CORPORATE MANSLAUGHTER AND HOMICIDE BILL

HOUSE OF LORDS

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COMMISSION FOR RACIAL EQUALITY

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1. The Commission for Racial Equality (the Commission) was established under the Race Relations Act 1976 (the Act) with the duties of working towards the elimination of racial discrimination and the promotion of equality of opportunity and good relations between persons of different racial groups.

2. The Commission for Racial Equality supports the Lords amendments 2, 3, 5, 6 and 10 which would ensure that all people held in custody, in the care of the state, are covered by the provisions of the Corporate Manslaughter & Corporate Homicide Bill, and would give much needed protection to the disproportionate number of ethnic minorities held in police custody, prison cells and in mental healthcare institutions, and the disproportionate number of ethnic minority children in the youth justice system.

3. As the Lords have argued in their amendment, custody must include "being held in prison, secure mental healthcare facilities, secure children's homes, secure training centres, immigration removal centres, court cells and police cells, and being subject to supervision by court, prisoner and detainee escort services;"

Lack of Accountability

4. Current provisions in the law mean that where there are deaths in custody, there is a complete lack of accountability. Existing mechanisms - such as the Independent Police Complaints Commission (IPCC), the Prison and Probations Ombudsman and the inquest system - are not able to determine liability and therefore cannot address accountability.

5. Of the 10 unlawful inquests into deaths in custody since 1990, and despite the 'unlawful killing' verdicts returned by those juries, none of these have resulted in any successful prosecutions**.**[1]

6. Opening the Report Stage debate in the Lords, the former Chief Inspector of Prisons, Lord Ramsbotham, said: " Had there been a risk that a charge of corporate manslaughter would have been brought against them, managers at all levels would have taken a great deal more care over the detailed exercise of their responsibilities in the cases of Christopher Edwards, Zahid Mubarek, Sarah Campbell, Joseph Scholes, Paul Day, Gareth Myatt and I dare say many others [including Christopher Alder and David "Rocky" Bennett] who might still be alive if that care had been properly exercised."[2]

7. Under our current laws, when inquiries and inquests rule that poor organisational arrangements are to blame rather than individual misconduct, there is no holding to account or any kind of closure for the victim's family. Addressing this gap in our justice system would not only bring peace for

[1] Inquest, January 2007
[2] House of Lords, 5th February 2007

families of victims of deaths in custody but would also ensure confidence in our public bodies.

Disproportionality in Corporate Care

8. For a variety of complex reasons, there are a disproportionate number of ethnic minorities held in police custody, prison cells and in mental healthcare institutions. Disproportionality in the mental health and criminal justice system is complex, including discrimination and the use of profiling, but means that ethnic minorities are more likely than others to be held in many kinds of custody.

9. Statistically, ethnic minorities are more likely to go to prison than to university and are more likely to die in custody than white detainees in most areas of the country.

10. The CRE maintains that the state have a duty of care and are ultimately responsible for people held in its care. It is crucial that where these people - including children - are compulsorily detained for any reason, that the same safeguards apply.

Cases of Ethnic Minority Deaths in Custody

11. Christopher Alder, was a black, former soldier who died in police custody in 1998. Despite CCTV footage of the events leading up to his death in a Hull police station, the case highlighted the serious shortcomings of our mechanisms for accountability. Following Christopher Alder's death the police have introduced new procedures which have contributed to an overall downward trend in deaths in police custody and the number of ethnic minorities amongst them. This shows that with determination and leadership progress can be made. But this must be underpinned by a provision for corporate manslaughter in extreme cases, especially as deaths in other types of custody have not shown the same downward trends.

12. Deaths of ethnic minority people held in prison custody have not gone down as in the case of police custody. Of the three homicides in prisons in 2004/05, two of the victims were from ethnic minority groups.

13. Gareth Myatt, a 15 year old mixed race boy, was the first child ever to die in the privately run Rainsbrook Secure Training Centre (STC) in 2004 and the first to die after losing consciousness while being restrained by three adult officers. The Carlile Inquiry[3] highlighted the high levels of restraint used

[3] **The Carlile Inquiry** An independent inquiry by Lord Carlile of Berriew QC into physical restraint, solitary confinement and forcible strip searching of children in prisons, secure training centres and local authority secure children's homes. 17 February 2006

against children in STCs and Young Offenders Institutions (FOIs). Worryingly, no information was available about the use of restraint against ethnic minority children and no evidence that this was being monitored. Given the over-representation of ethnic minority children in the youth justice system, this is a disturbing finding.

14. Twenty nine children have died in penal custody since 1990 yet there has never been a public inquiry into any of these deaths

15. The impact of poor management and organisational procedures on the incidence of deaths in prison custody is nowhere clearer than in the case of the murder of Zahid Mubarek by his racist cellmate at Feltham YOI in 2000. The public inquiry into Zahid's murder revealed a catalogue of individual and systemic failures that led to Zahid's death. Similarly, the CRE's Formal Investigation[4] into his murder identified 16 areas in which the Prison Service failed to provide an adequate level of custodial care or supervision of prisoners. This was underpinned by 4 underlying systemic failures, including the failure to give appropriate priority to race relations and the failure to implement 'mandatory' requirements. In 11 of these individual failure areas, proper action in any one of them could have prevented Zahid's murder.

16. David "Rocky" Bennett, a patient at the Norvic secure psychiatric clinic in Norwich died in October 1998, after being restrained by up to five nurses. The Independent Inquiry into his death made twenty-two recommendations including a call on Ministers to acknowledge "institutional racism in the mental health service and a commitment to eliminate it."[5] The Crown Prosecution Service decided not to prosecute anyone for David Bennett's death in November 2000.

17. These cases raise serious issues about the ability to hold agencies to account for institutional and systemic failures that result in deaths in custody. With rising prison numbers and overcrowding, as well as the over-representation of ethnic minorities throughout both the adult and youth justice systems, the CRE supports the extension of the corporate offence to deaths in custody in order to maintain public confidence in our criminal justice system.

18. As retired judge Sir John Blofeld, chairman of the independent inquiry team into the death of David 'Rocky' Bennett said: "Black and ethnic minority citizens should not have to claim their rights, they should be given them as a matter of course. They are not demanding more than they are entitled to, nor

[4] The Murder of Zahid Mubarek: Part 1 of a formal investigation by the CRE into HM Prison Service of England and Wales , 9 July 2003
[5] Independent Inquiry into the death of David Bennett February 2004

are they claiming preferential treatment. They are simply asking for justice, which has been denied them for too long."[6]

[6] Sir John Blofeld, The Guardian, 12 February 2004