 Compliance”. Article 2 of the European Convention on Human Rights (ECHR), as enshrined in the Human Rights Act, places an obligation on the state to protect life. This Office would be accountable to Parliament, and tasked with the collation, dissemination, implementation and monitoring of learning and ensuring the consistency of its application at a national level. INQUEST has also called for the creation of this national oversight mechanism, to monitor deaths in custody and the implementation of official recommendations arising from post death investigations to ensure changes in police and practice are sustained. The government rejected Angiolini’s recommendation, and the evidence of need continues to grow.

Another injustice that unites all families bereaved following a death in police custody is the inequality of arms between themselves and state bodies from the get go. It is imperative that families secure specialist legal advice from the earliest possible stage to provide expertise on matters such as access to the body, post-mortems, communication with investigation teams and securing of evidence. Despite state bodies receiving automatic legal representation which is not subject to a merits or a means test from the taxpayer’s purse, there is no equivalent right for families. INQUEST has long campaigned for legal aid for inquests and Angiolini backed our recommendation. Yet the government rejected the overwhelming evidence in support of non means tested public funding for bereaved families.

As INQUEST Director Deborah Coles has written, families have become powerful advocates for change, turning their grief into resistance and galvanising action against injustice. They have been forced to campaign because of failing systems of investigation and accountability. Their struggles and campaigns have played a critical role in challenging the inequality, racism, discrimination and unacceptable practices of the state. For the bereaved families who invested time, emotion and energy into the Angiolini review, the failure to make progress is a betrayal. Three years on from the Angiolini review, therefore, INQUEST is calling for the Independent Office for Police Conduct, the Home Office, NHS England and police forces to demonstrate how they have implemented the recommendations of Angiolini. There must be another progress report by the government to provide transparency on what recommendations have been “implemented” and how.

As the Black Lives Matter protests earlier this year saw hundreds of thousands of people across the world come onto the streets and stand in solidarity with George Floyd, attention was rightly drawn to the deaths of people that happen here in the UK. In October every year the United Families and Friends Campaign hold a march in London in memory of everyone who has died in state custody or care. This year on 31 October, due to COVID-19, the event took place online, with bereaved relatives of Christopher Alder, Kingsley Burrell, Darren Neville, Sheku Bayoh, Marc Cole, Cherry Groce, Jack Susianta, Adrian McDonald, Seni Lewis, Sean Rigg, Joseph Scholes, Gaia Pope, Matthew Leahy and others speaking powerfully of their loss and their experience of injustice.

In the United Families and Family Campaign film (by Migrant Media) Kadija George, a cousin of Sheku Bayoh who died in Kirkaldy, Scotland after what police called a “forceful arrest”, said: “We don’t like welcoming families into our group, because there shouldn’t be a group like this. Nobody should be treated like this.” Whatever actions have been taken to protect lives, it is clear that it is not enough. We need to ask, why there is always money for the rollout of ever more powerful Tasers



but youth clubs have to shut due to lack of funding? We need to think about how to create a safer and fairer and more equal society. To prevent further deaths and harm, we must look beyond policing and redirect resources into community, health, welfare and specialist services.

### Clarifying Causation in Gross Negligence Manslaughter

Brian O'Neill QC, Grace Forbes, 2 Hare Court: In 2017 a 24-year-old woman, Louella Fletcher Michie, died at the Bestival Music Festival, having taken 2-CP, a Class A drug, supplied by her boyfriend, the appellant. The Prosecution's case was that having supplied the drug and remained with her, the appellant owed Louella a duty of care to secure medical assistance as her condition deteriorated to the point where her life was obviously in danger. He was said to have been grossly negligent in failing to obtain timely medical assistance, which was a substantial cause of her death. The sole evidence relating to causation came from Professor Deakin, a Prosecution expert witness. His evidence was that had Louella received medical assistance prior to 9.10 PM, there was a 90% chance that she would have survived.

In overturning the appellant's conviction on appeal, a very strong Court of Appeal held that the case should have been withdrawn from the jury at the close of the Prosecution's case as had been submitted at trial. The Prosecution evidence could not, said the Court, prove to the criminal standard that with medical intervention as soon as possible after Louella's condition presented a serious and obvious risk of death, she would have survived (emphasis added). The Court rejected the Prosecution's contention that a jury could find a defendant guilty of gross negligence manslaughter where their negligence had deprived a person of "a significant or substantial chance of survival", available to them at the point of the defendant's negligence.

The case and the decision on appeal attracted widespread media attention as had Louella's death at the time. Whilst the decision does not change the law in relation to causation, it provides important clarity. It should, therefore, be regarded as the leading authority on causation in the context of gross negligence manslaughter, including cases involving medical professionals. The case provides useful guidance on the temporal relationship between key elements of gross negligence manslaughter, the distinction between scientific and legal certainty, and, on when issues of causation may properly be withdrawn from a jury.

**The Six Elements of Gross Negligence Manslaughter.** In reviewing the key authorities in relation to gross negligence manslaughter, the Court identified six elements that the Prosecution must prove before a defendant can be convicted of gross negligence manslaughter (para. 5): 1) "The defendant owed an existing duty of care to the victim. 2) The defendant negligently breached that duty of care. 3) At the time of the breach there was a serious and obvious risk of death. Serious, in this context, qualifies the nature of the risk of death as something much more than minimal or remote. Risk of injury or illness, even serious injury or illness, is not enough. An obvious risk is one that is present, clear, and unambiguous. It is immediately apparent, striking and glaring rather than something that might become apparent on further investigation. 4) It was reasonably foreseeable at the time of the breach of the duty that the breach gave rise to a serious and obvious risk of death. 5) The breach of the duty caused or made a significant (i.e. more than minimal) contribution to the death of the victim. 6) In the view of the jury, the circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction."

The primary focus on appeal was causation. The Single Judge had given leave on one ground, namely that the Prosecution had failed to adduce evidence from which the jury could be sure that the appellant's negligence was a cause of Louella's death. The Defence argued (set out at para.

8) that in a case concerning a negligent lack of medical attention, to establish that the breach of duty (here, the failure to obtain medical help) was a substantial cause of death, the Prosecution must prove to the criminal standard that the person concerned "would have lived".

The Prosecution argued (set out at para. 9) that a different test should apply. They submitted that the correct test was whether the jury could be sure that the defendant's negligence deprived the victim of "a significant or substantial chance of survival that was otherwise available to the victim at the time of the defendant's negligence". The Prosecution submitted (set out at para. 11) that requiring proof of certainty of survival would render many cases where death had ensued after gross negligence, medical or otherwise, "impossible to prosecute" because of the difficulty in proving to the criminal standard that there was no possibility that the person still would have died after treatment.

**Causation and Proof that the Person Would Have Survived:** In allowing the appeal, the Court of Appeal provided important clarification in relation to the test for causation in gross negligence manslaughter cases. Rejecting the Prosecution proposition that negligence depriving someone of a "significant or substantial" chance of survival was sufficient, the Court ruled that the key question in such cases was whether medical attention would have saved the person's life. The Court found (para. 102) that the expert's opinion that medical intervention at 9.10 PM would have given Louella a 90% chance of survival left a "realistic possibility that she would not have lived".

**A Temporal Connection Between the Elements:** Beyond the central dicta concerning causation, the decision also provides useful guidance in relation to other aspects of gross negligence manslaughter. For example, the case highlighted the temporal relationship between three core elements of gross negligence manslaughter in cases such as this. In summary, (and in line with discussion at para. 89), the Prosecution in Broughton had to establish: 1) That at some point, Louella's condition was such that there was "a serious and obvious risk of death" 2) That at that point, the appellant was grossly negligent in failing to obtain medical assistance for her, and, 3) At that point, such medical assistance would have saved her life. In this context, the Court emphasised the need for: "*a clear focus on when the condition of the deceased reached the threshold of serious and obvious risk of death, what the accused should have done then and the prospects of survival at that point*".

**Distinction Between Legal and Scientific Certainty:** The decision also highlighted the need for caution in conflating the conclusions of an expert with the function of a jury. At paragraph 100, the Court of Appeal held: "*It is unhelpful to attempt to contrast scientific certainty (put at 100%) with a different figure for legal certainty. Human beings asked the question whether they are sure of something do not think in those terms*". The Court therefore decisively rejected the conflation of scientific certainty and legal certainty, or, as counsel for the Prosecution on appeal described it, "*the impossibility of transposing the percentages expressed in medical opinion into the standards that a jury might equate with being sure*". However, and somewhat ironically, in determining that a 90% chance of survival meant that a jury could not be "sure", it is possible to envision a scenario in which the decision is in fact cited in support of the proposition that there is a percentage below which the jury cannot be "sure". Despite this, it is clear that Courts deciding cases in line with Broughton are unlikely to entertain suggestions that a percentage can or should ever be applied to the concept of legal certainty.

**Withdrawing Causation from the Jury:** Broughton also provides useful guidance in relation to when issues relating to causation should be left to or withdrawn from a jury. In essence the Court held that where, when considering the evidence in its totality, a jury could not be sure of causation, the case should be withdrawn from them. However, it was also made clear that this will be rare, and is unlikely where there is evidence before a jury relating to causation that

goes beyond a single expert's opinion. In support of the trial judge's decision to refuse the Defence's submission at the close of the Prosecution case, the Prosecution cited *R v. Misra* [2004] EWCA Crim 2375 (a medical case) in which, similarly, an expert had provided a variety of descriptors of the chances of survival. In *Misra*, Judge LJ (as he then was) said (para. 22): *"In our judgment the submission that there was no case to answer on the causation issue was untenable... The causation issue was entirely for the jury. If the submission was upheld, the judge would have usurped its function"*. In response, the Defence in *Broughton* argued (para 73) that the suggestion that causation was an issue entirely for the jury, "presupposed that that there was evidence which would enable a jury to be sure". The Court of Appeal in *Broughton* did not depart from *Misra* but rather distinguished it, noting (para. 103): *"this is one of those rare cases ... where the expert evidence was all that the jury had to assist them in answering the question on causation. That expert evidence was not capable of establishing causation to the criminal standard. [Prosecution counsel's] final submission that at 21.10 Louella was deprived of a 90% chance of survival was an accurate reflection of Professor Deakin's evidence but, for the reasons we have explained, that is not enough"*.

The decision in *Broughton* does not represent a departure from previous authorities but rather provides important clarification and guidance in what can be a confusing and nuanced area of the law for jurors and practitioners alike.

#### **EHRC Brings to an End Practice of Sending Incapax Elderly to Locked Units**

*Scottish Legal News*: The practice of sending elderly patients to live in locked units in Scotland has been brought to an end following court action by the Equality and Human Rights Commission. The EHRC said it reached a settlement on ending the "unlawful detention of adults with incapacity" by NHS Greater Glasgow and Clyde, *The Herald* reports. The placement in "interim care" of at least 54 patients prompted concerns. The EHRC said the practice began in 2017 and was referred to them in October 2018. It had sought judicial review of the decision after discovering patients who were medically fit but who were incapax (incapable of guilt) had been held in care homes in Glasgow "without consent or lawful authority".

Lynn Welsh, head of legal at the EHRC said: "It is critical that decisions about people's lives take account of their will and preferences and are centred on their dignity and human rights. NHS Greater Glasgow and Clyde have accepted that our human rights concerns were legitimate and have taken concrete steps to end the practice" "We are pleased to conclude the legal proceedings we have taken against NHS Greater Glasgow and Clyde and HC One Oval Ltd with an agreement which will safeguard the rights of elderly and disabled people. We are confident that the revised patient pathway we have agreed with NHSGGC should achieve that. We are grateful to the Mental Welfare Commission for lending their expertise as an interested party and to NHS Greater Glasgow and Clyde for working with us constructively to improve their practices. We will be ensuring other health boards are aware of the outcomes of this case and that they have safeguards in place to ensure their patients' human rights are respected."

At a hearing before Lady Carmichael in the Outer House yesterday 19/11/2020, all parties agreed to dismiss the judicial review following an agreement between the health board and HC One Oval Ltd. A health board spokesman said: "We have engaged with the EHRC over a number months to understand their concerns and to resolve issues raised during the process. We are confident that by working with the EHRC and by taking the agreed, that we can continue to provide for the wellbeing of our patients in the best environment possible and ensure the mechanisms are in place to protect patients' legal rights in line with immediate clinical

needs and family decision making."

#### **Staff Cultures - A Perrie Award-Winning Essay by Sean Parker**

A prison sentence has its own peaks and troughs, its own lifespan and dynamics. Experienced sentencing judges know this, as do experienced prison staff from a one-stripe officer to the Number One Governor. A first-time prisoner will be traumatised, numb and in shock as they enter prison, remaining in a state of semi-'denial' for maybe a year. Subsequent years go through stages resembling grief recovery, and while pretending not to notice, good staff know this.

In the public imagination, the stereotypical prison officer is middle-aged, blunt, probably ex-military, shouty and male. Recent recruitment drives have attempted to recast the career as sitting somewhere between social care and the implementation of criminal justice. Importantly, university graduate fairs seem to have been targeted with this in mind and the winds are duly filling up with reasonably bright-eyed young graduates replete with 2:2 degrees in PE, sociology, or social care. It must be a rude awakening when they begin to realise the realities of the role between cups of coffee and one of fifteen different alarms going off.

In Dartmoor, the staff culture trickles down from a very humane top: a Governor One who values the experience and humanity both in her staff and in her slow churn of prisoners. For example, with the prison on the Ministry of Justice closure list before the government's announcement of 10,000 prison places being requested, the Governor gave the go-ahead for the Desktop Publishing department to launch the *TorTimes* quarterly magazine. The prison is renowned for having one of the biggest, best-equipped gyms as well as a humane, quirky, twenty-first century reputation. However, the general public expects its criminals to be criminals, its prison officers to be prison officers, and its jails to be hardcore; the grimmer the perceived crime, the closer and longer the inmate should be manacled to the damp wall.

The term offender is to be replaced in the professional language with 'person subject to probation', alongside prisoners becoming residents and cells becoming rooms. Language affects how people think and feel about being labelled, but the more language shifts, the less any changes will be taken seriously. If you want deep, structural change in the behaviour of alleged 'offenders', bland humanising of terms will just be seen as tokenism. Changes arriving by official diktat from on high will be treated with similar derision. The prison service is recasting itself as some kind of place of refuge between the police station and the hospice, where new random 'offenders' and career criminals rub shoulders, but identity issues and the increasingly-maligned political correctness should not interfere with the wider good-running of the institution. A prison working well under a light-handed, no-nonsense, non-biased regime should surely be the goal for every gaol. gaol.

#### **Multiple Failings Contributed to Death of David Sparrow at HMP Norwich**

INQUEST: David Sparrow, 36, was found hanging in his cell in HMP Norwich on 4 June 2019 and died in hospital the following day. The inquest into his death has concluded with the jury identifying a series of failings contributed to his death including that: 1) Available information about David's mental health was not acted upon. 2) His antipsychotic medication was missed. 3) There were insufficient staff on duty on the night that he died. 4) There was a lack of comprehensive handover of information before the night shift. 5) There was a failure to follow prison policy regarding the need to enter cells as soon as possible when an observation panel has been blocked.

David had been recalled to prison on 18 May 2019. David had a history of serious mental ill health. He had diagnoses of psychosis and a personality disorder for which he was pre-

scribed anti-psychotics, and had previously been an inpatient in a mental health hospital. Prior to being recalled, he was under the care of the community mental health team. However, the inquest heard that this information was missed by the prison mental health clinical team leader when conducting a desktop assessment and David was not brought under the care of the mental health team in prison, which he accepted to be a mistake.

Evidence was heard that between 29 May and 4 June, David told prison staff multiple times that he was scared and under threat because other prisoners incorrectly believed he was a 'sex offender'. He had no history of sexual offending and there was no evidence for such threats. However, this was a known presentation of his paranoia which was a symptom of his schizophrenia. On two occasions his probation officer contacted prison officers with this information but the inquest heard this was not passed on. David began to behave increasingly bizarrely and was self-isolating in his cell because of fear of prisoners and staff. As he was self-isolating, he was discussed at a Safety Intervention Meeting on 4 June. Evidence was heard that the clinical team leader for mental health did not check their records in advance of the meeting and as such failed to recognise that he had an ongoing mental health condition, had previously been referred to the mental health team, and that his self-isolating was because of his schizophrenia.

On 18, 19, 20, 28 May and 2, 3 and 4 June there is no evidence that he was administered his anti-psychotic medication. Upon receiving letters from David, his partner became increasingly worried and called the prison 18 times over the two weeks prior to his death to express her concerns. Only two of these calls were logged, and only twice did she speak to a prison officer. On other occasions she was told that she would be called back and was not. At the inquest a nurse stated that had David been part of the mental health team's casework, missed medication would have been flagged up with them. David was then moved to another wing on 4 June on the mistaken understanding that the threats he described were based in reality. It was not until David self-harmed that afternoon that he was put under suicide and self-harm monitoring processes (known as an ACCT) and the mental health team saw him for the first time. At 11.24pm that evening, whilst conducting an ACCT check, night staff discovered his observation panel was blocked and David did not respond from behind the door.

Prison policy states that officers should enter a cell as soon as possible when an observation panel is blocked, particularly when the prisoner is on an ACCT. Despite this, the inquest heard that there was a 30-minute delay in staff entering David's cell. This delay was partly caused by prison staff, for no apparent reason, failing to use their personal radios and instead walking to an office to use a telephone. Prison staff also failed to realise that they had a key on their person, and that at the time there was only one staff member responsible for 170 prisoners. Upon finally entering the cell, they discovered David hanging. He died the following day in hospital.

Robert Sparrow (father of David), Lisa Sparrow (sister of David) and Sharon Harrowing (partner of David) said: "David must have felt terrified and hopeless to have taken his own life but it did not need to end this way and, had he been properly cared for, it seems that he would still be here with us. The failings of prison and healthcare staff were clear during the inquest. All we have wanted is justice for David and we are glad that, for David's sake, the jury recognised the failings too. We hope that changes will be now made because we would not wish what we have gone through to happen to any other family."

Bola Awogboro, Caseworker at INQUEST said: "This inquest has exposed a litany of failures by HMP Norwich which led to David's death. The signs of David's distress could not be clearer, and was highlighted to the prison time and time again by his partner, only to be ignored. People in prison and their families have no choice but to entrust prison staff to fulfil their duty of care, while the mech-

anisms for doing so frequently fall short of what is required. Prisons are inherently dangerous environments, ill-equipped to protect people from harm. Effective change can only come from a dramatic reduction in the prison population, and investment in diversion and community alternatives."

Aston Luff of Hodge Jones and Allen Solicitors, who represents the family, said: "The circumstances that led to David's death are shocking. This was an extremely vulnerable man whose mental health deteriorated into extreme paranoia under the strains of prison life. The prison had all the information they needed to recognise his vulnerability and care for him appropriately and yet his needs were missed over and over again. A huge proportion of the prison population are extremely vulnerable, both to mental health challenges and to the system they find themselves in. We hope that this is a stark reminder that prisoners need to be cared for, not just locked up. Otherwise the consequences can be devastating."

### **Criminal justice System is 'On Its Knees**

Owen Bocott, Guardian: Crown court cases are being delayed until 2023, the innocent penalised more than the guilty, and the under-funded, criminal justice system brought "on its knees", according to the chair of the Criminal Bar Association in England and Wales. James Mulholland QC told the Guardian that while Covid had intensified the crisis, deep cuts to the Ministry of Justice since 2010 had left it dangerously under-resourced. The result was that "very vulnerable people who have to go through the system are being let down," he said. "You can't have a completely under-funded system from beginning to end." Mulholland, 56, represents thousands of barristers who are struggling to hold the system together during the pandemic, but is still immersed in trial processes himself, and witness to the crisis first hand.

Approximately 50,000 crown court cases are waiting to be heard, of which 33,000 will involve full trials. Last year, without Covid, Mulholland pointed out, the crown courts managed to complete only 12,000 trials. "The system is in logjam," he said. "We are having some cases listed into 2023 for trials where people are being released on bail, sometimes for offences like rape, sexual offences, affray and significant burglaries. "Sentencing judges are now entitled to take into account the Covid experience [and deliver reduced prison terms] – so while the innocent may be held longer [in custody awaiting] trial, the guilty are benefitting [from coronavirus]. "We are holding people in custody for up to 18 months. There's no compensation if they are found not guilty. We have 17-year-olds who are not going to be tried until 2023. Will they have to spend their youth waiting for an outcome that will impact their whole life?"

He said while the government talked of being tough on sentencing, only 7% of offending recorded by the police resulted in a prosecution. "There's a one in 50 chance of an old-age pensioner who is burgled seeing that person brought to justice. The police don't have the resources. Only 1–1.5% of [reported] rapes result in charges. And even then it's 1,319 days for the average rape case to go through the system from actual offence to completion." Mulholland said he feared the criminal justice system was in danger of losing the public's confidence, generating miscarriages of justice and alienating victims. Even before the pandemic, the backlog of cases was growing because the courts service saved money by limiting the number of judges' sitting days. His diagnosis of the root cause of the problems hampering the criminal justice system is one thing: lack of money. All the main professional legal bodies agree with that analysis.

Mulholland said an extra £250m a year was needed to solve the problem, a figure derived from an Institute for Government assessment. While extra funding has recently been provided to boost the numbers of police and prosecutors, no equivalent resources have been granted to barristers. Instead, criminal barristers had faced cuts to fees of between 30% and 40% over the past 12 years, Mulholland



said. Diversity at the Bar was also suffering, he noted, because women were leaving mid-career when they realised it was not a profession in which they could have both a family life and receive decent pay. His experiences in court concern him: “We are seeing more litigants in person [unrepresented defendants] now as a result of legal aid entitlement thresholds [not being increased in line with inflation]. “They appear in quite serious cases. It’s become progressively worse. It’s so short-sighted. Trials involving [unrepresented defendants] take double or treble the time. It’s a false economy [not granting them legal aid].” Mulholland said he was also concerned about the increase in alleged victims refusing to “cooperate with the police because they feel they won’t receive proper treatment”. “Funding is crucial. We are on our knees. Under-funding risks miscarriages of justice. We need to fund the prosecution as well as the defence. Everyone needs to be paid more.” Where, he asked, was the royal commission on criminal justice that the government promised when it took office in 2019? Glancing around the marble halls of the Old Bailey from which the late afternoon light was fading, he observed: “This was built when justice was taken seriously.” The lord chief justice, Sir Ian Burnett, has also called for increased funding. “There must be sufficient resources to enable the courts and tribunals to work to full capacity ... otherwise backlogs [of cases] will be unsustainable,” he told the Bar Council. The cash required, he said, was “little more than a rounding error in [the budgets of] many departments”. If withholding money from the courts prevented people resuming their normal lives and working, he added, it was “a false economy”.

### Call for Detail on Older Prisoners Strategy and Screening for Dementia

The House of Commons Justice Committee has welcomed the Government’s acceptance that there should be a new strategy for dealing with the increasing number of older prisoners, but has called for more detail on that strategy and a timeframe for it. The Committee meanwhile regretted that the government had rejected its recommendation that older prisoners be systematically screened for dementia. The Committee’s comments came as it published the Government’s response to its in-depth report, Ageing Prison Population, which was itself published in July of this year.

The number of prisoners in England and Wales aged over 60 has increased by over 240% since 2002, primarily because of an increase in the number of older men being sentenced for sexual offences. Between 2002 and 2020 the number of prisoners over 60 has grown from around 1500 to over 5000. This increased population of older people has profound implications for the prison service. Older prisoners are more likely to have chronic diseases, disability and decreased mobility. Moreover, many of our prisons, especially those built in the Victorian era, were not designed to accommodate people with serious illnesses or mobility issues.

With these realities in mind, the Committee recommended that long-term prison estate strategy should reflect the needs of older prisoners, especially as the government is planning to build new prisons to accommodate a projected 10,000 more prisoners in the years to come. The Minister responsible for prisons, Lucy Frazer QC MP, acknowledged these findings and told the Justice Committee she had commissioned an older offenders strategy.

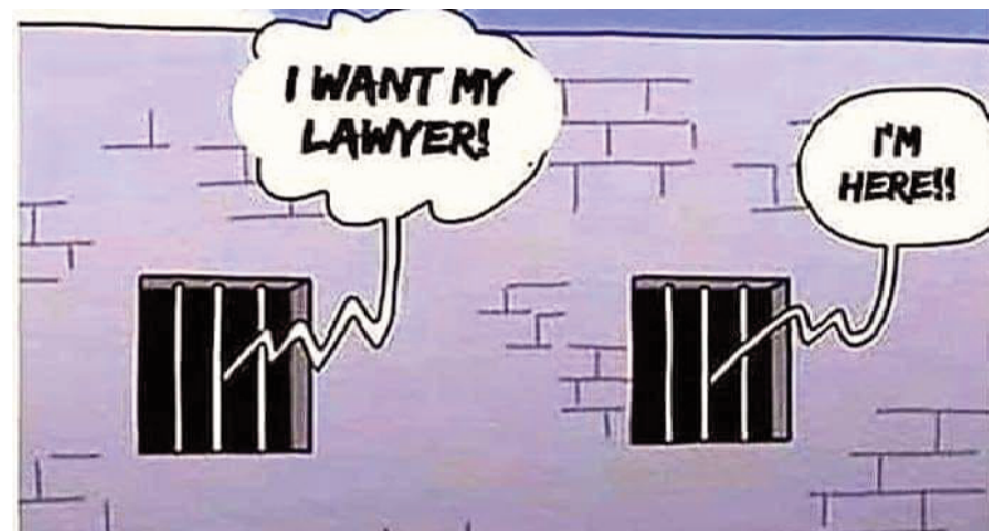
The Committee expressed disappointment that the government had rejected its recommendation that older prisoners be systematically screened for dementia, and that prison officers who work with older prisoners receive related training. The Justice Committee report published in July had noted that 85% of prisoners over the age of 60 have some form of major illness and that prisoners tend to “age” more prematurely than people in the general population because of a variety of social and physical disadvantages. In its response, the government said only that healthcare providers would be asked to look out for symptoms and ensure they knew what to do if these arise.

Chair of the Justice Committee, Bob Neill, said: “When many of our jails were built, in Victorian

times, it couldn’t have been imagined that so many people, including prisoners, would live much longer lives. Because of this, some of these buildings are no longer fit for purpose. So while we welcome the Government’s commitment to commissioning an older offenders strategy, we need more detail. We would ask the Ministry to set out the parameters. Who will it consult, for example, and how will we measure success? We would also ask the Minister for a clear timeline on this strategy. On the issue of dementia I am very disappointed that the Ministry of Justice did not agree that every older prisoner should have systematic access to screening and be treated accordingly. Left untreated, dementia can rob a person of their dignity and we should not go down that road. I would urge the Government to reconsider our proposal and to set out, on the record, what precise tools are currently in place to identify prisoners with dementia”.

### 2,000 Prisoners on Suicide Watch on Any Given Day!

Assessment, Care in Custody and Teamwork (ACCT) is used in prisons to support people at risk of suicide and self-harm. We cannot provide live data on the number of people managed by the ACCT process as quality assured data is only available up to March this year. The number of people managed by ACCT fluctuates daily, but data for 2020 has shown that on average of around 2,000 prisoners have been assessed as being at risk and are being supported through ACCT on any given day.



Serving Prisoners Supported by MOJUK: Walid Habib, Giovanni Di Stefano, Naweed Ali, Khobaib Hussain, Mohibur Rahman, Tahir Aziz, Roger Khan, Wang Yam, Andrew Malkinson, Michael Ross, Mark Alexander, Anis Sardar, Jamie Green, Dan Payne, Zoran Dresic, Scott Birtwistle, Jon Beere, Chedwyn Evans, Darren Waterhouse, David Norris, Brendan McConville, John Paul Wooton, John Keelan, Mohammed Niaz Khan, Abid Ashiq Hussain, Sharaz Yaqub, David Ferguson, Anthony Parsons, James Cullinane, 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, Warren Slaney, Melvyn 'Adie' McLellan, Lyndon Coles, Robert Bradley, Thomas G. Bourke, David E. Ferguson, Lee Mockble, George Coleman, Neil Hurley, Jaslyn Ricardo Smith, James Dowsett, Kevan & Miran Thakrar, Jordan Towers, Patrick Docherty, Brendan Dixon, Paul Bush, Alex Black, Nicholas Rose, Kevin Nunn, Peter Carine, Paul Higginson, Robert Knapp, Thomas Petch, Vincent and Sean Bradish, John Allen, Jeremy Bamber, Kevin Lane, Michael Brown, Robert William Kenealy, Glyn Razzell, Willie Gage, Kate Keaveney, Michael Stone, Michael Attwooll, John Roden, Nick Tucker, Karl Watson, Terry Allen, Richard Southern, Peter Hannigan.