INQUEST and the INQUEST Lawyers’ Group Response to “Transforming Legal Aid” (CP14/13)
About INQUEST and the INQUEST Lawyers’ Group

1. INQUEST is the only charity in England and Wales that provides an expert service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. INQUEST provides a general telephone advice, support and information service to any bereaved person facing an inquest and the Inquest Handbook is available to any bereaved person free of charge. INQUEST also runs a free, in-depth specialist casework service on deaths in custody/state detention or involving state agents and works on other cases that also engage Article 2 (the right to life) of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability.

2. INQUEST’s research, policy and parliamentary work is informed by our casework to ensure that the collective experiences of bereaved people underpin our evidence and submissions. For example, research reports such as How the Inquest System Fails Bereaved People (2002) and Unlocking the Truth – Families’ Experience of the Investigation of Deaths in Custody (2007) both included in-depth surveys of bereaved families’ views and experiences of obtaining funding for legal representation at inquests. Other INQUEST publications include: Learning from Death in Custody Inquests: A New Framework for Action and Accountability (2012); The Inquest Handbook: a guide for bereaved families, friends and their advisors; briefings on individual cases and on thematic issues arising; Inquest Law, the journal of the INQUEST Lawyers Group; and a regular e-newsletter. INQUEST is represented on the Ministerial Council on Deaths in Custody. INQUEST’s overall aim is to secure an investigative process that treats bereaved families with dignity and respect; ensures accountability and disseminates the lessons learned from the investigation process in order to prevent further deaths occurring.

3. INQUEST works in partnership with members of the INQUEST Lawyers’ Group, a national network of nearly 200 solicitors and barristers who provide preparation and legal representation for bereaved people and which promotes and develops knowledge and expertise in the law and practice of inquests.

4. This response draws directly on INQUEST and the INQUEST Lawyers’ Group collective experiences over the last thirty years and addresses a number of the proposals in the consultation paper that will impact adversely on the bereaved families we work with.

Overarching comments on the proposals

5. As well as addressing some of the specific questions posed by the consultation we want to make a number of points that are relevant to the proposals as a whole.

The importance of specialist legal representation in deaths in custody

6. If implemented, the proposals would seriously undermine the ability of families to access specialist, high quality legal representation in cases arising from deaths in custody or otherwise engaging Article 2 of the ECHR. Specialist legal aid lawyers have been vital in assisting bereaved families to hold the State to account following deaths in custody. This expertise has informed changes to custodial policies and practices and
played a vital role in alerting the authorities to action necessary to prevent further deaths. It has also developed inquest law and practice. Family representation in complex cases is now routinely welcomed and supported by coroners (indeed in recent years we have noted the increasing practice of coroners writing to support bereaved families’ applications for public funding). Without specialist family representation there would be no proper public scrutiny of what takes place behind the closed walls of custodial institutions or of the acts or omissions of state agents. The abuses of power uncovered at many of these inquests would remain unchallenged and hidden from public view. This would not only impact negatively on the bereaved families involved but would have worrying implications for society as a whole.

**Inequality of arms in public funding**

7. In his introduction to the consultation paper, the Lord Chancellor expresses his view that “the hard-working public pay for legal aid, and we must deliver a system which commands their confidence and spends their money wisely”.

8. However, in the types of cases targeted by the proposals in the consultation paper, lawyers representing the Government or public authorities are, to our knowledge, provided with funding which is not restricted or constrained (as is the situation for bereaved families or other claimants) and does not appear to be assessed and/or have its merits examined. INQUEST notes there are no proposals in this consultation to address the costs to the taxpayer of funding legal advice and representation of the Government and state agencies in exactly the same cases. This would further exacerbate the substantial inequality of arms that already exists.

9. INQUEST is not aware of a single inquest into a death in custody where the state has not had lawyers in attendance. For example:

- At the inquest in 2009 into the death of **Moyra Stockill**, who died in police custody, there were 11 legal representatives at the inquest looking after the interest of the Chief Constable, individual police officers and two custody officers, the NHS Trust, the relevant Hospital Consultant, individual nursing and outreach staff and the Care Quality Commission¹.
- During the 2012 inquest into the death in custody of **Sean Rigg**, 5 teams of lawyers represented the Metropolitan Police, South London and Maudsley NHS Trust and other public agencies with one team for the Rigg family. This specialist legal representation for the family was vital in challenging the original findings of a flawed IPCC investigation and resulted in the inquest jury returning a damning narrative verdict.²
- In the current inquest examining the death of **Jimmy Mubenga**, there are 5 teams of lawyers representing State and corporate interests, (Ministry of

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¹ Ruth Bundey “Inquest into the death of Moyra Stockill reveals gross failures by hospital and police” *INQUEST Law* Issue 19, INQUEST
Justice and Home Office), London Ambulance Service, British Airways, G4S, the individual G4S officers and one team for his family.

10. Parliamentarians have questioned the disproportionality between public funding for bereaved families and for the state. For example, parliamentary questions have revealed that the total amount of the money spent on exceptional legal aid (ie for *ALL* cases covered by the existing scheme not just representation for bereaved families at inquests as the Government asserts the figures can not be disaggregated) was £1.5 million in 2008/09 and £1.6 million in 2009/10. In contrast, in relation to the inquests into deaths of prisoners in custody for the public bodies which the Ministry of Justice alone has responsibility for, the costs for legal advice and representation from the Treasury Solicitor’s Department and Counsel came to £2.2 million in 2008/09 and £2.7 million in 2009/10. This does not include the public funds spent by the Department of Health or NHS bodies on representation at the same inquests. The Home Office has been unable to provide comparable figures in relation to legal representation following deaths in police custody. This raises questions about a significant inequality of arms.

11. INQUEST has made these points to the Ministry of Justice on several occasions. If the government is serious about “delivering a more credible and efficient system” they must finally address this inequality.

**Eligibility, Scope and Merits**

Q1. Do you agree with the proposal that criminal legal aid for prison law matters should be restricted to the proposed criteria. Please give reasons.

12. No.

13. Cases that would be excluded from legal aid under the proposals in the consultation include assistance to challenge an individual’s treatment in prison, YOIs or STCs in relation to, amongst others, the following types of matters:

   * **Treatment By Staff** – help where a prisoner allegedly has cause to complain about HMPS staff from general bullying to abuse.
   
   
   * **Communications & Visits** – help with issues surrounding correspondence which, on occasion, may be withheld or visits being barred from family members, friends etc.

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3 Parliamentary Question from Jeremy Corbyn MP to the Parliamentary Under-Secretary of State for Justice, Hansard, 18 January 2011
http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110118/text/110118w0001.htm#11011867003416

4 http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110124/text/110124w0002.htm#11012427001296

5 Most recently see our detailed response to the 2011 consultation, “Proposals for the Reform of Legal Aid in England and Wales” (CP12/10)
**Mother & Baby Issues** – help to mothers who are refused places on the units (and therefore the ability to be with their babies).

**Compassionate Release** – this is where a prisoner seeks release on severe health grounds.

**Other treatment issues** – for cases that do not fit neatly into either of the above categories. 

14. Our casework on deaths in prison has revealed that it is precisely these kinds of issues that may impact negatively on a person’s state of mind and increase the risk of serious self-harm or death. For example, our evidence based report *Fatally Flawed* (published by The Prison Reform Trust in 2012)\(^7\) examined the deaths of 200 children and young adults in prison and found that those who died had, *inter alia*, been exposed to bullying and treatment such as segregation and restraint\(^8\); been placed in prisons with unsafe cells and environments, and; experienced poor medical care and limited access to therapeutic services in prison.

15. In addition, our experience of casework is that the pressure on the prison system means that many of those prisoners with mental health problems do not get appropriate treatment. In some cases, the only way to do so is to seek legal advice to challenge a failure to treat or to obtain an assessment for transfer to psychiatric hospital. Under the proposals in the consultation paper these cases would no longer be funded. This will have a negative knock-on effect – including more pressure on staff, mentally disordered prisoners being housed in prisons unable to treat and manage them and, most importantly, an increased risk of serious self-harm and suicide.

16. If legal aid is not available to enable individuals to challenge their treatment in prison we are concerned that the trends in deaths we have documented will persist, and may worsen.

17. Finally, we note that the consultation paper suggests that the Prisons and Probation Ombudsman can take up some of the complaints about treatment as an alternative to legal advice and support. We are unconvinced by the feasibility of this suggestion. The PPO annual report for 2011/12 confirms a budget reduction of 21% between 2010/11 and 2014/15. From our casework we are aware that the PPO often experiences delays in completing death in prison custody investigations and in responding to complaints. We think that if the proposals in the consultation were implemented, the additional work created for the PPO, combined with the significant budget cuts, would lead to increased delays. This would affect the investigation and inquest process and the timeliness of the lessons learnt to prevent further deaths.

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\(^6\) Page 111 of the consultation document for the full list.

\(^7\) See *Fatally Flawed* via: [http://inquest.gn.apc.org/pdf/reports/Fatally_Flawed.pdf](http://inquest.gn.apc.org/pdf/reports/Fatally_Flawed.pdf)

\(^8\) The Prisons and Probation Ombudsman found that 20% of their fatal incident investigations into self-inflicted deaths in custody had found evidence that the person who died was subject to bullying or intimidation by other prisoners in the three months prior to their death. PPPO (2011) *Learning from PPO investigations: violence reduction, bullying and safety*
Introducing a residence test

Q4. Do you agree with the proposed approach for limiting legal aid to those with a strong connection with the UK? Please give reasons.

18. No.

19. Paragraph 3.54 of the Consultation Paper suggests that section 10 LASPO exceptional funding can be granted to fund cases excluded from the scope of the normal legal aid scheme. The suggestion here appears to be that exceptional funding can therefore somehow mitigate the effects of the residence test. INQUEST does not agree: we do not think section 10 funding will be available to people who are disqualified from eligibility altogether. There are a number of families we have supported who, in our view, would be denied funded representation altogether because of their residence status. For example:

- **Jean Charles de Menezes**: A Brazilian national shot dead by armed police at Stockwell Tube station after being mistaken for suicide bomber in London on 22 July 2005. A Health and Safety prosecution resulted in the Metropolitan Police Service being found guilty of endangering the public through their conduct of the operation which led to the fatal shooting. The inquest into his death also raised significant concerns about the MPS’s use of lethal force. His parents and family would not have been funded to be represented through the police complaints process and the inquest.

- **Jimmy Mubenga**: An Angolan national died on 12th October 2010 following restraint on a British Airways aeroplane whilst being forcibly removed from the UK by G4S security officers. His inquest is underway. Mr Mubenga’s widow Adrienne Kambana did not have residency at the time of death although this has been subsequently granted.

- **Mohamed Shuket**: A Pakistani national who died from a heart attack in Colnbrook Immigration Removal Centre on 2nd July 2011. Mr Shuket had a pre-existing heart condition. An inquest jury concluded that neglect contributed to his death and that there was a complete failure of care in the management of his health including a misdiagnosis of his cardiac arrest, systems failure in respect of a faulty defibrillator, failures to call an ambulance quickly and to immediately apply CPR.

- **AA**: Non self inflicted death of an American national in Colnbrook Immigration Removal Centre. This was the second death in a month in this IRC (see Mohamed Shuket above). The deceased’s mother lives in America. When it takes place, the inquest will address concerns about the healthcare service provided and, in particular, how the institutions responded to deteriorations in AA’s psychiatric condition whilst in Colnbrook and Harmondsworth.

- **Prince Kwabena Fosu**: A Ghanaian national found collapsed and died on 30th October 2012 in Harmondsworth Immigration Removal Centre. The circumstances of his death are under investigation and there are a number of concerns arising from the death including Mr Fosu’s mental capacity. Mr Fosu’s father lives in Holland.

- **Stephen Logan**: Self inflicted death of a Trinidadian national who died on 16th December 2010 in HMP Wakefield. The deceased’s mother is elderly and lives in Trinidad.
• Rafal Delezuch: A Polish national died in Leicester on 15\(^{th}\) August 2012 following arrest and restraint by police. The circumstances of death are currently under investigation. The deceased’s parents live in Poland.

20. The legal processes which examine the circumstances of these deaths not only enable the bereaved families to find out what happened to their relatives and why they died but are important for the public interest of society as a whole given they relate to fundamental issues such as the right to life and the protection of some of society’s most vulnerable people who are dependent on others for their treatment and care. In our experience it is because families are represented during these legal proceedings that the actions or any omissions of the state are properly scrutinised. INQUEST and the ILG are deeply concerned that if the proposed residency test were introduced, some of the most contentious deaths involving the state will not be properly scrutinised in the future.

Paying for permission work in judicial review cases

Q5. Do you agree with the proposal that providers should only be paid for work carried out on an application for judicial review, including a request for reconsideration of the application at a hearing, the renewal hearing, or an onward permission appeal to the Court of Appeal, if permission is granted by the Court (but that reasonable disbursements should be payable in any event)? Please give reasons.

21. No.

22. We have seen the draft response to the consultation from the Public Law Project. We echo their comments on the importance of judicial review and the rule of law. From our 30 years of experience of working on contentious deaths involving the state or state agents, INQUEST agrees with their observation that “restricting individuals’ rights to judicial review risks undermining the culture of accountability before the law”. In particular we support their critique of the figures relied on by the Government as justification for their changes which, we think, demonstrates that these proposals have not been drawn up on the basis of sound, properly analysed evidence.

23. If implemented, this proposal could have a severe impact on bereaved families because judicial review is the only avenue for bereaved families to challenge the lawfulness of coroners’ decision-making and/or their conduct of an inquest\(^9\). It has been crucial to the improvement of inquest law and practice (see paragraph 31).

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\(^9\) The only other avenue of “appeal” available to bereaved families is by persuading the Attorney General to exercise his or her power of fiat under s.13 of the Coroners Act 1988. This sets a high threshold to be met for an inquest verdict (inquisition) to be quashed and for ordering a new inquest into a death. It involves a complex and lengthy process which requires the Attorney-General’s consent. The Attorney General can only exercise his fiat if there is new evidence to be considered. As a result, this remedy has only been granted to bereaved families in rare cases – the most recent example being the quashing of the original inquests into the 96 deaths at Hillsborough Stadium in 1989.
24. An example of the importance of ensuring judicial review remains a legal remedy which is accessible to bereaved families is illustrated by the experience of Carol Pounder, the mother of 14 year old Adam Rickwood who died in Hassockfield Secure Training Centre in 2004. In the first inquest into Adam’s death, the coroner refused to rule on both the legality of the use of force on him by staff shortly before he died and whether the restraint used on him was causative of his death. Carol Pounder had to bring a judicial review to challenge these decisions and ask for a new inquest into Adam’s death. The High Court found that his treatment in custody amounted to inhuman and degrading treatment and was in breach of ECHR Article 3. In allowing the claim, the administrative court quashed the original verdict and ordered the coroner to conduct a fresh inquest\textsuperscript{10}. Carol Pounder also had to judicially review the coroner a second time when he subsequently refused to recuse himself from hearing the second inquest. The administrative court also granted that application and ordered the coroner to appoint a colleague to hear the second inquest\textsuperscript{11}. This was more than a “pyrrhic victory”. The second inquest was held in January 2011 and resulted in a far-reaching narrative verdict from the jury which condemned the conduct of bodies such as the Youth Justice Board and the private contractor Serco who ran the facility where Adam Rickwood died\textsuperscript{12}. Adam was the youngest person to die in custody and the evidence heard at the inquest into his death revealed that thousands of other children had also been systematically subjected to unlawful restraint in privatised secure training centres and that regulatory and inspection bodies had failed to stop these practices. Since that evidence was heard there has been significant public and parliamentary debate about the use of force on children in custody – resulting in the government introducing a new policy and practice framework in July 2012.

25. The effective operation of the rules and the process of judicial review are clearly important in the context of an inquest system which is acknowledged as having wide variations in the quality of coroners’ decision making. Tom Luce, the government-appointed independent reviewer concluded in 2003 that the system was “not fit for purpose”.\textsuperscript{13} INQUEST’s research reports and briefings have previously demonstrated how bereaved families face significant delays and a ‘postcode lottery’ of service\textsuperscript{14}. Partly in response to such evidence, Parliament passed the Coroners and Justice Act 2009 to improve the inquest process and included a provision to introduce a streamlined system of appeals against coroners’ rulings (section 40 of the 2009 Act).

26. It was against this backdrop that, during the November 2011 parliamentary debates on the Public Bodies Bill and the abolition of s.40 of the 2009 Act, government ministers assured parliamentarians that bereaved families would still be able to challenge poor

\textsuperscript{10} R (Pounder) v HM Coroner for the North and South Districts of Durham and Darlington [2009] EWHC 76 (Admin).
\textsuperscript{11} R (Pounder) v HM Coroner for the North and South Districts of Durham and Darlington [2010] EWHC 328 (Admin).
\textsuperscript{12} For full details see INQUEST press release, 27 January 2011 “Sero and youth justice agencies condemned for unlawful treatment of vulnerable boy in custody” available from www.inquest.org.uk
\textsuperscript{13} Para 1, the independent review of Coroner Services commissioned by the Home Office and chaired by Tom Luce, Death Certification and Investigation in England, Wales and Northern Ireland, 2003.
\textsuperscript{14} See INQUEST’s evidence based reports such as How the Inquest System Fails Bereaved People (2002) and Unlocking the Truth – Families’ Experience of the Investigation of Deaths in Custody (2007): both included in-depth surveys which sought bereaved families’ views and experiences of the inquest process
decision-making in coroners’ courts through judicial review. For example, the Government Briefing on the Bill circulated to MPs and Peers stated “a new appeals system [for coroners] will not be taken forward because of the significant costs that this would entail. However, we are retaining the existing appeal mechanisms, whereby the outcome of an inquest can be challenged by Judicial Review”.

27. INQUEST is concerned that a year after those parliamentary debates the Ministry of Justice has already put forward two sets of proposals which, if implemented, would severely restrict bereaved families’ ability to bring judicial review proceedings against flawed coroners’ rulings.

28. The first set of proposals were made in the consultation paper Judicial Review: proposals for reform (CP25/2012). INQUEST’s January 2013 response expressed concern that the consultation paper revealed a complete lack of understanding of the importance of judicial review for bereaved families. We urged the Ministry of Justice to reconsider their proposals: particularly in relation to shortened time limits and the proposed abolition of the right to an oral permission hearing in judicial reviews involving coroners’ decisions. We note that the government’s April 2013 response to that consultation does not pursue these proposals.

29. However, the proposals in this consultation show, once again, the Ministry of Justice has failed to understand the importance of effective access to justice for bereaved families facing an inquest into a contentious death. If implemented, the cumulative effect of the proposals in the consultation would be to restrict bereaved families’ access to judicial review as a remedy by: making it harder to qualify for any public funding to challenge coroners’ decisions, and; reducing the number of legal representatives able to take the financial risk of doing this type of work.

Civil merits test – removing legal aid for borderline cases
Q6. Do you agree with the proposal that legal aid should be removed for all cases assessed as having “borderline” prospects of success? Please give reasons.

30. No.

31. See our answer to Q5 above. The points raised in cases following contentious deaths are not only of high importance but often ground-breaking test cases. In INQUEST and the ILG’s experience, the nature of these cases is that the final outcome on what are often controversial issues cannot be fully predicted in advance. Test cases on “borderline” issues are vital for shaping the development of the law and clarifying difficult questions of inquest law. Removing this possibility is likely to mean that unlawful or poor decisions will go unchallenged and will reduce the accountability of public bodies such as coroners, the police and prisons, which risks perpetuating these practices. This is clearly worrying both for families but also for society as a whole as judicial review has been an important driver for the improvement of coronial standards across all inquests.

32. Again, Carol Pounder’s judicial review of the coroner’s decisions relating to the original inquest into her 14 year old son’s death in custody is a good illustration of the type of test cases which may be at risk if this proposal is implemented (see paragraph 24 above).

Client choice
Q17. Do you agree with the proposal under the competition model that clients would generally have no choice in the representative allocated to them at the outset? Please give reasons.

33. No.

34. Our work on the deaths of vulnerable people who end up in custody, particularly those with mental health problems, children and young people, highlights the important role that their lawyers can play in alerting the authorities to their vulnerability and risk of self harm and suicide. This is only possible because of the sustained knowledge and relationship of mutual trust between the lawyer and their client. Our fear is that the Government’s proposals could destroy these relationships to the detriment of the client’s health and safety. Indeed a number of the policies and procedures concerning the treatment and care of vulnerable and at risk detainees have been developed to reflect this and ensure effective communication between the authorities and those, such as lawyers, with specialist knowledge of an individual’s vulnerability.

35. Given our experience, INQUEST and the ILG are also concerned that the removal of client choice is likely to discriminate most severely against the BAME community who may have had difficulties in finding lawyers who they can trust and with whom they can engage. This is not adequately reflected in the equality impact assessment accompanying the consultation paper.

Expert Fees in Civil, Family, and Criminal Proceedings
Q33. Do you agree with the proposal that fees paid to experts should be reduced by 20%? Please give reasons.

36. No.

37. Very specialised and experienced experts are called on in inquests into contentious deaths involving the state or state agents. A decrease in fees will inevitably reduce the pool of experts available to bereaved families and their legal representatives. Our experience is that the use of the best experts enables a thorough investigation and inquest to take place. This proposal would impact on the legal processes following a death in custody in a number of ways including: significant failings not being discovered and the use of less experienced experts which may take up more court time and money (including seeking further expert evidence to clarify or supplement the original evidence). In particular, this proposal may hamper the coroner’s ability to fully scrutinise the death and make any necessary rule 43 report to alert relevant
agencies to dangerous practices, with the consequence of undermining learning and the important preventative function of inquests.

Concluding comments – Article 2 ECHR

38. Our answers to questions in the consultation paper reflect the core concerns of bereaved families to: have equal access to specialist legal representation; be able to effectively participate in the investigation and inquest process; ensure the legal processes following a contentious death (both inquests and any related civil case) enable the full facts surrounding the circumstances of their relative’s death are known, and; to prevent similar deaths occurring in the future. INQUEST’s view remains that bereaved families should have access to non means tested public funding for preparation and representation at the inquest and other legal processes following a death in any form of detention.

39. Our view is not exceptional and has been echoed by parliamentary bodies, independent reviewers and government sponsored advisory boards including:

- the Luce Review of the coroners service;\(^{16}\);
- a parliamentary inquiry into deaths in custody concluded with the Joint Committee on Human Rights\(^{17}\) recommending that “participation of the next-of-kin in the investigation into a death in custody is an essential ingredient of Article 2 compliance. [...][n] all cases of deaths in custody, funding of legal assistance should be provided to the next-of-kin.”;
- the Corston Report on women in the criminal justice system recommended: “Public funding must be provided for bereaved families for proper legal representation at inquests relating to deaths in state custody that engage the state’s obligations under Article 2 of the European Convention on Human Rights. Funding should not be means tested and any financial eligibility test should be removed whenever Article 2 is engaged. Funding should also cover reasonable travel, accommodation and subsistence costs of families’ attendance at inquests.”\(^{18}\)

40. In \(R\) (Amin) v Secretary of State for the Home Department\(^{19}\), Lord Bingham laid out the purpose and requirements of an Article 2 compliant investigation and inquest process:

...to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrong-doing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.

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\(^{19}\) [2003] UKHL 51
41. In INQUEST’s experience, for these objectives to be met and for bereaved families to participate effectively in the legal processes following a death in custody they need access to publicly-funded specialist legal representation. Where families are unrepresented, or insufficiently represented, the circumstances of the death do not receive the scrutiny which they otherwise would, with the danger that any acts or omissions which contributed to the death could happen again in the future. Our concern is that the measures set out in the consultation paper would exacerbate this situation and introduce new barriers to justice for bereaved families.

42. In light of this we question how, as currently laid out, the proposals would be compatible with the State’s obligations under Article 2 of the ECHR.

INQUEST
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