The Magazine of the Northern Ireland Human Rights Commission

NORTHERN IRELAND HUMAN RIGHTS COMMISSION

NIHRCreview

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Building human rights and social justice

I am delighted to contribute to the first issue of this magazine as it gives me an opportunity as the new Chief Commissioner to explain why I have taken up this post.

I have always believed that when we promote, respect, and fulfill the human rights of the 'other' (person), we also find ways to build healthy relationships, whether it is in our homes, streets, or community. Dealing with our differences has been hard work in Northern Ireland but human rights have something to offer not just to conflict prevention between groups but also to individuals.

For example, I have spent many years working with human rights abuses in the area of domestic violence. What that has taught me is that it is possible to introduce a set of human rights standards that ensure that what was once thought to be a private issue, such as abuse inside the home, can become a public responsibility. When the individual's behaviour is judged unacceptable by a new set of standards, and enforced by the law, then this can lead to a new set of attitudes. For example, seeing an abused woman as someone with 'human' rights hopefully promotes a culture where women are no longer treated as less equal. The same 'human rights' approach should apply to child abuse, racial abuse, etc. Of course, it is often an unfinished business and we have to continue promoting such a culture either by taking cases to court or by education and training. I am one of those who believe that it is possible to create such change especially with a strong Human Rights Commission. That is why I want to do this job.

What I also bring to this job is my experience working with political parties across the political divide in Northern Ireland. Two years ago, I had the opportunity to chair a round table of political parties on human rights, as part of the implementation of the Agreement. This process lasted for a number of months and, although it was missing the input of some of the main parties at the time, it promoted the idea of a Roundtable of political parties and civil society as one of the ways to seek consensus on what the proposed Bill of Rights should contain. I still believe that the Roundtable is the way forward and am currently meeting with political parties to encourage them to take this project seriously. I hope that the two governments who endorsed the proposal at the Leeds Castle Talks will also encourage the parties to come to the table. When they do, Northern Ireland politicians will have a 'healthy' problem to face – discussing how to offer advice on a Bill of Rights which will be there for generations to come. What better foundation could we ask for a country coming out of conflict.

A further priority for me as I take up this job is the contribution which human rights can make to conflict prevention. I believe that the Human Rights Commission, the Equality Commission, the Parades Commission, and the Community Relations Council should attempt to work collectively on difficult issues such as contentious parades and interface areas. More active involvement by all of us might help to resolve some potential crises within general human rights principles. The Office for the High Commissioner for Human Rights has asked the Northern Ireland Human Rights Commission to host a Roundtable on Human Rights and Conflict Prevention in June. Hopefully we will have had a number of local roundtables before the United Nations comes to town!

Another issue at the top of the human rights agenda is the wide range of anti-terrorist measures under consideration at Westminster. This clearly brings the balance between the protection of the public and the preservation of human rights into focus. Given the extent to which past experience in Northern Ireland is part of the debate, the Human Rights Commission hopes to make a valuable contribution in this area, not least in pointing out the dangers of

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Welcome...

Welcome to the magazine of the Northern Ireland Human Rights Commission, which hopefully, you will find of interest. We intend to publish three editions a year – our next issue is due to be published in summer 2006 and will focus on the proposed Bill of Rights for Northern Ireland. We hope the publication will help promote a discourse on human rights issues both locally and internationally and we welcome your views on the contents of this edition.

In this issue we focus on the most important human right, the right upon which all other rights rest, the right to life. This right, although not absolute, is the most fundamental in so far as the enjoyment of all other rights depends upon it being respected. Unsurprisingly, therefore, it is affirmed in numerous international human rights instruments including binding treaties to which the UK is a party and a much larger range of declaratory or soft law standards. Article 2 of the European Convention on Human Rights contains a number of subsidiary rights and duties such as the duty upon the state to protect life and the right to a proper investigation. We are delighted that experts in the field of death investigations such as Dame Janet Smith and Tom Luce, alongside local Coroner John Leckey, have kindly provided in-depth articles. Other contributors have illuminated other aspects of this developing field of inquiry which includes issues in regard to suicide prevention and the use of lethal force in Northern Ireland.

I hope you enjoy reading this edition of the Review and I look forward to receiving your views and comments. If you would like to receive further editions of this magazine please drop us a line.

Peter O'Neill
Editor

Continued from front cover

relying on excessive security powers and the need to find solutions to underlying political issues. The Commission will be making representations and lobbying at Westminster, as well as following the discussions at the Council of Europe and the UN.

How to deal with the past is also an issue for this Commission. A human rights approach would focus on the need for the acknowledgement of past abuses. Again I have some experience of this approach through my work with victims of domestic violence. Saying sorry is not what makes the difference, although it is part of a healing process. What matters most is a commitment to a new attitude – and that too is central to a human rights approach. The recently established Historic Enquiries Team by the PSNI and the appointment of a new Victims Commissioner will have an additional input to make to the debate in Northern Ireland.

Another important task for me is to hold the government to its promise to grant the Commission new powers to visit all places of detention and to require the production of evidence and papers from any body suspected of violating human right standards. I recently chaired a conference which was the outcome of the NIHRC's successful investigation into women in prison in Northern Ireland. What this conference highlighted was the importance of having such investigative powers. The NIHRC was granted access to prisoners in detention in this specific investigation but this should not remain at the discretion of the Prison Service. An effective Human Rights Commission should have these powers and they are long overdue – exactly one year after the Minister promised them. The government helped to ensure that the new Human Rights Commission in Sierra Leone had these powers. I expect them to ensure that we in Northern Ireland have them too.

Finally, I place much emphasis in my work on human rights on effective team building both inside and outside the office of the Human Rights Commission. I have a new team of Commissioners, and alongside our two existing Commissioners, we have all invested some time getting to know each other. We are also beginning to meet groups throughout Northern Ireland who are doing challenging work on human rights – on, for example, mental health, migrant workers, and asylum seekers. I have always found that expert knowledge – based on the testimony of someone who has suffered a human rights violation, alongside the knowledge of those who work on the issue every day, as well as the legal/academic knowledge in the field – leads to the kind of action that makes a real difference to people's lives. Bringing this kind of approach to my work with human rights activists and advocates and working within the current political context of Northern Ireland is a challenging one but one, I hope, will stand me in good stead during my term of office. Building human rights and social justice makes it all worth doing.

Who is stronger than death?

By Virginia McVea, NIHRC

Ted Hughes like many before and after posed the question "Who is stronger than death?"

Our automatic reaction is usually no-one, nothing, but that is in many ways increasingly less true. Psychiatrists tell us that our attitude to death and tragedy is changing, we are less 'accepting' – we are questioning. This, ability to question and make effective changes in response to the answers, the Commission would argue, is essential in securing our right to life. Indeed it always has been the key tool in improving our chances against death.

The intention of this brief article is to provide an overview of the work the Commission has been doing to secure what is often referred to as the most important human right, the right upon which all other rights rest, the right to life. This right, although not absolute, is the most fundamental in so far as the enjoyment of all other rights depends upon it being respected. Unsurprisingly therefore it is affirmed in numerous international human rights instruments including binding treaties to which the UK is a party and a much larger range of declaratory or soft law standards. The European Convention on Human Rights, Article 2, contains a number of subsidiary rights and duties such as the duty upon the state to protect life and the right to a proper investigation and the jurisprudence of the European Court of Human Rights has drawn on other international standards in its rulings which have specifically:

- framed a stringent test for the responsibility of the state to protect the right to life; acknowledging the 'equality approach', for example, the fact that the deceased were involved in illegal activity would not affect the duty of protection owed by the state
- acknowledged that where events lie wholly, or in large part within the exclusive knowledge of the authorities, a strong presumption of fact will arise in respect of injuries and death which occur, placing the burden of proof on the authorities to provide explanation
- highlighted that the procedural protection for the right to life means that the agents of the state must be accountable for their use of lethal force and investigation must scrutinise whether or not the force used was justified and identify those responsible
- called for the authorities to act of their own motion in initiating investigation
- held that the investigation must be independent, both practically and in terms of hierarchical connection of those alleged to have been involved
- stipulated that the investigation must take reasonable steps to secure evidence
- demanded promptness
- stated that there must be a sufficient element of public scrutiny, and
- outlined that the investigation should sufficiently involve the next-of-kin.

We have spoken to hundreds of people in Northern Ireland and across the world about protecting this right, looking at international standards and best practice and relating it to Northern Ireland. For this, the first edition of this magazine we have secured articles from prominent figures in the struggle to find the questions and which will protect life. These contributors refer to their more detailed examination of deaths and systems of investigation in a variety of situations: deaths caused by the state and others, deaths in places of detention, in care institutions and in the community.

We look at death where someone set out to harm and death as result of errors, unexpected death and deaths which could have been foreseen. Most importantly, using the tool of the Human Rights Act 1998 and the European Convention on Human Rights we examine how we question death. Each of the areas touched upon has its unique issues and we have already produced a variety of publications addressing specific contexts such as 'The Right to Life', 'Investigating Deaths in Hospitals' 'The Hurt Inside' and, shortly, the investigation of lethal force deaths. However, the Commission is attempting in this its first edition of the **Review** to highlight the need for co-ordination of investigative services. 'Whole image processing', examining all the contexts and sharing the most effective forms of questioning is as important as ensuring specialist expertise.

When the Commission first opened its doors in 1999, there was a real desire to prioritise the human rights involved in death investigation. Commissioners and staff had been told by the bereaved of unresolved and, oft-times, patently inadequate investigations, when their loved ones had died in a variety of settings. We drew lessons from the overwhelming sense that "the system" did not serve the 'everyday' sense of justice; indeed, contact with death investigation services was very often seen as having added to the burden of their grieving. Michael Finucane summed up the feelings of many bereaved families of all political persuasions across Northern Ireland when he said:

"Once again the families seem to be at the bottom of the British government's priorities".

Through the Commission's involvement with statutory bodies, it was evident that this opinion was not necessarily resisted by those working 'in the system'. In fact, they too told the Commission of the difficulties and frustrations in administering processes which were often unclear in terms of responsibility and under resourced.

As the UK government found itself answering awkward questions from the European Committee of Ministers following the Jordan decision in 2001, it promised that it had a 'package of measures' to deal with the problem. The government stated that when taken together, its investigation organs could satisfy Article 2 requirements. However the Committee of Ministers, who are charged with overseeing the state response to Court rulings, were not to be parried by vague promises and the questions continue.

This was, however, no longer a 'campaign' being waged solely on a European front. At home, Dame Janet Smith in the Shipman Inquiry and Tom Luce and his team in the Fundamental Review of Death Certification and Investigation in England, Wales and Northern Ireland were analysing how processes could work better to secure the right to life and they outline their conclusions in their own articles. Further, the domestic courts were considering cases in the wake of Jordan, considering deaths in a number of settings as outlined by Coroner, John Leckey's article. Finally, a number of long awaited inquiries were coming into being in relation to cases highlighted at Weston Park and considered by Judge Cory – Hamill, Nelson Wright and Finucane – and in her article Agnieszka Martynowicz looks briefly at these. Attempting to draw together the first three elements in particular, the government produced Home Office proposals in late 2004. There were some heartening suggestions around the nature of the investigation of the coroner, detailed medical assessment and talk of disclosure to the bereaved but such potential was seemingly deprioritised by passing the task to the Department of Constitutional Affairs with a nil budget. In Northern Ireland, the Court Service produced Proposals for the Administrative Redesign of the Coroners Service but despite the hopes expressed by Tom Luce in his article, in reality these tinkered at the edges of the major issues and defensively brought coroners into the Court Service with changes to how well the system could be 'monitored' but offered little by way of improvement for users or, indeed, coroners themselves.

And so we wait, as we have waited before. The Department of Constitutional Affairs has remained silent and the coroners districts have been amalgamated. Only three coroners remain, David Hunter, Deborah Malcolm and John Leckey, but so too does the massive backlog which stood at over 1,800 cases in 2004. With most of the coroners now retired and confusion over the impact of the 'line in the sand' drawn in the recent House of Lords decision in the McKerr ruling, that the Article 2 standards of investigation only applied to those who had died after the coming into force of the Human Rights Act in October 2000 (this is to be challenged in the Hurst case in early 2006), little has changed. Certainly less has demonstrably improved. Change was definitely in the air as John Leckey suggests but we are concerned that air so heavy with expectancy is beginning to turn stagnant. It would be unfair, however, to suggest that nothing significant has happened in Northern Ireland. There have, for example, been significant changes in the attitude to dealing with the 1,897 unsolved killings. Further to a number of meetings with the Chief Constable and members of the Crime Department the Commission knew that the PSNI had been making efforts to deal with 'cold cases' for a number of years and various suggestions were put to them regarding their systems. Their efforts came to a head in 2004 with the creation of a team and a system, which Alan Brecknell (and Paul O'Connor) of the Pat Finucane Centre report in their article. The Commission is at pains to point out that despite the UK government's recent attempts to sell this new department as a major plank in a construction to 'deal with the past', the Chief Constable has referred to a search for evidential potential and called upon politicians to face up to the broader issues of truth and reconciliation. In this context we are, as this edition goes to press, keenly watching for what may follow government's abandonment of the Northern Ireland Offences Bill.

The observance of human rights standards in death investigation is not however confined to lethal force cases. We are aware that the particular circumstances of Northern Ireland led many to keep their thoughts on, and dissatisfaction with systems and practices to themselves over the years and families are often only now speaking publicly about their frustration and disappointment with investigations into the deaths of their loved ones.

I have had the privilege of meeting with many people who have lost loved ones – beloved children, partners and parents, people who felt the added burden of their belief that there were failure by the state in its duty of care to those who had been placed in hospital to be looked after and/or its obligation to investigate when life was lost. In work which has moved the Commission into the field of economic and social rights, we have people from all walks of life, all cultures, and opinions recognising that – this is everyone's cause, this is everyone's future.

In prioritising this work, the Commission is learning from an increasing number of cases in which we are keeping a watching brief and the feedback which is continuing following our paper published last autumn on 'Investigating Deaths in Hospital'. Tony McGleenan's recommendations have proved invaluable in facilitating our exploration of the issues with all stakeholders including the bereaved, clinicians, nurses, clinical governance representatives, PSNI, Chief Medical Officer, Coroners, the Health and Safety Executive, the DHSS&PS, the new Regulation of Quality and Improvement Authority (responsible for primary and secondary care services, nursing homes, residential homes and children's homes), patients who have experienced adverse events and members of the legal profession. We have particularly noted the experience of families in their dissatisfaction with the route of civil litigation and Will Powell examines how the adversarial setting may not be the route to answers for families. We are deeply in the debt of those who have taken the time to share their knowledge and experience with us – thank you.

The Commission has been encouraged in particular by recent developments in the health service, although we continue to stress that overarching quality standards will have limited impact if care practices are not examined at ground level and results of reviews communicated into practice which is continually monitored. In making such points the Commission continues to advocate the policy and procedures used in New South Wales, Australia where exacting standards, robust review mechanisms and open disclosure in the health services is married with a powerful investigative coronial service which reports to Parliament annually on the recommendations it made and the response given. Adverse incidents have reduced in lead hospitals in Australia and patient satisfaction has improved. The Commission recently took up a longstanding invitation at the end of 2005, to study systems in operation within the coronial and health systems in Sydney and Melbourne, meeting with patient's representatives, lead clinicians, international commentators, human rights organisations and government representatives to examine what is happening within the inquest system generally and in hospitals and nursing homes specifically. This work will assist our new Commissioners in their consideration of further objectives in 2006.

Science and security can allow our society to be stronger against the threat of death in many instances and the Commission is committed to the promotion of human rights in securing the prevention of victimhood. Even when we get it wrong, the proper examination of what has occurred can undoubtedly aid us in prevention of further avoidable death.

Many of the bereaved have talked with us of their sense of obligation to their loved ones, their belief that they must ask questions about death and secure answers that might prevent similar loss. This is the right to life in operation, the value we place upon life is demonstrated by our strength in questioning death.

A personal voice

By Will Powell

Robbie Powell died at the age of ten on 17 April 1990 of a treatable condition called Addison's disease which, unknown to his parents, had been suspected four months before his death, when he had been an inpatient at Morriston Hospital, Swansea. The test to confirm the diagnosis was ordered by the hospital consultant but not performed. Addison's disease invariably results in death without treatment; however, if treated, the patient can live a full and normal life. The hospital informed Robbie's GPs of the suspicion of Addison's disease, by letter, and requested immediate referral if the child had a recurrence of, amongst other things, vomiting and/or abdominal pain. Between 2 and 17 April Robbie was seen by five GPs from the local health centre on seven separate occasions (that is, on 2, 6, 11, 15, 16 and twice on 17 April). In the two weeks leading to Robert's death he had been vomiting (a characteristic symptom of Addison's disease which had led to his initial hospital admission), was so weak he couldn't walk unassisted and had excessive weight loss. On the day he died the child had dilated pupils and central cyanosis when he regained consciousness after fainting. In the light of these symptoms and the several earlier consultations, a GP refused hospital admission on her first visit on the day of death. On her second visit, the GP again refused hospital admission but eventually agreed to do so following a heated argument. However, the Powells' request for an ambulance was refused. On arrival at the hospital, Mr Powell watched his youngest son take his last conscious breath. Robert was declared dead shortly afterward.

The hospital reported Robbie's death to the coroner and a pathologist employed by the health authority that would subsequently admit negligence and liability, for Robbie's death in 1996, in civil proceedings, was instructed by the coroner to perform the post mortem. The pathologist omitted from the post mortem report that Robbie had been suspected of Addison's disease, the previous December, and that the test to confirm the disease had been ordered by the hospital consultant but not carried out – had it been Robbie would not have died. The pathologist also misrepresented Robbie's external appearance by stating that he appeared normally nourished when his condition on arrival was subsequently described by the doctor, who treated him on arrival, as being like a child from a "concentration camp".

The coroner failed to have preliminary inquiries notwithstanding the Powells alleged medical negligence and had formally requested an inquest. Based solely on the flawed post mortem report, the coroner decided that Robbie's death was from natural causes and the Powells' request for an inquest was refused. It took the Powells ten years and a Fiat from the Attorney General before the coroner agreed to open an inquest. The inquest was opened and adjourned in December 2000 pending the conclusion of a third criminal investigation by an independent police force.

In March 2003, the Crown Prosecution Service informed the Powells that, although there was sufficient evidence to prosecute two of the GPs and a secretary for forgery and perverting the course of justice, they would not be charged. According to the CPS it would not be in the public interest to do so because of the passage of time, the failure of the local police to adequately investigate the case between 1994-2000 and because the local police had sent the GPs, who were acting police surgeons, an inappropriate letter in 1996 informing them that no further action would be taken against them. A complaint against the local police, which was made by the Powells, and investigated by another outside police force, found that the local police had been 'institutionally incompetent' between 1994-2000.

In April 2004, following a three-week inquest, which was spread over a three-month period, because of adjournments, a jury found that Robbie had died of 'natural causes aggravated by neglect'. It was reported in the press that the inquest had been 'reduced to a circus' and the article was entitled 'I promise to tell those bits of the truth which put me in a good light'.

Thirteen days after Robbie's death the Powells made a formal complaint through the NHS complaints procedure. A Medical Services Committee found, nine months after Robbie's death that four of the GPs had not been in breach of their terms of service, but that the GP who had seen Robbie twice on the day of death had been. She was told to conform to her terms of service in future, which was the minimum reprimand. The proceedings were a complete whitewash and the evidence of the Powells and that of their witnesses was completely ignored. The Powells' allegation regarding the post death falsification of Robbie's medical records, which was subsequently accepted by the CPS, was also ignored.

The Powells appealed to the Secretary of State for Wales against the MSC's decision and a hearing was listed for three days in March 1992. However, due to lack of time, the appeal was adjourned for six months. At the reconvened hearing it was established that Robbie's medical records had gone missing from the Welsh Office and been tampered with by the addition of medical notes, which originated from the respondent GPs, but had not been present or disclosed to the Powells previously. As a consequence of the appeal chairman's refusal to investigate this matter or call in the police the Powells were forced to withdraw from the appeal as they had lost all confidence in its independence. Although the Welsh Office had received Robbie's GP records, by recorded delivery, directly from the Powells' forensic document examiner, a week before the appeal started in March, the Welsh Office denied receipt, and continued to do so for three years. The receipt of the GP medical records was only accepted after the Powells submitted irrefutable evidence of their receipt.

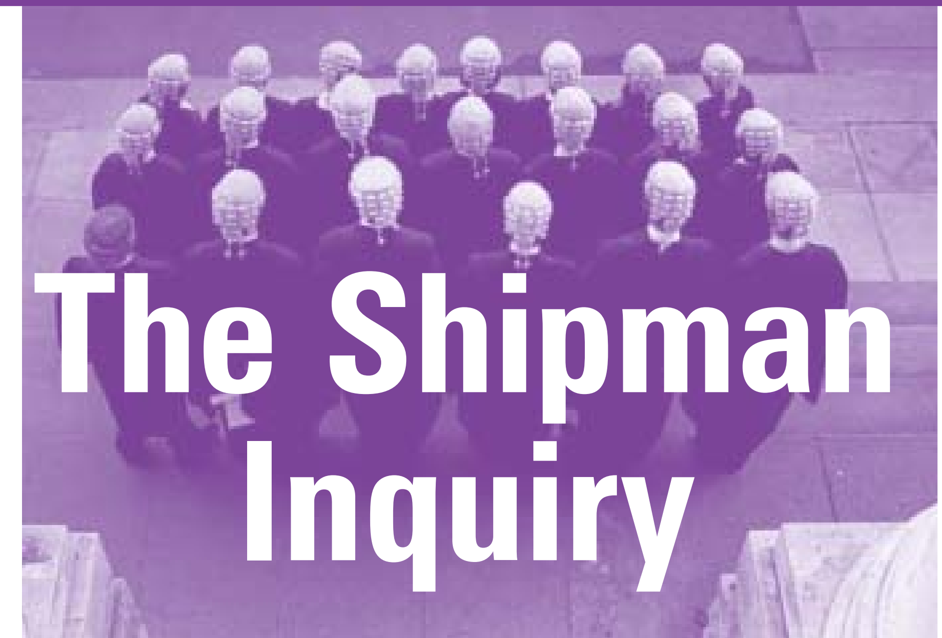
Following the Powells' withdrawal from the appeal they complained about the Welsh Office to the Parliamentary Ombudsman, via their MP, but were told that a complaint of maladministration against the Welsh Office was outside his jurisdiction. However, five years after the appeal the Parliamentary Ombudsman agreed to investigate the Powells' MP's complaint and seven years after the actual withdrawal of the appeal the Welsh Office was found guilty of maladministration.

In April 1993, with the support of public funding, the Powells issued writs against both the health authority and the GPs for negligence and causation. In June 1996 the trial was listed to be heard in the High Court in Cardiff for a period of six weeks. However, a month before trial, with the same information that was available on the night Robbie died, the health authority admitted negligence and liability for Robbie's death and paid £80,000 into court. Simultaneously, the GPs made an application to the court to strike out the Powells' claim for post death damage as a consequence of the GPs' negligence and dishonesty. The Powells refused to settle, as they wanted their case heard in court. However, before the trial could start, the judge had to consider whether or not to exercise his discretion to hear the GPs' late application to strike out the case against them. In his wisdom the judge decided to hear the application and, after four days in chambers, struck out the case against the GPs, but gave the Powells leave to appeal.

At this stage, the Powells' legal team and representatives from the Legal Aid Board informed the Powells that if they refused to accept the compensation from the health authority they would not be publicly funded to appeal against the judgment. The Powells had no other option but to accept the compensation on behalf of Mrs Powell. The £80,000 compensation was secured by the court pending the outcome of the Court of Appeal. The appeal was unsuccessful and the £80,000 compensation was therefore completely absorbed in legal fees. There was also an order for costs against the Powells for the deficit. With public funding the Powells petitioned the House of Lords but that was unsuccessful also.

The case was then submitted to the European Court of Human Rights but deemed inadmissible on 4 May 2000. The following was stated:
"Whilst it is arguable that doctors had a duty not to falsify medical records under the common law (Sir Donaldson MR's "duty of candour"), before Powell v Boladz there was no binding decision of the courts as to the existence of such a duty. As the law stands now, however, doctors have no duty to give parents of a child who died as a result of their negligence a truthful account of the circumstances of the death, nor even to refrain from deliberately falsifying records."

The ECHR also stated that the Powells could not claim to be victims under Article 2 because they had accepted compensation in civil proceedings, notwithstanding they had been forced to do so by the restrictions of public funding in the UK and, in any event, did not receive the compensation. The same court subsequently found in Jackson v UK that civil proceedings do not fulfil the State's obligation under Article 2. The Powells feel that the ECHR has been in breach of their human rights with no course of redress. ■



The Shipman Inquiry

By Dame Janet Smith

In 2001, Dame Janet Smith undertook an inquiry into the extent of Harold Shipman's crimes and the systems of certification and regulation that had failed to detect that he was a serial murderer. In 2002, she was appointed to the Court of Appeal to which she returned following the completion of the Shipman Inquiry in 2005. Here she reviews the inquiry.

The Shipman Inquiry and the Coroners Review

When Harold Shipman was convicted of murdering 15 patients in January 2000, and it was suspected that he might well have murdered many others, it was realised that our systems of death and cremation certification and coroners' investigation had completely failed to detect that anything was amiss. The government set up the Shipman Inquiry to look into the reasons why the systems had failed.

At about the same time, the Home Office set up a Fundamental Review of Coroners' Services, chaired by Mr Tom Luce. To a large extent, its terms of reference overlapped with my own, although, on post-death procedures, the Review had a wider remit than the Inquiry, particularly in respect of inquests. The Inquiry scarcely touched on inquests because Shipman had always managed to avoid them. He had certified virtually all the deaths himself without reference to the coroner. Another difference was that the Review was to encompass the systems in England, Wales and Northern Ireland; the Inquiry only considered England. So, the Review and the Inquiry complemented each other. If we were to make similar proposals, via our different routes, we should, between us, have a powerful voice for change.

Outline of conclusions

There was a large measure of agreement between us. We agreed about the defects within the present systems and on the objectives and principles that should underlie a new system. We agreed on the need for an improved system of death certification and reporting to the coroner. We agreed that cremation certification was wholly unsatisfactory and should be abolished. We agreed that coroners lacked guidance, leadership, training and resources and that there was a need for greater medical expertise in the coroner's office. Very few coroners are medically qualified; a mere handful have a dual qualification, legal and medical. The great majority are legally qualified and have no access to independent medical advice. We agreed that improvements were needed for a wide range of public interest reasons, not only the detection of wrongdoing, but also the advancement of medical science and the better targeting of healthcare resources.

We both agreed too, that the position of the bereaved must be improved. I have no doubt that many doctors and nurses deal sympathetically with bereaved families but the system takes very little official notice of them. A member of the family takes the medical certificate of cause of death to the register office in a closed envelope and often has no idea what is written on it. No one is responsible for ensuring that the family understands what is going on and why. Also, it appeared to both of us that many inquests are held which serve no public interest; they serve only to increase the distress of bereaved families.

Death certification – the problems

The need for improved death and cremation certification had been recognised decades before Shipman underlined the deficiencies of the present system. In 1965, the government of the day, realising that the systems that had been in operation since the early years of the 20th Century were past their 'use-by' dates, set up the Brodrick Committee. In 1971, that Committee recommended the strengthening of death certification and the abolition of cremation certification. Most of the systemic defects that the Inquiry had discovered were clearly described by the Brodrick Committee.

Under the present system, after a death, a doctor who has treated the deceased in the last illness completes a medical certificate of cause of death (the MCCD) unless s/he is uncertain of the cause of the death, in which case, s/he should report the death to the coroner. The doctor should also report the death to the coroner if it has occurred in circumstances that require a report. So, for example, if the death has occurred in a road traffic accident, the medical cause of death may be clear but the death must still be reported. When a doctor signs the MCCD s/he is, in effect, warranting two things: first that s/he knows the cause of death and second that the circumstances do not call for a coroner's inquest. The certificate goes to the registrar. If it is accepted, the death is registered and the family is free to bury the body. Registrars, in my view, do their work conscientiously, but they do not have the expertise to question the medical cause of death given by the doctor. Nor are they well placed to scrutinise the doctor's implied assertion that there is no need to report the death. They are not encouraged to ask the relatives about the death or whether they have any concerns about it. Thus, there is an opportunity for a dishonest doctor to certify the death and avoid an investigation. I am speaking not only of a doctor, like Shipman, who has deliberately killed a patient. The same opportunity exists for a doctor whose standard of care has fallen below par, or for a doctor who knows that the standard of care of a colleague or the collective standard of care of a medical team, has been less than satisfactory. In short, it gives doctors the chance to cover up.

If the family wishes to cremate the body, there are additional formalities. A relative applies for cremation on Form A. The treating doctor fills out Form B, in which s/he states the cause of death and provides some details of the circumstances of death. Another doctor signs Form C to say that s/he has examined the body and agrees with the cause of death given on Form B. Then the medical referee considers all the forms before deciding whether to authorise cremation. When cremation was first put on a statutory basis in 1902, the dangers of allowing the complete destruction of the body were recognised. The remains could not be exhumed for forensic examination. At that time, the additional formalities were treated very seriously. The second doctor had to form an independent opinion on the cause of death and knew that, to some extent, s/he was

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checking on the treating doctor. As cremation became the norm, the examination of the body and the countersigning of Form C became, for the majority of doctors, a routine event, little more than the application of a rubber stamp. Moreover, scrutiny by the medical referee became, for many, little more than a clerical exercise. In 1971, the Brodrick Committee reported that the system served no useful purpose. The Review and the Inquiry reached the same conclusion. Brodrick, the Review and the Inquiry all recommended improving death certification and abolishing the separate cremation procedures.

Death certification - Inquiry recommendations

In making recommendations for a new system, my first priority was a desire to take away from doctors the decision as to whether a death should be reported to the coroner. I wished to do this, not only to remove the potential for abuse. Research shows that, even when taken with complete integrity, as they usually are, doctors' decisions are often wrong. Many deaths that should be reported to the coroner are not. This is not altogether surprising. First, the statutory list of circumstances in which a death should be reported to the coroner is not clear or easy to apply; nor is it very comprehensive. As a result, many coroners supplement the list, in effect applying local rules. Even then, the decision whether to report a death is not always easy and many doctors find that they have to telephone the coroner's office for advice. Not all do. Even if a better statutory list were to be devised, as it could be, the decisions would still not be easy, particularly for doctors who do not have to make such decisions very frequently. Research undertaken at Sheffield University shows that doctors of all grades perform badly in this respect; they make a high proportion of errors. By contrast, coroner's officers, who have to deal with such issues day in and day out, recognise reportable circumstances much more reliably. Also, the research shows that some doctors make a conscious decision not to report a death to the coroner when they know that, really, they should. Some do so out of sympathy for the family, for whom they hope to avoid the additional stress involved in a coroner's investigation. Sometimes doctors yield to pressure from families, who do not want an inquest. So, for those reasons, I wanted the decision as to whether a full investigation is needed to be taken in the coroner's office rather than by a doctor.

I also wanted to take away from the single treating doctor the final responsibility of deciding upon the cause of death. Of course, the treating doctor will usually be in the best position to know the cause of death. But there are two problems. First, research shows that a significant proportion of certification errors are made, even by doctors who are doing their best. Death certification should be as accurate as reasonably possible. Therefore, some degree of scrutiny of the treating doctor's thinking is desirable. Second, it will not always be possible (particularly with the very old) to ascertain the precise cause of death without full investigation. It will not always be appropriate to undertake a full investigation; it might well be disproportionate. I do not think that the treating doctor is the right person to decide whether or not, in a particular case, a full investigation into an uncertain cause of death is warranted. So, for those two reasons, I think it preferable that, in all cases, the final decision as to certification is taken not by the treating doctor but by the coroner or someone acting under the coroner's authority. Every one accepts that the great majority of deaths do not require an in-depth investigation. At the moment, most cases go direct to the registrar with a MCCD. If a death is reported to the coroner, it is automatically referred for autopsy. Sometimes a coroner's autopsy is less than satisfactory. Often the pathologist does not have the medical records and knows nothing of the circumstances of death. Often the coroner will not pay for histology or toxicology. The opinion as to cause of death is given on the basis of the autopsy findings alone. Usually, the coroner just accepts the pathologist's opinion. I want to get away from these routine and unsatisfactory autopsies. I want to see pathology resources used where they are needed and not squandered where they are not.

However, before the stage is reached of deciding whether a case needs to go to autopsy, someone has to decide which deaths can proceed straight to registration and disposal and which require some further investigation. Often this is obvious but sometimes it is not. What cannot be done, in my view, is to create categories of death which are 'straightforward' and require only a simple procedure before certification. I have tried hard to devise such categories and I am convinced it cannot be done. Certainly the fact that the patient was old and/or ill before the death does not mean that the death is necessarily 'straightforward'. It usually will be but, if we have a system that assumes that it always is, we will have learned nothing from what Shipman did. Many of Shipman's victims were old and many were in poor health. Most already had a significant history of chronic disease that would, in time, have led to their deaths. If the deaths of patients who were old and ill were to be automatically excluded from full investigation and were to be registered on the basis of the doctor's certificate, the old and ill could be killed and their deaths certified by another Shipman. In any event, if age and ill-health were to be the criteria for a straightforward death, you would have to ask, 'how ill?' and 'how old?' Nor would it be satisfactory to say that an 'expected' death is straightforward and does not require full investigation. Expected to whom, you would have to ask. Shipman always said that the deaths of his murdered patients were expected to him. If a death were expected to the family but not the doctor, it would surely have to be investigated. I repeat, I cannot think of any set of criteria by which deaths could be satisfactorily categorised as not requiring full investigation. Yet plainly a large proportion of deaths do not need full investigation. In my view, the only safe way of deciding which deaths require full investigation and which do not is to consider each case individually, after an initial or basic investigation.

How could this be done without imposing unacceptable burdens on the medical profession and on the exchequer? My view is as follows:

First, we need a brief contemporaneous record of the circumstances of death. At present, the fact that someone has died does not have to be formally recorded. I think it should be and, at the same time, the circumstances (the time, place and who was present) should be noted. If the deceased died alone and was found dead, a note should be made of the person who last saw him or her alive and at what time. This form, which I call Form 1, need not be completed by a doctor. A nurse or paramedic would be quite capable of making such a record, although if

convenient, it might be done by a doctor.

Second, I want the treating doctor to complete a form (Form 2) stating the cause of death with reasons. At the moment, the doctor states on the MCCD what s/he believes to be the cause of death and any underlying causes but does not have to say why s/he is of that view. I am not suggesting a long exposition of the medical history. Usually two to three sentences would suffice but it should explain the doctor's thinking. If the medical records contain an adequate summary of the patient's terminal condition, that could be photocopied or sent electronically with Form 2, thereby reducing the amount of writing to be done by the doctor.

Third, I want a member of the deceased's family to be consulted, preferably face to face, although a telephone call would suffice in many cases. If Forms 1 and 2 revealed, as they might, that it was going to be necessary to conduct a full investigation, possibly including a post mortem, the family should be told this, officially, and the reasons should be explained. That is only humane. If the two forms, in themselves, suggested that the death did not require further investigation, the relative should be asked to give his or her account of the death. Then s/he should be told what was in Forms 1 and 2 and be asked if he or she had any concerns. In my view, it does not need a doctor to conduct that interview; a properly trained member of the coroner's staff could quite well do it. If no inconsistencies were found and no concerns expressed, that would be a 'straightforward' death, which could be certified without more ado on the basis of the treating doctor's opinion. If, any inconsistencies were found or concerns expressed, the case would be referred for further investigation. I estimate that as many as 80 per cent of all deaths could be certified after such a 'basic' investigation. I envisaged that that further investigation should be carried out by or under the direction of a medically qualified coroner. Cause of death is essentially a medical matter. It does not seem to me to be sensible to refer the issue to a legally qualified coroner who then becomes wholly dependent on the opinion of a pathologist after autopsy. I wanted to see the medical coroner able to undertake a range of investigations. These might only be a consideration of the medical records and a discussion with a person who was present at the death or who saw the deceased shortly beforehand. On the other hand, the medical coroner would have the power, in an appropriate case, to give instructions for an autopsy, with or without toxicology and any other tests thought necessary. I recommended that a death need not be referred to a legally qualified coroner for inquest unless the circumstances fell within clearly defined limits, such as deaths in custody, or if there was a conflict of evidence as to the circumstances, or there was some public interest reason why an inquest should be held.

Government's Position Paper

The government set out its proposals in a Position Paper published in March 2004. The space available here does not permit me to discuss the proposals in detail. They follow my recommendations to some extent and, although they do not go as far as I would wish (in particular in respect of my recommendations that we should have medical coroners and that a member of the deceased's family or a carer should be consulted in each), they would, I believe lead to considerable improvement. The government has consulted on its proposals and a draft Bill is expected shortly. At present, I am reasonably optimistic as to the outcome. ■

The coroner's inquest in death investigation

By Tom Luce, Chair of the Fundamental Review of Death Certification and the Coroner Services in England and Wales and Northern Ireland (2001–2003)

One of our objectives in the Fundamental Review of Death Certification and the Coroner Services was to re-establish the coroner's inquest as a viable and effective procedure for investigating complex and contentious deaths, which would enjoy public confidence and security from challenge in the higher courts. We were struck by the amount of litigation in the higher courts over inquest scopes and outcomes (not least in Northern Ireland cases), the scale and instancy of demand for *ad hoc* public inquiries after contentious or multiple deaths, the development of European Convention on Human Rights jurisprudence, and the evidence of a large number of people – lay and professional - who had been through inquests in complex or highly contentious cases and found the process unsatisfactory. All these factors combined to convince us that the inquest in its traditional form and with its traditionally narrow scope was in need of serious reform and reinforcement before it could meet the needs and expectations of the modern public to the standards increasingly required by modern law.

In our report we addressed this objective with recommendations in two areas:

- the scope, management and outcomes of inquests
- the structure of the coroner service.

Inquests

We recommended that:

- The outcome of the inquest should be primarily a factual account of the cause and circumstances the death, an analysis of whether there were systemic failings which had they not existed might have prevented it, and of how the activities of individuals bore on the death. The analysis should in suitable cases examine whether there was a real and immediate risk to life and whether the authorities took, or failed to take, reasonable steps to prevent it.
- The analysis should cover the regulatory or safety regimes designed to protect from risk in the circumstances of the death, and determine whether or not the safety regulations were properly observed or were, so far as the evidence shows, adequate.
- There should be improvements in the rights of bereaved families to disclosure of evidence and rights to address the inquest court, and in the coroner's powers to obtain material.
- The short-form "verdicts" ("accidental death", "misadventure", "unlawful killing" etc) traditional in England and Wales inquest outcomes, and the brief and general descriptive outcomes characteristic of Northern Ireland inquests, should be replaced in both jurisdictions by the fuller narrative and analytical outcomes described above, in cases where such a depth and breadth of inquiry is warranted.
- Formal public inquests should always be held in certain defined categories of case, including deaths apparently at the hands of law and order services, prison deaths unless the cause is beyond reasonable doubt natural, certain child deaths, and in other cases where a public forensic examination of the cause and circumstances of death is necessary and justified. Inquests into, for example, suicides not involving neglect or the participation of any third party, and some traffic deaths, would be replaced by investigations accessible to the family and others with a close interest, but not held in public.

Structure of the coroner service

In order to set and implement uniform standards and practices in the new coroner service, we recommended:

- The incorporation of the historically separate local coroner districts into two new national coroner jurisdictions, for England and Wales and Northern Ireland respectively.
- The appointment of full-time legally qualified coroners to head the new service in each local area, and of a new medically qualified statutory office-holder to oversee the certification of all deaths in each such area
- The appointment of senior judges to act as the judicial head of each of the new national coroner jurisdictions, with powers to give practice directions to the jurisdiction, settle appeals on points of law referred from the first instance level, and to hold inquests in cases of exceptional complexity or contentiousness or appoint another senior member of the judiciary to do so.

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Progress so far

Since we reported two and a half years ago, there has been progress in Northern Ireland with the structural reforms, and cases have been decided in the House of Lords, which expand the boundaries of the inquest to provide suitable death investigations where Article 2 of the European Convention on Human Rights is engaged.

In Northern Ireland, the individual coroner districts are being reorganised into a unified national jurisdiction with full-time leadership, and a High Court Judge is to be appointed as the overall judicial head of the new jurisdiction. This welcome progress is owed to the leadership of the Northern Ireland Court Service and its Ministers, the constructive interest and encouragement of the senior judiciary in Northern Ireland, and the flexibility of Northern Ireland coroners. Also relevant is the fact that Northern Ireland coroner legislation – the Coroners (Northern Ireland) Act 1959 – provides more scope for structural modernisation without fresh primary legislation than the Coroners' Act 1988 which governs the service in England and Wales.

There has so far been no change to the statute law or regulations governing the conduct of inquests in Northern Ireland or England and Wales. However, in what is generally seen as a landmark case, the Judicial Committee of the House of Lords has ruled that, in cases where Article 2 of the European Convention on Human Rights is engaged, the outcome of the inquest as provided for in the England and Wales Coroners' Rules by the phrase "how the deceased came by his death" should be interpreted "in the broader sense previously rejected, namely as meaning not simply 'by what means' but by what means and in what circumstances". The judgment also refers approvingly to the provision in S 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 governing the conduct of Fatal Accident Inquiries in Scotland: "..where and when the death took place; the cause or causes of such death, the defects in the system which contributed to the death, and any other factors which are relevant to the circumstances of the death."

This judgment, and the related judgment in the *Sacker* case, are both concerned with deaths in prison and they evidently apply also to the investigation of deaths at the hands of state agents since these have also been found to be within the scope of Article 2 of the European Human Rights Convention.

These cases go at least much of the way to establish a scope of inquiry for inquests into Article 2 cases which meet the reform objectives we set ourselves of "re-establish[ing] the inquest as a viable and effective procedure for investigating complex and contentious deaths, which would enjoy public confidence and security from challenge in the higher courts". But they do not of themselves make any direct contribution to the investigation of cases in which Article 2 is not engaged or has not so far been found by the courts to be engaged. These can include, for example, traumatic workplace deaths, deaths (sometimes multiple deaths) from train, bus or aircraft crashes, the sinking or collisions of passenger vessels, deaths to which medical procedures (or their absence) may have contributed, or deaths through catastrophes at football grounds. Such cases are relatively more numerous than prison deaths or deaths at the hands of the law and order services. They do not necessarily occur in facilities directly provided by the state, or implicate personnel directly employed by the state. However, they can certainly be complex and contentious, and all occur in environments where the state recognises a regulatory responsibility in the interests of public safety and protection. Some such cases have in recent years proved highly controversial and difficult to handle through the coronial process, in large part because of the restrictions on the scope of the inquest which the House of Lords has now probably remedied for Article 2 cases and the structural weaknesses in the coroner service which, for Northern Ireland, the Northern Ireland Court Service is now addressing.

Article 2 begins with a declaration of apparently wide import – "Everyone's life shall be protected by law". As a layman I would not presume to offer an opinion as to whether, as a matter of law, this declaration should be held to cover health and safety protection, medical regulation and transport safety regulation, for example. But it is hard to see any convincing public policy grounds for failing to correct a system in which those bereaved by deaths occurring in such settings cannot be confident of securing investigations of the same depth or quality as are rightly now to be available to those bereaved by deaths in prison or at the hands of the law and order services.

There are two ways in which this anomaly could be addressed. One is to wait and see whether in the course of time the courts extend the interpretation of Article 2 to deaths in these regulated settings. This would necessarily be an uncertain and untidy process, depending as it must on the somewhat random manner in which cases reach the higher courts. The other – far preferable in my view – is for the Government to recognise the strong public policy grounds for tackling the traditional weaknesses of the inquest in all the areas where there is a public need for a properly rounded inquiry, and to put beyond doubt the coroners' powers to provide a suitable inquiry by amending the regulations (and if necessary the primary provisions) so that the standards of inquiry envisaged by the House of Lords for Article 2 cases can be provided equally in other cases to which they are necessary and proportionate.

There are other important reforms outstanding from the recommendations of the Fundamental Review, and the related recommendations of the Shipman Inquiry. They include, in England and Wales, a general modernisation of the structure of the coroner service to match what is already under way in Northern Ireland; a serious and effective response to the problems – notably of scale and quality control - around the coroners' autopsy (in England and Wales the compulsory un-consented autopsy rate remains very high); and providing casework support for coroners independent of the police. A government White Paper and Draft Bill are promised later this year.

Above all, there is the need to replace the present dangerously unreliable death certification process with something safer. That is less obviously a "human rights" issue than some of the others we looked at. It is, however, interesting to speculate whether, if the courts were in due course to extend the interpretation of Article 2, they might find, if presented with a series of cases in which the death certification process had failed to provide a suitable protection of life, that leaving its obvious defects unreformed represented a breach of the obligations placed on the state by the European Convention on Human Rights. ■

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Inquests and human rights in Northern Ireland

By JOHN L LECKEY LL M[1]
Coroner for Greater Belfast[2]

The coronial landscape now is very different to what it was twenty years ago when I was appointed as Deputy Coroner for Greater Belfast. Then, some would have regarded it – unfairly in my view - as little more than a sinecure. Possibly, it was in some coroners' districts elsewhere in the United Kingdom, but the advent of "the troubles" in the late 1960s removed any basis for making such an assertion in relation to Northern Ireland coroners. They were confronted with the task of processing on top of their existing workload the very many troubles-related deaths and often that necessitated the holding of an inquest. Many deaths occurred in controversial circumstances, particularly where the death resulted from direct intervention by the security forces, and the subsequent inquests were often contentious. The adequacy of a coroner's inquest as the means of investigating such deaths was called into question, and from the mid 1980s this led to an exponential growth in legal challenges to coronial decisions. Whilst Northern Ireland led the way, the same exponential growth was experienced also in England and Wales. Within a few years a judicial review of a coronial decision was no longer a rarity but commonplace.

After many decades of stagnancy and inertia in coronial law one only had to sniff the air to know change was coming[3]. In my view there were a number of reasons for this. First, the coronial experience in Northern Ireland in relation to holding inquests into the troubles-related deaths was not a happy one: the remit of an inquest was strongly criticised by many bereaved families; the person suspected of causing the death was not a compellable witness[4] and the short-form verdicts available at inquests in England and Wales[5] – such as lawful or unlawful killing – were not available in Northern Ireland[6]. Second, bereaved families' expectations of what an inquest could and should deliver changed radically, and an increasing number of families are now legally represented at inquests[7]. Third, the enactment of the Human Rights Act 1998 which came into force on 2 October 2000. The effect of this legislation was complemented and enhanced by the establishment of the Northern Ireland Human Rights Commission which came into existence on 1 March 1999[8]. It was tasked to "…keep under review the adequacy and effectiveness in Northern Ireland of law and practice relating to the promotion of human rights"[9].

Whilst each was significant in itself, without doubt the key reason was the Human Rights Act. The coronial landscape was forever changed. Within a few years of it coming into force it became noticeable to me how the human rights' "language" was being used routinely by bereaved families whether in court or in correspondence. I was impressed by the grasp so many non-lawyers had acquired of the important human rights concepts and of their impact on the investigation of deaths through the medium of a coroner's inquest[10].

Article 2 of the European Convention on Human Rights provides:

"Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

Section 6(1) of the Human Rights Act provides that "it is unlawful for a public authority to act in a way which is incompatible with a Convention right". ("Public authority" includes any court or tribunal, which would include coroners' courts.[11]) Section 2 provides that a court or tribunal determining a question which has arisen in connection with a Convention right must take into account the European jurisprudence. Section 3 provides that domestic primary and subordinate legislation "must be read and given effect in a way which is compatible with the Convention rights"[12].
The obligations imposed by section 6 as well as sections 2 and 3 are most important. The obligation to take account of the European jurisprudence means much more than a mere acknowledgement. In his speech in R v Secretary of State for the Home Department, ex parte Amin[13], Lord Bingham stated:

Leah describes what it was like to lose her Aunt and Papa when she was 7

"Even though there may be room for flexibility in the procedures by different Member States, the European Court of Human Rights has insisted on a minimum threshold. In my opinion, even if the United Kingdom courts are only to take account of the Strasbourg Court decisions and are not strictly bound by them (section 2 of the Human Rights Act 1998), where the Court has laid down principles and, as here a minimum threshold requirement, United Kingdom courts should follow what the Court has said. If they do not do so without good reason the dissatisfied litigant has a right to go to Strasbourg where existing jurisprudence is likely to be followed."

R (Middleton) v West Somerset Coroner[14] was of particular importance in developing and clarifying the role of coroners' inquests in the new human rights era. It removed any previous uncertainty or ambiguity (and there certainly had been some– at least amongst coroners). In his speech Lord Bingham stated:

"The European Court has repeatedly interpreted Article 2 of the European Convention as imposing on member states substantive obligations not to take life without justification and also to establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life…

The European Court has also interpreted Article 2 as imposing on member states a procedural obligation to initiate an effective public investigation by an independent official body into any death occurring in circumstances in which it appears that one or other of the foregoing substantive obligations has been, or may have been, violated and it appears that agents of the state are, or may be, in some way implicated."[15]

Lord Bingham went on to answer the question he had posed – what form is the "effective public investigation" to take? His answer was in unequivocal terms[16]:

"In the absence of full criminal proceedings, and unless otherwise notified, a coroner should assume that his inquest is the means by which the state will discharge its procedural investigative obligations under Article 2."[17]

The use of the phrase "unless otherwise notified" is of particular significance as it implies that it is unnecessary for the coroner to seek the permission of the state before holding an Article 2 compliant inquest. The

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inquest must be held on that basis unless the state gives a specific direction to the contrary . To put it a different and, in perhaps, a more provocative way, the coroner is required to be proactive whilst the state may be reactive.

The coming into force of the Human Rights Act 1998[19] coupled with the developing jurisprudence of the European Court, which had been consistently critical of the law and practice governing coroners' inquests in Northern Ireland[20], inevitably necessitated a re-interpretation of the meaning of "how" as it is used in Rule 15 of the 1963 Coroners' Rules. In Middleton, Lord Bingham stated[22]:

"It is correct that the scheme enacted by and under the authority of Parliament should be respected save to the extent that a change of interpretation (authorised by section 3 of the Human Rights Act 1998) is required to honour the international obligations of the United Kingdom expressed in the Convention. Only one change is in our opinion needed: to interpret 'how' …. In the broader sense previously rejected, namely, as meaning not simply 'by what means' but 'by what means and in what circumstances'."

It is submitted that Middleton is now authority for the following propositions where Article 2 rights are engaged:

- "how" should be given a broader interpretation – "by what means and in what circumstances" rather than "by what means"[23];
- "In the absence of full criminal proceedings, and unless otherwise notified, a coroner should assume that his inquest is the means by which the state will discharge its procedural investigative obligation under article 2."[24]
- the jury should be permitted to express their conclusion on the central, factual issues in the case[25];
- the coroner will have to consider the form of verdict that is most appropriate for that purpose: the traditional short form verdict; a narrative form of verdict in which the jury's factual conclusions are summarised; or the jury's answer to factual questions put by the coroner. In relation to the latter possibility, Lord Bingham stated[26] "If the coroner invites either a narrative verdict or answers to questions, he may find it helpful to direct the jury with reference to some of the matters to which a sheriff will have regard in making his determination under section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976: where and when the death took place; the cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death".

In Re McKerr[27] the House of Lords stated that the obligation on the state to hold an investigation in respect of a violent death which complied with the requirements of Article 2, did not arise in respect of deaths occurring before the Human Rights Act 1998 came into force on 2 October 2000. However, the Northern Ireland Court of Appeal in Re Jordan[28] stated that irrespective of whether the death occurred before or after the implementation of the Human Rights Act, "how" should be given the broader interpretation of "by what means and in what circumstances"[29].

The decision of the European Court of Human Rights in Menson[30] illustrates how the jurisprudence of the European Court is evolving. It provides that Article 2 rights are engaged in cases where there is no alleged state involvement in the death and it extends to cases where there has been a life-threatening attack, whether or not death results. Therefore it is arguable that an inquest arising out of any violent death constitutes "the means by which the state will discharge its procedural investigative obligation under article 2"[31]. That being so, it is submitted that the discretionary power to hold inquests granted by section 13 of the 1959 Act may not exist in respect of inquests that must be Article 2 compliant[32]. Arguably, it is now mandatory that the coroner holds such inquests, unless notified to the contrary on behalf of the state, and, it is submitted, the unequivocal statement of Lord Bingham at paragraph 47 of Middleton provides authority for that proposition.

Article 2 rights may also be engaged in respect of deaths in hospital[33], prisons, nursing homes or other state institutions. Inquests in Northern Ireland have been held on that basis and without legal challenge as to the correctness of that approach.

It is hoped that this short article will go some way to demonstrating the radical impact human rights legislation and case law has had on coronial law after only five years. Perhaps, it is not surprising that the resultant domestic jurisprudence that has emerged within this short time-span has not always been consistent and that some measure of confusion remains. However, as I have indicated the House of Lords now has an opportunity to shed light where there is darkness. Whether doing so will settle the debate is an entirely different matter, particularly, as our domestic courts are required to take account of the evolving jurisprudence of the European Court of Human Rights. It would be a brave, perhaps foolish, lawyer who would claim that the final chapter would then have been written.

If history is the story of everyman, then the common law chronicles his quest for legal rights and justice. Human rights aficionados will argue that human rights are his hard won rights also. I am unaware of any statement in current domestic jurisprudence that argues the contrary and moreover, I am satisfied that everyman knows what his rights are.

footnotes

1. *© John L Leckey, October 2005. The views expressed in this article are the personal views of the author.*
2. *Following a public consultation process undertaken by Northern Ireland Court Service in 2004 on the modernisation of the Coroners' service in Northern Ireland, a final position paper was published in April 2005: "Modernising the Coroners Service in Northern Ireland: The Way Forward". It is planned that by April 2006 Northern Ireland will be a single coroner's district. The author will be the senior coroner and two other coroners will be appointed. It is anticipated that the Lord Chief Justice will appoint a High Court Judge as presiding judge for the new coroners' service. At the time of writing four part-time coroners' districts have been amalgamated with the Greater Belfast district.*
3. *See: Recommendation 123 of the Review of the Criminal Justice System in Northern Ireland (March 2000); "Death Certification and Investigation in England, Wales and Northern Ireland – The Report of a Fundamental Review 2003" (Cm 5831) and Death Certification and the Investigation of Deaths by Coroners" – Third Report of the Shipman Inquiry, 2003 (Cm 5854).*
4. *This is no longer the position as Rule 9 of the Coroners (Practice and Procedure) Rules (NI) 1963 has been amended by SR 2002 No 37. All witnesses are now compellable but a witness may refuse to answer a question tending to incriminate himself or his spouse.*
5. *See Jervis on Coroners, 12th ed, para 13-16.*
6. *The terms of a Finding at an inquest in Northern Ireland could not stray beyond the parameters of a brief, neutral, factual statement. See R v HM Coroner for North Humberside and Scunthorpe ex p Jamieson [1994] 3 WLR 82.*
7. *Often despite the fact that legal aid was not available for such representation. Now exceptional funding for inquests is available under Article 12(8) of the Access to Justice (NI) Order 2003.*
8. *It was created as a result of the Good Friday Agreement of 1998. See the Northern Ireland Act 1998 (Ss 68-71 and Sch 7).*
9. *1998 Act s 69(1). As to the right of the Commission to intervene in an inquest see In re Northern Ireland Human Rights Commission [2002] UKHL 25.*
10. *Much of the credit for this must be attributed to the pro-active educative role of the Northern Ireland Human Rights Commission under the chairmanship of Professor Brice Dickson.*
11. *S 6(3)(a).*
12. *As to whether a coroner is required to take account of the United Kingdom's international obligations see Metropolitan Police Commissioner v Hurst [2005] EWCA 890, CA.*
13. *[2003] UKHL 51 at para 44.*
14. *[2004] 2 WLR 800.*
15. *See paras 2 and 3.*
16. *Para 47.*
17. *Normally an inquest is not held following a full criminal trial where the relevant facts have been fully explored.*
18. *What form the notification to a coroner is to take has not been clarified. Could it take the form of a written direction from a government minister?*
19. *On 2 October 2000.*
20. *See five judgments of the European Court: Jordan (Application no 24746/94); Shanaghan (Application no 37715/97; McShane (Application no 43290/98); McKerr (Application no 28883/95); and Kelly (Application no 30054/96).*
21. *Rule 15 of the Coroners (Practice and Procedure) Rules (NI) 1963 provides that one of the matters to be ascertained at an inquest is how the deceased came by his death.*
22. *See paras 34 and 35.*
23. *This had the restrictive meaning given in fn 6.*
24. *See para 47 of the speech of Lord Bingham in Middleton.*
25. *Presumably this would apply also to a coroner holding an inquest without a jury.*
26. *Para 36.*
27. *[2004] 2 All ER 409. This decision was given on the same day as Middleton.*
28. *10 September 2004.*
29. *The debate continues to evolve. See Metropolitan Police Commissioner v Hurst [2005] EWCA 890, CA. At the time of writing three petitions are before the House of Lords for leave to appeal on a series of issues arising out of Middleton, McKerr and Hurst.*
30. *(App no 47916/99) (2003) ECHR. See also"Scrutinising the bill" New Law Journal 1 August 2003 p1194.*
31. *See Middleton at para 47.*
32. *It is submitted that Middleton has had the implied effect of interpreting s 13 of the 1959 Act in a manner that ensures compatibility with the European Convention.*
33. *See Investigating Deaths in Hospital in Northern Ireland by Tony McGleenan (Sept 2004), published by Northern Ireland Human Rights Commission. The position is unclear in respect of deaths in private hospitals or as a consequence of private medical treatment. In relation to Article 2 and hospital deaths see R (Khan) v The Secretary of State for Health [2003] EWCA Civ 1129, CA and R (Goodson) v Bedfordshire Coroner [2004] EWHC 2931 (Admin) (Richards J). Arguably the latter is a retreat from the position adopted by the English Court of Appeal in the former.*

The search for truth – pulling hen's teeth

By Alan Brecknell and Paul O'Connor The Pat Finucane Centre

Relatives for Justice Remembering Quilt

The Pat Finucane Centre has for many years assisted families in their search for truth relating to the deaths of their relatives. This search has taken many different routes. We have been involved in taking witness statements, corresponding with state agencies, instigating legal actions, lodging cases with the Police Ombudsman, all in an attempt to help families find the truth they are entitled to.

Many have asked why we should 'open old wounds'. Priscilla Hayner, in her book 'Unspeakable Truths' quotes Argentinean journalist, Horacio Verbitshy, who offers this answer:

> **"Because they were badly closed. First you have to cure the infection, or they will reopen themselves."**

If we do not look at our past and acknowledge it there is always the possibility that the wounds of the past will come back to haunt us in the future. We will have learned nothing from our history and surely this would be the worst possible legacy of 'the troubles'; to have learned nothing and to let the same happen again.

The Pat Finucane Centre has found interaction with state agencies (RUC, PSNI, NIO, DPP and Court Service) to be a long and difficult process, the term 'pulling hen's teeth' comes to mind. We have over the years written to all the above requesting information on behalf of families who have asked for our assistance. This is obviously not an ideal situation and we feel that serious consideration needs to be given to some form of internationally led truth seeking process to enable those who are victims of the conflict here to get the answers they are seeking.

On 8 March 2005, Paul Murphy, the then Secretary of State, announced that he was releasing funds to establish a new unit which:

> **"will be under the direction and control of the Chief Constable and will look at some 1800 murders from 1969 up to the signing of the Agreement that remained unsolved."**

It was also announced that some of the funding was to be used to establish:

> **"a dedicated team in Forensic Science Northern Ireland to provide comprehensive forensic advice to the review."**

This process should not and cannot be seen as the British government's response to calls for a 'truth process'. Even the Chief Constable agrees that this essentially police initiative cannot be regarded as an alternative to a truth process. Speaking recently at Trinity College, Dublin he said:

> **"it is important to emphasise that this work must not be seen as some alternative to a wider truth commission. … Rather it should be viewed as a significant contribution to a broader process to address the past."**

The exact role and remit of this 'Historical Enquires Team' (HET) has yet to be clarified and this has led to much debate as to how the team will operate. Neither the British Government nor the PSNI have provided clear information to the general public as to the HET's remit or operational responsibilities. In an effort to get this information into the public domain we sent an open letter to the Chief Constable in April 2005 outlining a number of issues we had relating to the process. Outlined below are the issues we raised and the answers which have been obtained to date.

Issue 1 - The reference by the Secretary of State in the March statement to "1800 murders" is deeply offensive and inaccurate. This is based on the entirely fictitious premise that only two people were actually murdered by the British Army or RUC. The use of this language sends out a dangerous signal.

Response - The Chief Constable has since stated that the HET will be re-examining over 2000 deaths related to the security situation during the period 1968 to 1998.

Issue 2 - The Serious Crime Review Team, (SCRT) which is an internal PSNI unit, will have no further responsibility for deaths which occurred before the Agreement and will focus on post Agreement serious crime only. All cases previously reviewed by the SCRT will be revisited by the new unit without prejudice to any decisions reached in the past. The new unit will liaise with families throughout this process.

Response - Again, the Chief Constable stated at the conference in Dublin that "There will be a twin track approach to examining cases, with one underpinning the other. The first track will be an assessment in chronological order, commencing with those from 1968. The second will supplement this and include other cases taken on specific grounds, including:

- Cases which were already re-opened before HET was established;"

Issue 3 - The Historical Enquiries Team will be led by Dave Cox, formerly of the Metropolitan Police and senior investigating officer in the Stevens 3 inquiry. The Head of Investigations will be Philip James, formerly of the Stevens 3 Inquiry and Metropolitan Police and now seconded to the PSNI. The new unit will be staffed by members of the PSNI, former members of the RUC and officers recruited from England, Scotland and Wales and the Garda Síochána.

Response - "The Historical Enquiries Unit (HET) will be headed up by two officers who worked with me the [Chief Constable] on the Stevens 3 inquiry, David Cox and Philip James, who will operate under the direct supervision of ACC Sam Kinkaid who is in charge of major crime investigation in NI. It will operate in accordance with legislation and within the criminal justice system. It will be a police based enterprise thus reviews and investigations will be conducted to a criminal burden of proof level and appropriate cases passed to Director of Public Prosecutions."

Issue 4 - The unit will review all conflict related deaths where no 'principals' have been convicted and subject to support from the family of the victim.

Response - The HET have confirmed that where multiple perpetrators are suspected and only a small number have been prosecuted that these cases will be looked at.

Issue 5 - All cases involving state killings and those involving allegations of collusion will be referred by Dave Cox to a special team within the unit made up of officers who are not drawn from the PSNI or RUC. The unit will not rely on existing PSNI files to decide if allegations of collusion exist and will accept additional information from families, NGOs and/or legal representatives.

Response - "The unit will have an assessment, review, evidence gathering and investigative capability. It is likely to be structured around two investigative units, a 'Special Case' section made up of seconded officers from other forces and a 'Review and Investigation team'. The 'Special Cases' section will undertake particular enquiries

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where allegations of collusion or involvement of the security forces are intrinsic elements of enquiries."

Issue 6 - The prioritisation of cases will be based primarily on issues of chronology and a set of criteria will be set out, (for instance to look at older cases first before witnesses die).

- There are four situations where the PSNI would deviate from this:

1. Cases already opened by the SCRT which will be revisited (approx 100),
2. Cases taken out of order because they are linked,
3. Humanitarian concerns (e.g. very elderly or ill next-of-kin),
4. Over-riding public interest (e.g. major allegations of collusion with the security forces).

Response - "There will be a twin track approach to examining cases, with one underpinning the other. The first track will be an assessment in chronological order, commencing with those from 1968. The second will supplement this and include other cases taken on specific grounds, including:

- Cases which were already re-opened before HET was established;
- Cases where there are overriding humanitarian considerations (e.g. an elderly surviving relative in poor health);
- A case is shown by evidence or analysis to be part of a series or linked to one already re-opened, and where investigative good practice requires concurrent examination;
- A case where an overriding Public Interest element is established."

Issue 7 -The protocols for liaison with families, NGOs and legal representatives have yet to be decided.

Response - "Family liaison will present particular challenges and any chance of success will require a bespoke approach in each case. Individual needs will be diverse. Many families will be content for the Senior investigating officer (SIO) and the Family liaison officer, (FLO) to deliver the findings, while for others, confidence in the police as an institution will be so low that no level of independent support will assist. Other families will fall at points between these approaches and meeting those varied attitudes effectively will require the advice and involvement of churches, community leaders, family support groups, and politicians. In short, there is no ready-made single solution here."

Issue 8 - The non-investigation by the Military Police of a large number of killings by British soldiers in the early seventies was raised by the NGOs. By definition there is little or no information in these files because of the decision not to investigate these killings. Therefore it would be unacceptable to make any decisions on these cases on the basis of empty files. This remains a major issue of concern which has yet to be resolved.

Response - No formal response as yet.

Issue 9 - Following review of a file and where no further investigative or criminal issues are outstanding the Historical Enquiries Team would adopt a policy of maximum disclosure of information to families subject to certain legal constraints. (For example families will not be informed of the identities of suspects who have not been convicted in the courts.)

Response - "Current best practice in this area was not designed to manage the expectations of some 2,000 families spanning a 30-year period. We are currently developing a strategy to deal with this area, because if we fail to deliver in this crucial aspect, the operation itself will fail. I have spent many hours over the past three years listening to families' stories whether directly, through interest groups or through lawyers. A number of themes emerge but the starkest is the desire to be told the story of the original investigation - what was done, what was not done and why. People also have some personal but deeply important questions about the circumstances of their loved one's death. It was through this listening that I began to understand just how little many families knew and just how important basic knowledge could be in terms of closure. This quest for knowledge crosses all divisions in Northern Ireland and led me to determine that our operating principle must be one of 'maximum disclosure'."

Issue 10 - It was agreed that the current language, whereby state killings are not referred to as 'murders', is hurtful and inaccurate. This remains a major issue of concern which has yet to be resolved.

Response - No formal response though the Chief Constable and the HET have both moved away from the '1,800 murders' formulation which by definition suggested that state killings did not constitute murder.

Issue 11 - The PSNI does not regard this initiative as constituting the British government or PSNI response to the debate around truth recovery processes. The unit may be in a position to provide information to individual families but this should not and cannot be seen as the truth and reconciliation model. Notwithstanding the stated PSNI position many have major concerns that the British government will attempt to portray this initiative as the template for any truth and reconciliation model.

Response - The Chief Constable sees the HET as "only part of the complex equation that will sum to a comprehensive solution to the past. It is frustrating that although there has been some smoke around a wider debate on the past, there has been little action".

As can be seen from the above, a number of issues remain to be addressed. It is unfortunate that so little information is yet in the public. According to senior staff within the HET they expect to be fully operational by the first week of 2006. Meetings have however already taken place with a number of families and groups.

The majority of cases that the Pat Finucane Centre deals with either involve the security forces directly or involve allegations of collusion. This therefore raises major issues in relation to the compatibility of HET investigations with Article 2 of the European Convention on Human Rights which requires independent investigations in such circumstances. The ECHR Article 2 ruling in 2001 and the subsequent legal battles over retrospective applicability have yet to be fully resolved. What is an independent investigation and when must one be held? Whatever the eventual outcome, it is reasonable to assume that the British government will put the HET model forward as fulfilling the Article 2 obligations. Whether the European Court agrees that the necessary independence is provided for with a unit which is ultimately answerable to and therefore controlled by an Assistant Chief Constable in the PSNI, an officer with long standing in the RUC, is as yet unclear. **"According to the European Court of Human Rights, an investigation will only be independent if 'the persons responsible for and carrying out the investigation are independent from those implicated in the events' … The Court has stressed that 'this means not only a lack of hierarchal or institutional connection but also a practical independence […]'. Clearly, this means that it would not be acceptable for a complaint about unlawful killing only to be internally investigated by members of the force against which the complaint had been made. The notion of 'practical independence' indicates that the Court is also prepared to look behind the appearance of independence, in order to ascertain whether or not investigators are genuinely free of any professional connection with those whom they are investigating."** ('The Right to Life', NIHRC, 2005, p18)

In addition, as the Human Rights Commission has noted, the notion of 'practical independence' may have implications for:

" … investigative systems which allow serving police officers to be seconded to investigate the conduct of police officers serving in neighbouring jurisdictions." ('The Right to Life', p19)

The HET is obviously such an 'investigative system'. It may serve a useful role in providing information to individual families. It cannot and should not be identified as a substitute to an internationally led 'truth seeking process'. The Chief Constable appears to accept this. As for the securocrats in the NIO ... *As the NIHRC **Review** went to print, the Historical Enquiries Team was formally launched on 20 January 2006.*

Public inquiries into conflict-related deaths

By Agnieszka Martynowicz, NIHRC

The issue of public inquiries into conflict-related deaths in Northern Ireland has been in the public arena for a number of years. Calls for investigations by independent panels of cases such as the murder of solicitor Patrick Finucane gained international attention and are the subject of campaigns by families of victims, national and international organisations, and political representatives. Such inquiries were seen as particularly necessary in cases where there were long-standing allegations of collusion between state forces and paramilitary organisations, and where any other process of investigation was seen as unsatisfactory. Particular importance has also been attached to the fact that any such investigation or inquiry should comply with standards set under the European Convention on Human Rights (ECHR), especially Article 2 (the right to life).

In 2004, three inquiries (out of four recommended by Judge Cory in his reports into allegations of collusion in a number of high-profile murders in Northern Ireland) were established under different pieces of legislation in force at the time – section 44 of the Police (Northern Ireland) Act 1998 (the Rosemary Nelson Inquiry and the Robert Hamill Inquiry) and section 7 of the Prison Act (Northern Ireland) 1953 (the Billy Wright Inquiry). Alongside this process, the Government consulted on and introduced new legislation, the Inquiries Act 2005, consolidating the basis for inquiries spread around different pieces of law and integrating inquiry powers into one piece of legislation. While this aim was largely achieved, doubts were raised and still remain as to whether the new system – which includes the possibility of a conversion of any existing inquiries into ones run under the new legislation – can deliver effective, independent inquiries into deaths. There are particular concerns around cases where there have been allegations of the involvement of agencies of the State or where deaths occurred in the custody of the State.

In its submissions on the Inquiries Act, the Commission expressed concern about the capacity of the new inquiries regime to deliver effective investigations into conflict-related deaths in a manner that fully satisfied the requirements of international human rights law. The proposed inquiry regime was subject to a high degree of ministerial control. Under the Act, a Minister appoints the chairperson and (in consultation with the chairperson) any other members of the panel, and the Minister sets out and has powers to alter the terms of reference. The Minister has powers to suspend or end the inquiry and to impose restrictions on attendance at an inquiry or any part of it. The Minister may restrict indefinitely the disclosure or publication of any evidence or documents given, produced or provided to the inquiry and has the responsibility for publication of the final report, with powers to suppress or redact parts of it. It was immediately apparent to the Commission that these powers offered considerable scope for ministerial intervention at practically every stage of the inquiry process, and this raises a number of questions around the structural independence of any process investigating cases where the disclosure of full truth about particular events could cause difficulty or embarrassment to government. The difficulties are compounded by the fact that the 2005 Act, which repealed the Tribunals of Inquiry (Evidence) Act 1921 and various inquiry provisions under other laws, does not include any provisions for direct involvement of Parliament in establishing inquiries. Ministerial responsibility in relation to Parliament is limited to the duty to inform it of the establishment, terms of reference or suspension of any inquiry, in person or in writing, with little provision for Parliamentary debate of any of these issues. The potential for ministerial interference led Judge Peter Cory and Lord Saville (the Chairman of the Bloody Sunday Inquiry) – among others – to publicly state their opposition to the Act.

Of particular concern to human rights organisations was the inability of the 2005 Act to deliver investigations that would fully comply with the standards relating to procedural requirements of Article 2 of the ECHR, which was brought into domestic law through the Human Rights Act 1998 (HRA). Article 2 (the right to life) has been interpreted by the European Court of Human Rights and domestic courts not only as imposing on the State an obligation to protect life, and not to take life unlawfully, but also as requiring deaths to be investigated in a particular manner. The "procedural requirements" of Article 2 demand that when a death occurs, any investigation should be independent, prompt, effective and transparent. Critics of the legislation say that it is inappropriate to give to the state extensive discretion over any inquiry which may involve an investigation of the state's own actions and omissions.

It is the Commission's view that the independence of the process should not depend exclusively on the personal integrity of those running the inquiries, but should be secured by structural and legal guarantees enshrined in the law. We welcome assurances given by the Government and chairpersons of the respective inquiries that they will be guided by the standards of human rights law, including the requirements of Article 2. The Commission's view remains, however, that a firm legal obligation needs to be established and the inquiry system redesigned to follow this obligation without leaving any scope for doubt.

One of the most worrying features of the 2005 Act is the power of the Minister to convert any existing inquiry into one run under the new Act. It is worth mentioning that with the introduction of the Act, all other bases for inquiries (including, as mentioned, provisions of the Police Act and the Prison Act) have been repealed so that any new inquiry is limited to the 2005 Act. When the 2005 Act was in draft, the Commission made representations addressing the issue of conversions, seeking assurances that none of the existing inquiries would be converted. We also expressed the view that in particular in the case of Pat Finucane, the character of evidence that has emerged through criminal trials and other investigations to date, pointing to collusion and incitement, means that the process under the new Act could not command the confidence of the Finucane family or a wider public. Unfortunately, the inquiry in the Finucane case was not instituted in time to be run under prior legislation and the 2005 Act is now the only vehicle available.

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In the context of these concerns, the Commission shared the disappointment of David Wright, the father of Billy Wright, the Committee on the Administration of Justice, British Irish Rights Watch and other human rights organisations with the announcement by the Chairman of the Billy Wright Inquiry, Lord MacLean, that he had requested the Secretary of State to convert the inquiry into a procedure conducted under the 2005 Act.

While this brief overview does not allow for a full rehearsal of all arguments for and against conversion (readers interested in the exchange of arguments will find the Chairman's initial statement on the Inquiry's website), it is worth mentioning that the main points raised by Lord MacLean related to the scope of the inquiry, the availability of evidence and the decision-making process in relation to public interest immunity applications. Lord MacLean argued that under the Prison Act, the panel would not have been able to look at matters related to Billy Wright's death that did not directly relate to the prison and would not be able to investigate what information, if any, was available from State agencies other than the Prison Service. In his view, the 2005 Act provided a better basis for the Inquiry to fulfil its Terms of Reference and to be able to look into wider matters, not directly connected to the prison. He also argued that the 2005 Act would provide the Inquiry panel with a clearer basis to obtain all documentation and see all relevant documents that might be subject to Public Interest Immunity (PII) certificates, allowing for restrictions on disclosure.

Lord MacLean's views are not shared by organisations such as the Commission. In relation to the scope of the Inquiry, the Commission takes the view that the phrase in the Prison Act stating that an inquiry can look into matters "otherwise in relation to the prison" can and should, when seen through the lens of the Article 2 obligations, give the Inquiry sufficient scope to investigate all matters having a bearing on the death in prison of Billy Wright and to look at all matters capable of elucidating the truth, including materials held by all state agencies. It is interesting to note in the context of this conflict of interpretation that in terms of the scope for inquiry, section 44 of the Police Act (forming the basis of the other two inquiries) has not been challenged in the same way, although it states that the Secretary of State can institute an inquiry into actions or inactions of "the police" only. The Terms of Reference of the Rosemary Nelson Inquiry provide for the investigation to go beyond the actions of the police and to look into conduct of the Army and the Northern Ireland Office, yet no need for conversion was expressed by the inquiry panel in this case.

The Commission's position is that concerns raised by Lord MacLean on the defects of the Prisons Act could have been satisfactorily addressed by interpreting the Act in light of the procedural requirements of Article 2 of the ECHR. This would have included decisions on disclosure of documents, obtaining all relevant information and publication of the final report.

The Secretary of State announced on 23 November 2005 that he had granted Lord MacLean's request. While any new inquiries will have to follow the 2005 procedure, the decision on conversion of the Billy Wright Inquiry will potentially have a bearing on the other inquiries already established and we will follow with interest any developments in this respect.

The Human Rights Act 5 years on

By Professor Monica McWilliams, NIHRC

The Human Rights Act 1998 has now been in force for five years. We should celebrate the contribution this legislation has made and reflect on where we go from here. The Northern Ireland Human Rights Commission continues to regard the Act as central to human rights promotion and protection. Its enactment was a major advance. By giving effect to the European Convention on Human Rights in domestic law the Act heralded a shift in focus towards a rights-based approach and expressly recognised that people have legal rights which should be respected. It introduced a set of values that flow from the Universal Declaration of Human Rights – dignity, pluralism, tolerance and mutual respect - values developed over centuries and designed to protect our common humanity. The dire predictions of some have not come to pass. The legal system and public administration have not collapsed under the weight of unfounded human rights claims. Where reform is needed this fact has been exposed; where rights are violated redress is available. There is much more to do, but we should acknowledge the progress made so far.

We need to tackle some misconceptions. For example, the Act is not simply a tool for lawyers nor is it about embedding a culture of human rights litigation. The aim is to mainstream respect for human rights within public administration and society generally. Effective consideration of Convention rights must become a normal part of policy development and implementation in all sectors. Viewed in these terms, litigation is a sign of failure. We cannot leave human rights exclusively to judges and lawyers. The Human Rights Act is for everyone. It protects majorities and minorities. European Convention rights are relevant in housing, planning and the welfare system. Convention principles are applicable to the health service and education system as much as the policing service and criminal justice system.

But we cannot be complacent about the rights which are protected by the Human Rights Act, based as it is on a 55 year-old document, the European Convention on Human Rights. Other, subsequent international treaties have highlighted issues such as environmental rights, women's rights, children's rights, language rights – all of which have equal relevance and importance today. As there has been nothing to fear from the introduction of the Human Rights Act, so the government should be giving consideration to introducing other international standards into domestic law. In Northern Ireland we are proposing the introduction of a Bill of Rights that would supplement the protections included in the Human Rights Act to ensure that there is in place an over-arching framework of legal protections for all our citizens.

However, debates on the human rights implications of the response to terrorism still rage in the UK and globally. In Northern Ireland we are familiar with these debates. We know from experience that respect for human rights is key to a stable, peaceful and prosperous society. The proposals of this government to amend our human rights legislation in light of terrorist threats threaten to undermine the core values of the European Convention and diminish the progress made in introducing the Human Rights Act. The experience in Northern Ireland of the futility of derogating from international human rights standards as a means of tackling terrorism is well documented and should be heeded. We cannot stand in judgement over the human rights records of other countries while we propose to introduce measures such as three months' detention without charge.

The Human Rights Commission believes the Human Rights Act is a significant achievement. We should all be proud of it. Critics of the law have not fully understood its principal objectives, the contribution it has made and it's potential. It has led to changes which we can all be pleased with. But we recognise that there is more work to do if we are to witness the emergence of a human rights culture in Northern Ireland. Compliance with the Act is an ongoing process. We will work in partnership with others to mainstream a culture of respect for human rights in the governance of Northern Ireland. In our view, this is a shared institutional responsibility which can be achieved through dialogue and co-operation. The Human Rights Act 1998 is at the heart of this objective. It is at the core of our work and fundamental to our shared vision of human rights protection and promotion in Northern Ireland.

The need for an effective suicide prevention strategy

By Michael Doherty

Seven years ago following a cluster of suicides within the Lenadoon area in Belfast, individuals and families concerned about friends, neighbours and family members contacted the Lenadoon Community Forum seeking professional help. At the time the level of service provision locally was nonexistent. Over the next twelve months through the goodwill of a number of qualified counsellors, the Forum operated an ad-hoc counselling service for emergency situations. What became apparent was that the level of need was such that a holistic, professional and structured approach was needed to cope with the demand for services.

In 1999 the Lenadoon Community Counselling Project was established to provide counselling to individuals who were self harming or who were experiencing difficult issues in their lives such as depression, sexual / physical abuse, relationship difficulties, trauma induced stress or bereavement. This Project has continued over the past seven years to provide professional support to hundreds of individuals and families in a community setting, as opposed to a surgery or hospital. The location of the service in a community setting is important in that those receiving counselling are encouraged to avail of other services in the Complex such as Childcare, Family Support, Personal Development, Parenting, Education and Training. GPs and health professionals across West Belfast make referrals to the Project every week and families who have been bereaved as a result of suicide have been supported also. Families and individuals are offered a holistic package of support. A significant aspect of the project is the high percentage of young males who regularly attend the service – traditionally a hard group to reach.

In 2004, an Evaluation of the Project was carried out by Quaesitum. The evaluation spoke of the Project as being "a model of good practice" and "offering value for money" GPs had told the consultants that they now referred clients to Lenadoon Counselling Project as an alternative to prescribing medication. Yet despite the positive evaluation, under funding and under resourcing are still major issues. They are issues that affect not only Lenadoon Counselling Project but similar effective Projects across North and West Belfast. At a time when these communities are experiencing an increase in the levels of suicide and self-harm, vital community projects are still being inadequately funded.

During the period February to June 2005 over twenty-five people, mainly young males, took their own lives in North and West Belfast. Within the Lenadoon area three local people took their own lives in the space of a fortnight and it was following the funeral of a local woman that feelings of sadness and desperation turned into anger at the government's indifference to the suicide crisis in disadvantaged communities.

Families of those bereaved through suicide and local community activists organised a series of protest actions which were aimed at highlighting the suicide crisis and the under investment by statutory bodies in mental health services. During this period Lenadoon Counselling Project lost the services of three part-time counsellors (who were each seeing 15 clients a week) when their funding ended. The protest campaign gained a lot of publicity and momentum and indeed the Health Minister, Shaun Woodward was pressurised into meeting the campaigners.

As a result of the relentless lobbying by the bereaved families, the Minister agreed in summer 2005 to extend the remit of the Regional Suicide Task Force that he set up. The Task Force which is chaired by Colm Donaghy, Chief Executive of the Southern Health and Social Services Board, has now been given the brief of developing a regional strategy for the prevention of suicide, which will include a costed regional action plan. As part of the consultation process towards developing the suicide strategy the Task Force has held a number of meetings with families bereaved through suicide and community activists from North and West Belfast and the Shankill. The key objectives in any new strategy for the families are:

- promotion of all available support services for those in need of help
- development of a 24/7 Crisis Response Team for North and West Belfast
- tracking and long term support for those who have attempted suicide and self harm
- adequate funding and resources for existing and emerging community based projects
- suicide awareness training for frontline medical and teaching staff
- promoting good mental health and suicide awareness sessions in schools, and
- support for bereaved families in the aftermath of a suicide.

The issue of suicide is one that has affected not only North and West Belfast but families, individuals and communities across Ireland. One person in Ireland attempts suicide every forty-five minutes. The devastation that is left behind when a loved one takes their own life is immeasurable. Suicide causes a ripple effect among families, friends and neighbours.

The proposed suicide strategy for the North of Ireland needs to take a long term co-ordinated and integrated approach. Effective interventions and projects that have demonstrated they are capable of meeting the need must be adequately resourced. Information on available services (especially late at night and at week-ends) should be accessible for everyone in the community especially the vulnerable.

Local communities and those bereaved through suicide want to work in partnership with government in designing a Suicide Prevention Strategy that can have a real impact on those who are contemplating taking their own lives. ■

Screensaving our rights

The Human Rights Commission has launched a unique competition for students to design a screensaver on the theme of human rights. Students on design courses at the University of Ulster, as part of their final degree programmes, have been invited to submit entries in the form of a screensaver depicting an aspect of human rights in Northern Ireland.

The Commission in partnership with the Community Foundation for Northern Ireland (CFNI), the University of Ulster (UU) and the Arts Council of Northern Ireland has set up this new design project to encourage students and young people to express their views on human rights in Northern Ireland.

The competition aims to harness the skills of young graphic designers in order to enhance public awareness of local human rights issues by producing creative visual communication in the form of a screensaver which can be downloaded by the general public.

Welcoming the project, Christine Blaney, Lecturer in Multimedia and Animation Design for Visual Communication said: "Students are encouraged to think creatively about human rights and express their ideas about issues relevant to young people in Northern Ireland."

The showcase will be piloted this year with approximately 80 students as part of their final degree course work and presented as an exhibition in March 2005.

An award of £1,000 will be made to the successful entrant with £500 and £250 provided to second and third placed entries.

Why a screensaver?

Nearly everyone with a computer uses a screensaver. Some use a blank screen, some use built-in screensaver samples, and others buy or download them from the internet. Some people even collect screensavers as examples of digital/computer art.

Screensavers can come with a variety of distribution options such as downloading from websites or distribution on CD or floppy disk. They can be a very powerful Internet marketing and promotional tool when used for the promotion of issues such as human rights work.

A screensaver is a program that starts on a computer when you stop typing or using the mouse for a specified period of time. If a screensaver is exciting and innovative, people will download it and send copies to friends.

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Consideration will be given to turning the successful screensavers into desktop wallpaper for download as well.

Screensavers can host and feature: animations, games, news, video clips, music tracks or samples.

Judges drawn from the sponsoring agencies and experts in this design field will review all entries. It is hoped that in the second year of the competition entry will be open to any member of the public.

We will judge entries on innovative content that exploits the strength of the screensaver medium, and displays a clear identity and understanding of a human rights issue or theme. We want to see ease of use combined with good design. The award selection will be based on the following criteria:

- breadth and quality of creative solutions
- effective communication of a Northern Ireland related human rights theme
- technical considerations
- usability considerations
- inventive use of design/communication

The Commission wants to encourage creative ways of stimulating thinking and debate about human rights and the opportunities for students and young people to put human rights into practice in a society emerging from conflict.

It is hoped that new work created through this competition can be used to inspire people by giving expression to the meaning of human rights in the local context and shaping images that capture the essence of human dignity and equality.

The students have already spent a considerable period of time researching their themes including attendance at a special presentation on human rights provided by the Commission last November.

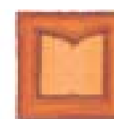
Student participants have enjoyed working on the project with Rachael Moody noting: "It's interesting working within boundaries to come up with something innovative that's more positive than negative. The hardest part is communicating about Northern Ireland."

Robert McKnight added: "I'm really enjoying the animation and it has made me think more about human rights."

Other students on the Design for Visual Communication course such as Dearbhla McCoy told us: "We are getting good feedback and because its a 'live' project it gives us useful experience of working in a professional design environment"; and Andrew Mearns said: "Once I got started on the animation, I got interested and now I don't want to stop."

Further information

For further information about the competition, please contact Peter O'Neill at the NIHRC on tel: 028 9024 3987, and/or visit the Commission's website at www.nihrc.org.



NORTHERN IRELAND HUMAN RIGHTS COMMISSION

A review of cases touching upon Article 2 of the European Convention on Human Rights in the Northern Ireland Courts December 2004 – December 2005 has been recently compiled by the Commission.

Please check our website

www.nihrc.org

Welcome for proposed new powers

The government has published a consultation paper on its proposals to enhance the powers of the Northern Ireland Human Rights Commission.

In welcoming the announcement, Chief Commissioner, Professor Monica McWilliams, stated:

"We are delighted that the Northern Ireland Office has issued this consultation paper which, although it does not offer the Commission everything that it sought, includes several recommendations, which if accepted, will empower us to more effectively carry out our investigations work. We first called for the power to compel evidence way back in March 2001 and it is gratifying that, at long last, we may soon be able to more effectively investigate allegations of human rights abuse.

At the moment, contrary to the United Nation's Paris Principles on human rights institutions, we have no power to compel anyone to provide evidence during the course of our investigations, nor do we have access rights to places of detention. Hopefully these new powers will enable us to act fully independently in the conduct of inquiries and investigations."

Commenting on the consultation, Political Development Minister, David Hanson MP, said: **"The Government believes strongly in the importance of human rights and is committed to ensuring that the Commission has the right powers to enable it to carry out its duties effectively.**

"The Government has assessed recommendations put forward by the Commission and is satisfied that it already broadly possesses the right powers to carry out its duties efficiently. However in two important areas, the right of access to places of detention and the power to compel evidence and witnesses, we agree that it is right to amend the Northern Ireland Act 1998 to make sure that the Commission can fulfil its existing functions properly.

"The consultation will run until 8 February 2006 and I invite views on all aspects of the paper, but particularly on how these two powers should be implemented and how we can make sure that the right safeguards are in place."

The Northern Ireland Act 1998 provided for the creation of the Northern Ireland Human Rights Commission. The Act sets out the functions, remit and the powers of the Commission. Section 69(2) of the Act required the Commission to make recommendations regarding its effectiveness to the Secretary of State for Northern Ireland within the first two years of its existence.

The Secretary of State received the Commission's 25 recommendations in March 2001. Subsequent to this in May 2002, the Northern Ireland Office issued a consultation paper, which outlined the Government's initial response to the recommendations. In April 2004 the Commission submitted a supplementary report containing four additional recommendations.

In December 2004, the then Secretary of State, Paul Murphy, announced that the Government had decided in principle that the Commission should be granted the right of access to places of detention and the power to compel evidence and witnesses, subject to appropriate safeguards, in conducting its investigations. He also confirmed that a full statement of the Government's conclusions on each of the Commission's recommendations would be published. A copy of the consultation document is available on the Northern Ireland Office website. The Commission will be pleased to provide further information on these proposals to interested parties. Please contact us at information@nihrc.org.

The views contained in the magazine do not necessarily reflect the views of the NIHRC. NIHRC Review is published by the Northern Ireland Human Rights Commission.