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### Criminal liability for child deaths in custody and the Corporate Manslaughter and Corporate Homicide Act 2007

#### Running head

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Title: Author

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Corporate manslaughter – custodial deaths – restraint – youth custody – youth justice system

Example3Begin

*It is a scandal that in the 21st century child offenders, some of society's most vulnerable and disadvantaged individuals, still die in the care of the State. Deteriorating and potentially lethal conditions in youth custodial institutions throw into sharp relief the ineffectiveness of the Corporate Manslaughter and Corporate Homicide Act 2007 to operate as a deterrent against unsafe custody practices. Despite applying to adult and child deaths in custody, the Act has never been invoked to prosecute such a fatality. The applicability of corporate manslaughter to child deaths in custody has been almost completely neglected by legal scholars. This article addresses such dereliction of academic scrutiny by analysing how the corporate manslaughter offence might interact with the labyrinthine youth custody system. The conclusion is that the complexity of the system, combined with the technicalities of the Act, would lead to obfuscation at every step of the prosecution process. The death in custody provisions in the Act need to be amended if they are to provide any meaningful protection for vulnerable children in custody. At present the UK is not complying with its duty under Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person in custodial institutions. There must be systemic change in the attitudes, policies and accepted practices which generate the routine and systematic degradation of the rights of children in custody in the UK.*

Example3End

#### Introduction

April 2018 will be the ten-year anniversary of the commencement of the Corporate Manslaughter and Corporate Homicide Act 2007 (the Act).<sup>1</sup> The Act was significant in that it

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<sup>1</sup> The Act received Royal Assent on 26 July 2007 and came into force on 6 April 2008, save for s 2(1)(d) and s 10.

introduced a specific offence for corporate killing in the United Kingdom (UK) for the first time.<sup>2</sup> Whilst the remit of the Act was extended in September 2011 to apply to custodial deaths, it was certainly not designed with these in mind. The inclusion of the death in custody provisions were strongly resisted by the government on the basis of cost, risk aversion and that existing methods of accountability were adequate, but ultimately the government capitulated.<sup>3</sup> Although it has now been possible for a number of years to prosecute an organisation for corporate manslaughter if a child (or adult) dies in custody, no such prosecution has ever been attempted.

Since 2000, at least 16 children have died in custody, four of these have been since September 2011. Custody strips child offenders, some of society's most vulnerable and disadvantaged individuals, of their personal freedom and renders them almost entirely dependent on the custody provider and youth justice authorities for their health and safety. It appears conditions in youth custodial institutions are deteriorating. The recent Annual Report of the Chief Inspector of Prisons described the speed of decline in youth custody standards as 'staggering'<sup>4</sup> and noted 'the current state of affairs is dangerous, counterproductive and will inevitably end in tragedy unless urgent corrective action is taken'.<sup>5</sup>

There are of course other, non-criminal accountability mechanisms in place when a child or adult dies in custody. Surely though if such investigations and inquests were sufficient in themselves, custody providers would have learnt from past errors and we would have seen a notable decrease in the number of deaths in custody. If anything, conditions in prisons and youth custodial institutions appear to be declining, as noted above. There are a number of reasons why the corporate manslaughter offence was extended to apply to deaths in custody. Firstly, it was to send a powerful symbolic message that all life is sacred, including the lives of vulnerable prisoners and detained children. The provisions were no doubt meant to be more than just a symbolic gesture though. The non-criminal accountability mechanisms were not proving to be effective, so the threat of a criminal sanction was hoped to provide a more powerful message that custodial institutions needed to get their house in order. Criminal sanction can only ever be effective, however, if the potential offender believes there is actually a chance of being prosecuted.

Whilst the applicability of the Act to child deaths in custody has hardly received any academic scrutiny, some academics have briefly mentioned it or discussed issues relevant for both adult and child deaths in custody. Doyle and Scott undertook a fairly detailed analysis of the Act's provisions in as far as they apply to prison custody, but did not scrutinise child custodial institutions in any depth.<sup>6</sup> Ormerod and Taylor include some general analysis of custody deaths in their 2007 article, but do not discuss child custodial deaths at all<sup>7</sup> and neither does Horder in his book chapter considering corporate manslaughter and public

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Section 2(1)(d) (duty of care owed to a person in custody) came into force on 1 September 2011.

<sup>2</sup> In England, Wales and Northern Ireland the offence is known as 'corporate manslaughter' and in Scotland it is known as 'corporate homicide': Corporate Manslaughter and Corporate Homicide Act 2007, s 1(5).

<sup>3</sup> *Hansard*, HC Deb, vol 460, col 664 (16 May 2007).

<sup>4</sup> Inspectorate of Prisons, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016 to 2017*, HC 208 (TSO, 2017), 9.

<sup>5</sup> *Ibid*, 10.

<sup>6</sup> DM Doyle, S Scott, 'Criminal Liability for Deaths in Prison Custody: The Corporate Manslaughter and Corporate Homicide Act 2007' (2016) 55(3) *The Howard Journal of Crime and Justice* 295.

<sup>7</sup> D Ormerod, R Taylor, 'The Corporate Manslaughter and Corporate Homicide Act 2007' (2008) 8 *Criminal Law Review* 589.

bodies.<sup>8</sup> Most academic scrutiny of the Act has overwhelmingly focused on worker deaths. As Doyle and Scott iterate: ‘scholars have tended to focus on the duty owed by private companies to their employees almost to the complete exclusion of the duty of [care?] owed by custodial institutions to those detained’.<sup>9</sup> The applicability of corporate manslaughter to child deaths in custody has been severely neglected by legal scholars. This article addresses such dereliction of legal scrutiny by analysing how the corporate manslaughter offence might interact with the labyrinthine youth custody system. The youth justice system involves a range of public bodies, private companies and local authorities which each have various statutory or contractual roles to play. Rather than consider the specific complexities of the youth justice system (or even the wider justice system), the death in custody provisions were essentially bolted on to a largely finalised Bill primarily formulated with private companies and workplace accidents in mind. This article explores the challenges this brings to securing a child death in custody conviction and provides insight as to the probable reasons no prosecutions have been brought. The analysis in this article will highlight that the death in custody provisions in the Act are not fit for purpose, provide no deterrent against unsafe custodial practices and accordingly have not resulted in any meaningful engagement with protecting the rights of young people in custody, under both domestic and international law.

The death in custody provisions in the Act should be amended to clarify areas of uncertainty and to ensure they have the intended deterrent effect Parliament envisaged. At present, the UK is not complying with its primary duty under Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (the European Convention) to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person in custodial institutions. There must be systemic change in the attitudes, policies and accepted practices that generate the routine and systematic degradation of the rights of children in custody in the UK.

## Legislative background

In the 1980s and 1990s there was growing impetus for reform due to a public perception that private sector companies were putting profits above safety. There had been a series of high profile, multi-fatality, disasters<sup>10</sup> and the annual number of workplace deaths was viewed as a cause for concern.<sup>11</sup> Whilst it was possible for a company to be prosecuted under the common law offence of gross negligence manslaughter<sup>12</sup> by applying what is known as the identification doctrine, this was widely regarded as an ineffective mechanism for attributing liability.<sup>13</sup> The identification doctrine tended to be an insurmountable hurdle to securing a conviction of any company with anything other than a very simple management structure.<sup>14</sup>

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<sup>8</sup> J Horder, *Homicide and the Politics of Law Reform* (Oxford University Press, 2012), ch 4.

<sup>9</sup> Doyle and Scott, n 6 above, at p 298.

<sup>10</sup> For example: the sinking of the Herald of the Free Enterprise (1987); the Kings Cross Fire (1987); the Clapham Rail crash (1988); the Piper Alpha oil platform disaster (1988); the sinking of the Marchioness (1989); the Southall rail crash (1997); the Paddington rail crash (1999); and the Hatfield rail crash (2000).

<sup>11</sup> See discussion in Home Office, *Reforming the Law on Involuntary Manslaughter: The Government’s Proposals* (TSO, 2000), para. 3.1.5.

<sup>12</sup> As confirmed by *R v P & O European Ferries (Dover) Ltd* (1991) 93 Cr App Rep 72.

<sup>13</sup> House of Commons Home Affairs and Work and Pensions Committees, *Draft Corporate Manslaughter Bill, First Joint Report of Session 2005–2006*, Volume 1: Report, HC 540-I (TSO, 2005), 3. See also discussion in C Wells, ‘The Law Commission Report on Involuntary Manslaughter: the Corporate Manslaughter Proposals: Pragmatism, Paradox and Peninsularity’ (1996) 8 *Criminal Law Review* 545.

<sup>14</sup> *Ibid.*

Only a handful of convictions were ever secured and only then in relation to small, usually ‘one man’ companies.<sup>15</sup> None of the high-profile disasters had resulted in a conviction of a company for gross negligence manslaughter, only failed prosecutions.<sup>16</sup> Prior to the Act, Crown bodies could not be charged with the common law offence because they had Crown immunity.

The Act abolished the common law offence of gross negligence manslaughter insofar as it applied to organisations<sup>17</sup> and removed certain aspects of Crown immunity. A draft Bill in 1996 proposed liability only for corporations.<sup>18</sup> The second iteration in 2005 contemplated a wider scope of liability and the removal of Crown immunity in relation to a number of government departments, but made no mention of liability arising from deaths in custody.<sup>19</sup> The death in custody provisions were only added during the final stages of the Bill’s progress through Parliament, the House of Commons eventually capitulating at the dogged insistence of the House of Lords.<sup>20</sup> The death in custody provisions, whilst ultimately implemented, were not given as much detailed consideration as the rest of the Act. For example, the Regulatory Impact Statement for the Bill does not even discuss deaths in custodial institutions.<sup>21</sup> Doyle and Scott have described the extension of liability as ‘hasty’ and opine that the provisions were not given enough consideration because prisoners, unlike workers, did not have a powerful interest group, only a few concerned members of the House of Lords like Lord Hunt.<sup>22</sup> Whilst the majority of the Act’s provisions came into force on 6 April 2008, the death in custody provisions were implemented in 2011 by an affirmative order.<sup>23</sup> It was argued that a delay in implementation was required for custody providers to ‘understand fully the extent of [their] obligations’ and to avoid officers becoming too risk averse.<sup>24</sup>

## Child custody context

The Ministry of Justice (MoJ) is the government department that has overarching responsibility for the justice system in England and Wales, including prison services.<sup>25</sup> The MoJ is supported in its work by a wide range of other executive agencies and public bodies. In relation to youth justice specifically, the Crime and Disorder Act 1998 established a new body corporate, the Youth Justice Board (YJB) for England and Wales.<sup>26</sup> The YJB is a non-

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<sup>15</sup> Ibid, at 11.

<sup>16</sup> For example, a prosecution arising out of the Herald of the Free Enterprise disaster failed due to issues with the application of the identification doctrine. See discussion in C Wells, *Corporations and Criminal Responsibility* (Oxford University Press, 2nd edn, 2001), 106 of earlier attempts to prosecute companies for corporate manslaughter.

<sup>17</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 20.

<sup>18</sup> Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter: Item 11 of the Sixth Programme of Law Reform: Criminal Law*, Cm 237 (1996), 137.

<sup>19</sup> Home Office, *Corporate Manslaughter: The Government’s Draft Bill for Reform* (TSO, 2005), 25–28.

<sup>20</sup> See discussion in Doyle and Scott, n 6 above, at 297–298.

<sup>21</sup> Home Office, *Corporate Manslaughter and Corporate Homicide: A Regulatory Impact Assessment on the Government’s Bill* (TSO, 2006). Available at: <http://webarchive.nationalarchives.gov.uk/+/http://homeoffice.gov.uk/documents/ria-corporate-manslaughter.pdf?view=Binary> (accessed 6 April 2017).

<sup>22</sup> Doyle and Scott, n 6 above, at 297.

<sup>23</sup> Corporate Manslaughter and Corporate Homicide Act 2007 (Commencement No 3) Order 2011 (SI 2011/1867).

<sup>24</sup> *Hansard*, HC Deb, vol 463, col 333 (18 July 2007).

<sup>25</sup> See: [www.gov.uk/government/organisations/ministry-of-justice/about#priorities](http://www.gov.uk/government/organisations/ministry-of-justice/about#priorities) (accessed 20 October 2017).

<sup>26</sup> Crime and Disorder Act 1998, s 41(1).

departmental public body and was created to oversee the youth justice system.<sup>27</sup> The YJB has traditionally been responsible for monitoring the youth justice system as well as commission and placements for under 18-year-old offenders. The YJB has contractual relationships with HM Prison and Probation Service (HMPPS), local authorities and private companies who manage various types of secure youth accommodation on its behalf. HMPPS, previously called the National Offender Management Service or NOMS, is the executive agency which, more generally, has responsibility for the commissioning, provision and regulation of prisons.<sup>28</sup> In practice, HMPPS provides its day-to-day prison/youth custody operations through another executive agency, HM Prison Service.<sup>29</sup> In December 2016 Charlie Taylor's review of the youth justice system made recommendations for extensive reform (the 2016 Report).<sup>30</sup> As part of the government's response, it was announced in February 2017 that operational responsibility for the youth estate would transfer to a new Youth Custody Service (YCS), a distinct arm of HMPPS (the new government quango mentioned above which has replaced NOMS).<sup>31</sup> Accordingly, since 1 September 2017 it is the YCS which is responsible for deciding in which type of secure accommodation a young person is to serve their period of detention. The Director of the YCS will have operational responsibility for the day-to-day running of the youth estate, is required to keep a firm grip on performance, and will be a board-level member of HMPPS.<sup>32</sup> The YJB's commissioning function has also been transferred to the MoJ but the YJB retains its statutory function of providing independent advice and scrutiny of the youth justice system.<sup>33</sup>

The three types of secure accommodation for children are: young offender institutions (YOI); secure training centres (STC); and secure children's homes (SCH).<sup>34</sup> A placement is made taking into consideration, amongst other things, the young person's age, maturity, resilience, risk of harm to self/others and educational and training needs.<sup>35</sup> YOIs house the vast majority of under 18s within the secure estate (around 69 percent, 605 young people, as at December 2017)<sup>36</sup> and most closely reflects a traditional prison environment. YOIs hold offenders aged 15 to 21 (people under 18 are held in different buildings).<sup>37</sup> Boys cannot be accommodated in YOIs unless they are aged 15 or over and there is no YOI accommodation for girls.<sup>38</sup> YOIs can accommodate relatively large numbers and house between 60 to 400.<sup>39</sup> YOIs are run by either HM Prison Service or private sector companies like G4S Care & Justice Services (UK)

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<sup>27</sup> 'Youth Justice System' is defined in the Crime and Disorder Act 1998, s 42 as the system of criminal justice insofar as it relates to under 18s.

<sup>28</sup> See: [www.gov.uk/government/organisations/her-majestys-prison-and-probation-service/about](http://www.gov.uk/government/organisations/her-majestys-prison-and-probation-service/about) (accessed 20 October 2017).

<sup>29</sup> See: [www.gov.uk/government/organisations/hm-prison-service/about](http://www.gov.uk/government/organisations/hm-prison-service/about) (accessed 20 October 2017).

<sup>30</sup> Ministry of Justice, *Review of the Youth Justice System in England and Wales*, Cm 9298 (2016).

<sup>31</sup> See: [www.gov.uk/government/speeches/youth-justice-update](http://www.gov.uk/government/speeches/youth-justice-update) (accessed 17 October 2017).

<sup>32</sup> Ibid.

<sup>33</sup> Ibid.

<sup>34</sup> Youth Custody Service, *The Youth Custody Service Placement Team – Overview of Operational Procedures* (YCS, 2017), 12.

<sup>35</sup> Ibid, 7–9.

<sup>36</sup> Youth Justice Board, *Youth Custody Report December 2017* (YJB, 2018).

<sup>37</sup> See: [www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people](http://www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people) (accessed 16 October 2017).

<sup>38</sup> Youth Custody Service, *The Youth Custody Service Placement Team – Overview of Operational Procedures* (YCS, 2017), 8.

<sup>39</sup> See: [www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people](http://www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people) (accessed 16 October 2017).



Limited (G4S).<sup>40</sup> The YJB entered into a service level agreement with HMPPS (when it was NOMs) pursuant to which HMPPS agreed to provide over 800 custodial places in four public sector YOIs that accommodate under 18s (Cookham Wood, Feltham, Werrington and Wetherby).<sup>41</sup> These public sector YOIs are operated by HMPPS through HM Prison Service. YOIs operate within many of the same rules and regulations as prisons for adults.<sup>42</sup> The Youth Offender Institution Rules 2000 set out the specific and detailed rules for the regulation and management of YOIs.<sup>43</sup>

Secure Training Centres (STCs) are purpose built centres which aim to provide a more constructive and educational environment designed to allow children the opportunity to develop and to stop reoffending.<sup>44</sup> This approach requires a relatively high staff to young person ratio.<sup>45</sup> STCs are designed for children aged up to 17 and house between 50 and 80 individuals, split into units of five to eight persons.<sup>46</sup> STCs held around 19.5 percent (171) of young people in the secure youth estate as at December 2017.<sup>47</sup> There are currently three STCs: Oakhill, Rainsbrook and Medway. All three STCs were originally managed by G4S, but the running of the centres has been marred by controversy. In 2015, an Ofsted inspection<sup>48</sup> found the overall effectiveness of Rainsbrook STC to be inadequate and G4S subsequently lost the contract to manage it to another private company, MTCnovo Ltd.<sup>49</sup> HMPPS (then NOMs) subsequently took over the running of Medway.<sup>50</sup> G4S announced its intention sell its STC contracts in February 2016<sup>51</sup> but for the time being it continues to manage Medway STC.

Secure Children's Homes (SCH) housed 11.5 percent (100 young people) of the secure youth estate as at December 2017.<sup>52</sup> They are run by local councils<sup>53</sup> and accommodate children placed by the YCS (previously the YJB) as well as caring for adolescents who have been placed there on welfare grounds by local authorities and the courts.<sup>54</sup> Historically, YJB placements represented the majority share of SCH places but recent years have seen a reversal of this trend.<sup>55</sup> SCH focus on attending to the physical, emotional and behavioural

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<sup>40</sup> Ibid.

<sup>41</sup> National Offender Management Service, *National Offender Management Service Annual Report 2016/17*, HC 196 (TSO, 2017) 26.

<sup>42</sup> See: [www.justice.gov.uk/offenders/types-of-offender/juveniles](http://www.justice.gov.uk/offenders/types-of-offender/juveniles) (accessed 15 November 2017).

<sup>43</sup> Young Offender Institution Rules 2000 (SI 2000/3371).

<sup>44</sup> R Arthur, *Young Offenders and the Law: How the Law Responds to Youth Offending* (Routledge, 2010), 107.

<sup>45</sup> See: [www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people](http://www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people) (accessed 16 October 2017).

<sup>46</sup> Ibid.

<sup>47</sup> Youth Justice Board, *Youth Custody Report December 2017* (YJB, 2018).

<sup>48</sup> Ofsted, *Inspection of Rainsbrook Secure Training Centre : February 2015* (Ofsted, 2015).

<sup>49</sup> See: [www.gov.uk/government/news/contract-award-announced-for-rainsbrook-and-medway-secure-training-centres](http://www.gov.uk/government/news/contract-award-announced-for-rainsbrook-and-medway-secure-training-centres) (accessed 19 October 2017).

<sup>50</sup> See: [www.gov.uk/government/news/yjb-response-to-medway-improvement-board-report](http://www.gov.uk/government/news/yjb-response-to-medway-improvement-board-report) (accessed 19 October 2017).

<sup>51</sup> See: [www.g4s.com/en-GB/Media%20Centre/News/2016/02/26/G4S%20Sale%20of%20UK%20Childrens%20Services%20business](http://www.g4s.com/en-GB/Media%20Centre/News/2016/02/26/G4S%20Sale%20of%20UK%20Childrens%20Services%20business) (accessed 19 October 2017).

<sup>52</sup> Youth Justice Board, *Youth Custody Report December 2017* (YJB, 2018).

<sup>53</sup> See: [www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people](http://www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people) (accessed 16 October 2017).

<sup>54</sup> Department for Education, *Children accommodated in secure children's homes at 31 March 2017: England and Wales* (DFE, 2017), 3.

<sup>55</sup> Ibid, 4.

needs of the children they home.<sup>56</sup> They aim to provide intensive one-on-one work with young people and accordingly SCHs have the highest ratio of staff to residents of the three types of secure accommodation. They are also generally smaller, housing around 8 to 40 children.<sup>57</sup> They normally accommodate children aged 10 to 14 and provide 30 hours of education and training a week following a school day timetable.<sup>58</sup> There are currently 15 SCHs in England and Wales.<sup>59</sup>

Children in custody have often had difficult, deprived backgrounds and serious multiple problems in terms of their school achievement, psychological health and drug abuse.<sup>60</sup> They are far more likely than the general population to have been in local authority care, to have suffered family breakdown or loss, to be homeless or insecurely housed and to have experienced child abuse. These children are the most disadvantaged, have the poorest educational experiences and are more likely to suffer from poor health, including mental health and substance misuse.

David Lammy's independent review of the treatment and outcomes of Black, Asian and Minority Ethnic (BAME) people in the criminal justice system highlighted his biggest concern as being the disproportionate representation of BAME groups throughout the youth justice system and the declining outcomes for BAME young people at a time when outcomes for white young people have been improving.<sup>61</sup> Despite making up just 14 percent of the population, over 40 percent of young people in custody are from BAME backgrounds. The BAME proportion of youth prisoners has risen from 25 percent to 41 percent in the decade 2006–2016, while numbers of young offenders in custody fell to record lows during the same period. The Lammy Report expressed concern about the differential treatment of BAME young people, for example in the magistrates' court, for every white young male sentenced to custody, 1.23 young black males were sentenced to custody. Young BAME men are more likely to be tried in the Crown Court than their white equivalents. At the Crown Court, BAME defendants were more likely than white defendants to receive prison sentences for drug offences, even when factors such as past convictions are taken into account. Young BAME prisoners are also less likely to be recorded as having problems, such as mental health, learning difficulties and troubled family relationships, suggesting many may have unmet needs.

## Relevant laws and human rights issues

There is a plethora of statutory provisions, rules, regulations and policies that govern how young people in custody are to be treated. For example, the Children Act 2004 sets out a framework of law for the safeguarding of all young people, including those in custody. The 2004 Act places a responsibility on the governors or directors of secure establishments to

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<sup>56</sup> Arthur, n 44 above, 106.

<sup>57</sup> See: [www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people](http://www.gov.uk/young-people-in-custody/what-custody-is-like-for-young-people) (accessed 16 October 2017).

<sup>58</sup> Ibid.

<sup>59</sup> Department of Education, *Children accommodated in secure children's homes: 31 March 2017* (DfE, 2017), 3.

<sup>60</sup> T Gyateng, A Moretti, T May, P Turnbull, *Needs and Interventions* (Youth Justice Board, 2013), 39; ECOTEC, *An Audit of Education Provision within the Juvenile Secure Estate: A Report to the Youth Justice Board* (Youth Justice Board, 2001), 9; H Fazel, N Doll, N Långström, 'Mental Disorders Among Adolescents in Juvenile Detention and Correctional Facilities: A Systematic Review and Metaregression Analysis of 25 Surveys' (2008) 47(9) *Journal of the American Academy of Child and Adolescent Psychiatry* 1010; Royal College of Speech & Language Therapists (2009) *Locked up and Locked out: Communication is the key* (Wales Justice Coalition, 2009), 8.

<sup>61</sup> D Lammy, *The Lammy Review: An independent review into the treatment of Black, Asian and Minority Ethnic individuals in the Criminal Justice System* (TSO, 2017).



promote the welfare of, and safeguard, the young people in their care.<sup>62</sup> In addition, young offender institutions are required to have a specific strategy to develop the physical, mental and social health of young people in their care and are obliged to prevent the deterioration of health during custody.<sup>63</sup> There are a number of rules, regulations and guidelines by which prisons are run, referred to as Prison Service Instructions (PSIs)<sup>64</sup> and Prison Service Orders (PSOs).<sup>65</sup> Most PSIs and PSOs apply to young people in the same way as they do to adult prisoners. Where there are particular differences for the regimes appropriate to young people, these will be set out in the Care and Management of Young People PSI, currently 08/2012. Young people who are on remand are subject to the Prison Rules 1999.<sup>66</sup>

In *R (Howard League for Penal Reform) v Secretary of State for Home Department*<sup>67</sup> Munby J held that the duties which a local authority would otherwise owe to a child in need under section 17 of the Children Act 1989 do not cease to be owed merely because a child is currently detained in a young offender institution (YOI) or other Prison Service establishment, subject to the necessary requirements of imprisonment. Thus the Children Act 1989 applies, in addition to the 2004 Act, to children in any such establishment and, accordingly, local authorities are under an obligation to respond to a child in need referral concerning a child in custody and undertake a child in need assessment, to see whether the child satisfies the criteria in s 17(10).<sup>68</sup> The emphasis in the Children Acts 1989 and 2004 and Munby J's judgment in *R (Howard League for Penal Reform) v Secretary of State for Home Department* is on the equality of treatment between young people in trouble and young people with troubles and a reminder to custodial institutions that all young people placed in custody, some in appalling conditions, have human rights as children which must be upheld.

The UK has obligations towards young people in custody under the European Convention. As a signatory to the European Convention, the United Kingdom must uphold the fundamental human rights guaranteed by the Convention. The Convention rights were given further effect in the UK in 2000, with the coming into force of the Human Rights Act 1998. Article 2 of the European Convention states that the right to life of all citizens shall be protected by law. Article 2 is relevant to deaths in custody in two ways. Firstly, when a person dies in the custody of the State it will raise the question as to whether the State has complied with its Article 2 obligation to protect life (discussed further below). However, the obligation extends more widely beyond this primary obligation, as the court noted in *R (Amin) v Secretary of State for the Home Department*:<sup>69</sup>

‘The first sentence of Article 2(1) enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction. It is common ground that the State’s obligation in this respect extends beyond its primary duty to secure the

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<sup>62</sup> Children Act 2004, s 11.

<sup>63</sup> Prison Service Order 3200: Health Promotion (23 October 2003).

<sup>64</sup> See: [www.justice.gov.uk/offenders/psis](http://www.justice.gov.uk/offenders/psis) (accessed 15 November 2017).

<sup>65</sup> Ibid.

<sup>66</sup> Prison Rules 1999 (SI 1999/728).

<sup>67</sup> [2002] EWHC 2497 (Admin), [2003] 1 FLR 484.

<sup>68</sup> Section 17(10): ‘a child shall be taken to be in need if—(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part; (b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or (c) he is disabled’.

<sup>69</sup> [2003] UKHL 51, [2004] 1 AC 653.

right to life by putting in place effective criminal law provisions to deter the commission of offences against the person backed up by law-enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions.’

Secondly then, there is a more general question about whether by failing to impose effective legislation and sanction in relation to deaths in custody, the UK is in breach of its Article 2 obligations to deter the commission of corporate manslaughter offences in custodial settings.

The European Court of Human Rights in *Kats v Ukraine*<sup>70</sup> stressed that: ‘Persons in custody are in a particularly vulnerable position and the authorities are under an obligation to account for their treatment’<sup>71</sup> and concluded that where an individual dies in suspicious circumstances while in custody, this should automatically raise an issue as to whether the State has complied with its obligation to protect that person’s Article 2 right to life. In this case the prisoner’s death was the result of inadequate medical assistance in circumstances where the prison authorities were aware of the deceased’s HIV status. In *Tyrell v HM Senior Coroner County Durham and Darlington*<sup>72</sup> Burnett LJ concluded that *Kats* broadened the positive obligations under Article 2 to encompass not only the obligation to take reasonable measures within the scope of their powers to avert a real or immediate risk to the right to life,<sup>73</sup> but also an obligation to account for the cause of any death which occurs in custody.<sup>74</sup> *Edwards v United Kingdom*<sup>75</sup> and *Amin* both concerned prisoners who had been killed by their cellmates, as also occurred in the case of *Zahid Mubarek* which will be discussed later in this article. Both *Edwards* and his cellmate, *Linford*, were suffering schizophrenia when *Edwards* was killed by *Linford*. The European Court of Human Rights ruled that the obligation under Article 2 to protect life extended to taking preventive operational measures to protect an individual against the criminal acts of another, where the authorities knew (or ought to have known) of a real and immediate risk to the life of an identified individual. Information was available identifying *Linford* as posing such a risk. The failure to pass on this information, and the inadequate screening of *Linford*, amounted to a breach of Article 2. In *Amin* the deceased was a young Asian prisoner who was placed in a cell overnight with, and killed by, a prisoner known to be racist, extremely violent and mentally unstable. The court concluded that when taking prisoners into custody, the State is accountable for failures in their care. Thus, where prison authorities know, or ought to have known, of a real and immediate risk to the life of a prisoner, there exists a positive obligation to take actions to prevent this outcome. Where an individual dies in State custody, and where knowledge of the facts surrounding that death are likely to be in the hands of the State (as is always the case in State custody), Article 2 requires that the State provide an independent investigation into that death.

Article 3 of the European Convention may also be relevant to a death in custody. It provides an absolute protection against conduct that has serious physical or psychological effects on individuals. In *Z v United Kingdom*,<sup>76</sup> the European Court of Human Rights ruled that Article 3 of the European Convention ‘enshrines one of the most fundamental values of democratic

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<sup>70</sup> (Application No 29971/04) (2008) 51 EHRR 1066.

<sup>71</sup> *Ibid*, para [104].

<sup>72</sup> [2016] EWHC 1892 (Admin), 153 BMLR 208.

<sup>73</sup> *McFeeley v United Kingdom* (Application No 8317/78) (1980) 3 EHRR 161.

<sup>74</sup> [2016] EWHC 1892 (Admin), 153 BMLR 208, para [26].

<sup>75</sup> (Application No 46477/99) (2002) 35 EHRR 487.

<sup>76</sup> (Application No 29392/95) (2001) 34 EHRR 97.

society’ and requires States to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment or punishment by State agencies or others, including private individuals:

‘These measures should provide effective protection, in particular, of children and vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge.’

The European Court ruled that in the context of how young people are treated by the criminal justice system, the main aim of Article 3 was to protect a person’s dignity and physical integrity.<sup>77</sup> In *Keenan v United Kingdom*<sup>78</sup> the suicide in custody of a mentally ill prisoner was found to breach Article 3 as there had been insufficient and inadequate monitoring and psychiatric assessment and the prisoner had been subjected to disciplinary measures which did not conform with the required standards of treatment for the mentally ill.

The United Nations Convention on the Rights of the Child (UNCRC) is another international treaty which is binding on the UK. It comprehensively promotes children’s rights – civil, political, economic, social and cultural – informing other human rights standards through a framework of state responsibilities applicable to all children within signatory States’ jurisdictions. Article 3 of the UNCRC requires that ‘in all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative bodies or legislative bodies, the best interests of the child shall be the paramount consideration’. In *R (SR) v Nottingham Magistrates’ Court*<sup>79</sup> it was held that Article 3(1) applied when assessing the appropriateness of placing a 16-year-old boy in a YOI. This means that public authorities involved in the care and management of young people have an obligation to consider the best interests of the young person as a primary consideration. Article 40(3) of UNCRC provides that young offenders must be treated in a manner consistent with the promotion of the ‘child’s sense of dignity and worth ... and which takes into account the child’s age’. Article 37 of UNCRC requires States to treat young people in custody with humanity and in a manner which takes into account the needs of persons of their age and to protect them from torture and other cruel, inhuman or degrading treatment or punishment. Article 19 of UNCRC requires States to take all appropriate measures, including legislative, to protect those aged under 18 years from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation. Ratification of the United Nations Convention on the Rights of the Child is a commitment binding in international law. Thus, the UK has a Conventional obligation to ensure that the traditional objectives of criminal justice must give way to rehabilitation and restorative justice objectives in dealing with young offenders. In December 2010, prior to the implementation of the death in custody provisions of the Act, the government made a commitment in a written Ministerial statement to Parliament to give ‘due regard’ to the UNCRC when making new policy or legislation.<sup>80</sup> Although this commitment is not a statutory obligation, it does commit the government to considering the compatibility of legislation with the UNCRC. The UNCRC should also be read alongside the United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) 2015, which require respect for the dignity and value of prisoners as human beings and the

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<sup>77</sup> *Tyrer v United Kingdom* (Application No 5856/72) (1978) 2 EHRR 1.

<sup>78</sup> (Application No 27229/95) (2001) 33 EHRR 913.

<sup>79</sup> [2001] EWHC Admin 802, 166 JP 132.

<sup>80</sup> *Hansard*, HC Deb, vol 520, col 17WS (6 December 2010). See also, Cabinet Office, *Guide to making legislation* (TSO, 2014), 12.29.

prohibition of torture and other cruel, inhuman or degrading treatment or punishment. Custodial institutions also need to identify the individual needs of prisoners and ensure protection of vulnerable groups. The European Prison Rules<sup>81</sup> are based on the UN Nelson Mandela Rules. These rules refer specifically to the prison authorities' obligation to safeguard the health of all prisoners (rule 39). Although they are not legally binding for member states of the Council of Europe, they do provide recognised minimum standards of principles and practices in the treatment of detainees.

Child custody in itself involves a complex set of statutory provisions, rules, regulations and policies. The Act was implemented without any real regard to this complexity. Custody providers can now theoretically be prosecuted for corporate manslaughter if a child dies in their care, but this has never happened in practice. In addition, if a child dies in the care of a State custody provider, there is also the question as to whether the UK has failed to uphold its European Convention and UNCRC obligations, most notably the right to life. The authors would argue the UK is also in breach of its Article 2 obligations by failing to impose effective legislation to deter the commission of corporate manslaughter in custodial settings.

## Deaths of young people in custody

In 2014, the YJB reported that sixteen boys had died in custody since it took responsibility for placements and commissioning in April 2000.<sup>82</sup> Unfortunately, there appear to have been at least two further deaths of children in custody since 2014. In 2015, 16-year-old Daniel Adewole died in his cell at Cookham Wood YOI following an epileptic fit and in 2017, the YJB confirmed in its Annual Report for 2016/17 that a 'child died in one of [the YJB's] commissioned secure children's homes'.<sup>83</sup> The vast majority of young people who die in custody commit suicide. Since 2000, one child has died while being restrained and one child has died from natural causes. The majority of deaths occur at YOIs, although there have been two deaths at STCs and one recent death at a SCH. See Table 1 for an overview of confirmed deaths in custody since 2000.

**Table 1 – Child deaths in custody since 2000<sup>84</sup>**

No.	Year	Name	Age	Cause of death	Type of secure accommodation
1.	2017	TBC	17	TBC	Newton Aycliffe SCH
2.	2015	Daniel Adewole	16	Natural causes (epilepsy)	Cookham Wood YOI
3.	2012	Alex Kelly	15	Suicide	Cookham Wood YOI
4.	2012	Jake Hardy	17	Suicide	Hindley YOI
5.	2011	Ryan Clark	17	Suicide	Wetherby YOI
6.	2007	Liam McManus	15	Suicide	Lancaster Farms YOI
7.	2005	Sam Elphick	17	Suicide	Hindley YOI

<sup>81</sup> REC (2006)2 of the Committee of Ministers.

<sup>82</sup> Youth Justice Board, *Deaths of Children in Custody: Action Taken, Lessons Learnt* (YJB, 2014), 4.

<sup>83</sup> Youth Justice Board, *Annual Report and Accounts 2016/17* HC 157 (TSO, 2017), 7.

<sup>84</sup> Information on deaths 3–18 taken from *Deaths of Children in Custody: Action Taken, Lessons Learnt* (YJB, 2014), 11–13.

8.	2005	Gareth Price	16	Suicide	Lancaster Farms YOI
9.	2004	Adam Rickwood	14	Suicide	Hassockfield STC
10.	2004	Gareth Myatt	15	Accidental death while being restrained	Rainsbrook STC
11.	2002	Ian Powell	17	Suicide	Parc YOI
12.	2002	Joseph Scholes	16	Suicide	Stoke Health YOI
13.	2001	Kevin Jacobs	16	Suicide	Feltham YOI
14.	2001	Mark Dade	16	Suicide	Wetherby YOI
15.	2001	Anthony Redding	16	Suicide	Brinsford YOI
16.	2000	Kevin Henson	17	Suicide	Feltham YOI
17.	2000	Philip Griffin	17	Suicide	Wetherby YOI
18.	2000	David Dennis	17	Suicide	Brinsford YOI

The boys whose deaths were found to be self-inflicted (or were thought to be, where inquests were not yet concluded), all used ligatures.<sup>85</sup> In the hours before his death, Liam McManus was taunted by his fellow inmates who encouraged him to tie a ligature around his neck.<sup>86</sup> Similarly Jake Hardy reported being bullied at Hindley YOI but ‘no one acted to protect him’.<sup>87</sup> Joseph Scholes died in HMYOI Stoke Heath in 2002. He was a vulnerable boy with a history of self-harming behaviour who, despite clear warnings by himself, took his own life, by hanging, in his prison cell just nine days into his sentence. The youngest of the boys to take his own life was 14-year-old Adam Rickwood who in 2004 hung himself using his shoelace in his room at Hassockfield STC.<sup>88</sup> Hours before his death, Adam had been struck on the nose, using the so called ‘nose distraction technique’.<sup>89</sup> He had been subjected to use of force because he had refused to move from a communal area to his room.<sup>90</sup> The second inquest into Adam’s death concluded that this use of force was unlawful (because it could not be used just to maintain good order and discipline) and that it contributed to Adam’s death.<sup>91</sup> In a review of three child deaths in 2012, the Prisons and Probation Ombudsman found that there was often a conflict between processes designed to support those at risk of self-harm and suicide and disciplinary procedures, concluding that the ‘adult-orientated adjudication system appeared an inappropriate way to manage vulnerable children’.<sup>92</sup> The Chief Inspector of Prisons noted in 2017 that boys in crisis at one YOI were living in cells bare of furnishings

<sup>85</sup> Ibid, 11.

<sup>86</sup> Prisons and Probation Ombudsman, *Investigation into the Circumstances Surrounding the Death of a Boy at HMYOI Lancaster Farms in November 2007* (2009).

<sup>87</sup> Prisons and Probation Ombudsman, *Investigation into the Circumstances Surrounding the Death of a Young Person at Hospital in January 2012, while in the Custody of HMP and YOI Hindley* (2013).

<sup>88</sup> [www.theguardian.com/society/2007/jun/02/youthjustice.politics](http://www.theguardian.com/society/2007/jun/02/youthjustice.politics) (accessed 20 October 2017).

<sup>89</sup> *Deaths of Children in Custody: Action Taken, Lessons Learnt*, op cit 20.

<sup>90</sup> Ibid.

<sup>91</sup> Ibid.

<sup>92</sup> Prisons and Probation Ombudsman, *Investigation into the Circumstances Surrounding the Death of a Young Person at Hospital in January 2012, while in the Custody of HMP and YOI Hindley* (2013).



and personal belongings, despite being under constant supervision.<sup>93</sup> He admonished that these sterile conditions gave too much priority to mitigating risk rather than providing a humane environment that promoted well-being.<sup>94</sup>

The use of restraint was also a factor in the 2004 death of Gareth Myatt at Rainsbrook STC.<sup>95</sup> While being restrained, Gareth vomited and died from positional asphyxia.<sup>96</sup> The inquest recorded a verdict of accidental death but made 34 recommendations, 11 of which related directly to the governance, use and policy relating to restraint.<sup>97</sup> Since the deaths of Gareth Myatt and Adam Rickwood, the YJB and other relevant bodies have changed the approved system for restraint. The restraint techniques used in both cases have been banned, and the Government commissioned an independent review.<sup>98</sup> In 2012 a new approved system for restraint, Minimising and Managing Physical Restraint (MMPR), was approved for use in STCs and YOIs which confirms that use of force must always be viewed as the last available option.<sup>99</sup> Despite this, in March 2013, the Justice Committee published its report on youth justice in which it expressed serious concern that: ‘despite the fact that the use of force in restraining young offenders has now been definitively linked to the death of at least one young person in custody, the use of restraint rose considerably across the secure estate last year’.<sup>100</sup> Deteriorating conditions within the secure youth estate have led to a rise in the use of restraint as a behaviour management technique. The most recent report of the Chief Inspector of Prisons in 2017 has highlighted that the use of force is high at all YOIs inspected and had risen at Keppel, Parc and Cookham Wood.<sup>101</sup> In 2016, a Freedom of Information Act request revealed that an independent medical review of restraints applied in YOIs and STCs suggested certain restraints carried a 40–60 percent chance of death or severe permanent disability affecting their everyday life.<sup>102</sup> Clearly, an increased use of restraint means there is a higher risk of human rights abuses and another accidental death occurring.

In 2015, 16-year-old Daniel Adewole was found unresponsive in his cell at Cookham Wood YOI following an epileptic fit. There was a delay in entering his cell and attempts at resuscitation proved unsuccessful. An inquest concluded that he died of natural causes and that whilst events at the YOI were concerning, the coroner was not satisfied Daniel’s death could have been prevented had his cell been entered earlier.<sup>103</sup> An independent investigation into the death by the Prisons and Probation Ombudsman noted that staff did not have sufficient understanding of Daniel’s condition and that there was an unacceptable delay in going into Daniel’s cell when officers could not get a response.<sup>104</sup> In 2000, 19-year-old Zahid

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<sup>93</sup> Inspectorate of Prisons, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016 to 2017* (HC 208) (2017) 63.

<sup>94</sup> *Ibid.*

<sup>95</sup> Youth Justice Board, *Deaths of Children in Custody: Action Taken, Lessons Learnt* (YJB, 2014), 41.

<sup>96</sup> *Ibid.*

<sup>97</sup> *Ibid.*, 42.

<sup>98</sup> *Ibid.*, 20

<sup>99</sup> *Ibid.*, 22.

<sup>100</sup> House of Commons Justice Committee, *Youth Justice Seventh Report of Session 2012–13* (TSO, 2013).

<sup>101</sup> Inspectorate of Prisons, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016 to 2017*, HC 208 (TSO, 2017), 63.

<sup>102</sup> See: [www.theguardian.com/uk-news/2016/dec/05/approved-restraint-techniques-can-kill-children-moj-found](http://www.theguardian.com/uk-news/2016/dec/05/approved-restraint-techniques-can-kill-children-moj-found) (23 October 2017).

<sup>103</sup> See: [www.bbc.co.uk/news/uk-england-kent-39720186](http://www.bbc.co.uk/news/uk-england-kent-39720186) (accessed 20 October 2017).

<sup>104</sup> Prisons and Probation Ombudsman, *Independent Investigation into the Death of Daniel Adewole, at HMYOI Cookham*



Mubarek was murdered by his cellmate while serving a short sentence at a Feltham YOI.<sup>105</sup> It was his first time in custody. Robert Stewart, his murderer, was a known racist and had personality problems but was never examined by a doctor whilst at the YOI.<sup>106</sup> An official inquiry into the death of Zahid Mubarek was published in 2006 and it found 186 failings that led to his death. It also found there was a casual disregard towards racism at Feltham.<sup>107</sup> The Chief Inspector for Prisons and Probation noted in his most recent report increased levels of violence within the secure youth estate: ‘levels of violence had risen ... in our survey, 41 percent of children told us they had felt unsafe’.<sup>108</sup> An increase in violence within the youth estate means there must be an increased risk of a child dying at the hands of another inmate.

The children who die in custody are some of the most disadvantaged in society and have often experienced problems with mental health, self-harm, alcohol and/or drugs. Goldson and Coles’ research on the deaths of children in custody between 1990 and 2004 concluded that those who died had been ‘routinely disfigured by multiple and intersecting forms of social disadvantage’.<sup>109</sup> Involvement with social services and the care system, mental health needs, incidence of substance misuse and domestic violence in the family and the deaths of significant family members were common experiences. School exclusion, ADHD diagnosis and drug and alcohol dependency also featured prominently. Often children are housed far from home and fewer custodial institutions now mean this is more likely than ever, increasing their sense of isolation.<sup>110</sup> The evidence examined above suggests that youth custodial institutions over-emphasise the status of young people as prisoners who must be controlled rather than their status as children with welfare and care needs.<sup>111</sup> This approach to young people in custody is further evidenced by the most recent annual report by HM Inspectorate of Prisons on the experiences of 720 detained children aged 12 to 18. The report found that staffing problems meant far too many boys were locked up in cells nearly all day (over 22 hours per day) in YOIs and in STCs staff were being redeployed from their assigned unit to cover gaps elsewhere in the centre. The report also found that almost 40 percent of young people in YOIs had felt unsafe and 20 percent of young people in STCs said they had no one to turn to if they had a problem, meaning vulnerable children with complex needs were trying to manage their problems without support. This evidence indicates that there is a gap between how the youth custodial estate operates and what young people in custody actually need, as the very practice of imprisoning children is very damaging for those young people. This gap represents a significant political, organisational, and moral failure to protect the fundamental basic human rights of young people. Youth custody is inherently a place of danger and degradation that systematically undermines the welfare and rights of the young people incarcerated.

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Wood, on 4 July 2015 (2016).

<sup>105</sup> House of Commons, *Report of the Zahid Mubarek Inquiry*, HC1082-I (TSO, 2006).

<sup>106</sup> See: [www.theguardian.com/world/2015/may/09/mubarek-amin-my-son-zahid-was-murdered-by-racist-we-are-monster](http://www.theguardian.com/world/2015/may/09/mubarek-amin-my-son-zahid-was-murdered-by-racist-we-are-monster) (accessed 23 October 2017).

<sup>107</sup> House of Commons, *Report of the Zahid Mubarek Inquiry*, HC1082-I (TSO, 2006).

<sup>108</sup> Inspectorate of Prisons, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016 to 2017*, HC 208 (TSO, 2017), 62.

<sup>109</sup> B Goldson, D Coles, *In the care of the state? Child deaths in penal custody in England and Wales* (TSO, 2005), 24.

<sup>110</sup> Ministry of Justice, *Review of the Youth Justice System in England and Wales*, Cm 9298 (2016), 36.

<sup>111</sup> K Gooch, ‘A childhood cut short: child deaths in penal custody and the pains of child imprisonment’ (2016) 55(3) *Howard Journal of Criminal Justice* 278; K Gooch, J Treadwell, *Prison bullying and victimisation* (University of Birmingham, 2015).

## Is there any value in having and enforcing a corporate manslaughter offence?

The fact that the law of corporate manslaughter applies to deaths of young people in custody represents a significant symbolic statement. As Gobert argued on the Act's introduction: 'There is no gainsaying the importance of simply having a corporate manslaughter statute on the books ... the Act signifies that companies and other organisations (as well as Crown bodies) are not above the law and are capable of committing crimes as grave as manslaughter'.<sup>112</sup> The law is not only a means of social control but also symbolises the public affirmation of social ideals and norms and subject positions.<sup>113</sup> The statement, announcement or enforcement of law can enhance the social status of groups and contribute to claims for social justice and human rights on behalf of victims.<sup>114</sup>

The Act was intended to have a more tangible impact though too. One of the key aims of the Act was to deter offending: 'a more effective corporate manslaughter offence would provide an incentive for organisations where serious failings exist in the management of health and safety risks to review current arrangements and organise themselves in a way that minimises failings that might cause death'.<sup>115</sup> The premise of the corporate manslaughter offence was that organisations, unlike people, can generally be expected to act rationally. Corporate manslaughter is not a crime of passion or motive. It is a crime committed because of negligence and often systemic failure. No organisation, private or public, wants to be fined, or wants to attract the kind of negative publicity a corporate manslaughter conviction brings. While public bodies, unlike private companies, are not motivated by profit, this does not mean a fine would be an ineffective sanction. The State does not operate as single unit and, as the vast majority of public bodies will have a finite pre-determined budget, the threat of a fine could still be a powerful disincentive. The threat of a corporate manslaughter conviction helps to emphasise to all organisations the importance of risk management and health and safety compliance. The Act cannot be said to have a deterrent effect in relation to custodial institutions at present, however, because this aspect of the Act is not being enforced.

A successful prosecution under the Act could provide a powerful message about the need to systematically change the attitudes, policies and accepted practices that generate the routine and systematic degradation of children's rights that characterise youth custody in a way that the various inquest findings, inspectorate reports and inquiries have not. Such a prosecution could provide the impetus for a re-imagining of how young people in conflict with the law should be treated – such as a commitment to using youth custody only as a last resort (as required by Article 37 of UNCRC); and where custody is used it is smaller, better resourced custodial institutions that are focussed on providing an individualised therapeutic environment primarily concerned with the welfare of young people. A lack of funding may be the root cause of problems within the secure youth estate. If it is, then surely a corporate

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<sup>112</sup> J Gobert, 'The Corporate Manslaughter and Corporate Homicide Act 2007 – Thirteen years in the making but was it worth the wait?' (2008) 71 *Modern Law Review* 413, at 431.

<sup>113</sup> G Mason, 'The symbolic purpose of hate crime law: Ideal victims and emotion' (2014) 18(1) *Theoretical Criminology* 75; W De Haan and I Loader, 'On the emotions of crime, punishment and social control' (2002) 6(3) *Theoretical Criminology* 243; A Freiberg, 'Affective versus effective justice: instrumentalism and emotionalism in criminal justice' (2001) 3(2) *Punishment & Society* 309.

<sup>114</sup> JR Guseld, 'On Legislating Morals: The Symbolic Process of Designating Deviance' (1968) 56 *California Law Review* 54.

<sup>115</sup> Home Office, *Corporate Manslaughter and Corporate Homicide: A Regulatory Impact Assessment on the Government's Bill* (2006), available at: <http://webarchive.nationalarchives.gov.uk/+http://homeoffice.gov.uk/documents/ria-corporate-manslaughter.pdf?view=Binary> (accessed 6 April 2017).

manslaughter conviction arising from a child's death in custody would attract such widespread criticism and publicity that the government would be forced to reconsider the issue. Moreover, the UK is under an obligation to secure the right to life under Article 2 of the European Convention by putting in place effective criminal law provisions to deter the commission of offences against the person, backed up by law enforcement machinery for the sanctioning of such breaches. At present the law is neither effective in relation to deaths in custody, nor is there a realistic prospect of sanction.

## Could the Corporate Manslaughter Act 2007 be used to prosecute a death in the secure youth estate?

In order to secure a conviction for corporate manslaughter in relation to a death in custody in the secure youth estate, the prosecution would need to:

- (a) obtain consent from the Director of Public Prosecutions to bring the prosecution;<sup>116</sup>
- (b) decide which 'organisation(s)' (within the meaning of the Act) to prosecute;<sup>117</sup>
- (c) prove that the organisation owed a relevant duty of care to the deceased (this is a question of law for the judge);<sup>118</sup>
- (d) prove that there was a gross breach of the duty of care as a result of the way the organisation's activities were managed or organised (this is a question of fact for the jury);<sup>119</sup>
- (e) prove the way in which the organisation's activities were managed or organised by its senior management was a substantial element in the breach (also a question of fact for the jury);<sup>120</sup> and
- (f) prove this caused the deceased to die (the usual principles of causation in criminal law apply).<sup>121</sup>

Each element of the offence will be analysed sequentially to determine the difficulties in securing a conviction following the death of a child in custody.

### A. Consent of the Director of Public Prosecutions

The consent of the Director of Public Prosecutions (DPP) is required to bring any corporate manslaughter prosecution. Should a prosecutor team wish to bring a corporate manslaughter charge in relation to a death in custody, obtaining consent is the first hurdle it would have to overcome. Horder suggested that consent may be refused if some other more satisfactory means of holding the public body to account is being pursued, such as an inquiry. Although inquiries are not routine following a death, inquests are.<sup>122</sup> The point has not been tested, but perhaps the fact an inquest has been held, or the possibility of an inquiry, might lead to consent being withheld. It is unlikely in practice that an inquiry will follow a death in custody though. Despite the numbers of young people who have died in custody, there has only ever

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<sup>116</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 17.

<sup>117</sup> Ibid, s 1(2).

<sup>118</sup> Ibid, s 1(1)(b) and **s 2; s 2(5)**. The judge must make any findings of fact necessary to decide this question.

<sup>119</sup> Ibid, s 8(1)(b); s 1(1)(b).

<sup>120</sup> Whether a gross breach has occurred is a question of fact for the jury and accordingly the jury in making its decision will be required to consider whether the senior management played a substantial role in such breach. Corporate Manslaughter and Corporate Homicide Act 2007, s 1(3).

<sup>121</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 1(1)(a). See also Ormerod and Taylor, n 7 above, at 605.

<sup>122</sup> Horder, n 8 above, at 133.

been one public inquiry and that was into the murder of 19-year-old Zahid Mubarek at Feltham Young Offender Institution, noted above.<sup>123</sup> This inquiry was allowed only after a four-year campaign by his family and other supporters, and the report was not published until six years after his death. Deaths in custody raise fundamental issues about the treatment of young people in State custody and the protection of the human rights of society's most vulnerable children.

## B. Which 'organisation(s)' could potentially be prosecuted?

The offence of corporate manslaughter can be committed by a wide range of organisations: corporations;<sup>124</sup> police forces;<sup>125</sup> certain government departments and bodies listed in a schedule;<sup>126</sup> and some unincorporated bodies (such as partnerships) but only where they are an employer.<sup>127</sup> Private companies, such as contracted custody providers, could potentially be indicted for corporate manslaughter because they would fall within the definition of 'corporation' in the Act which includes 'any body corporate wherever incorporated'.<sup>128</sup> The definition of 'corporation' would also extend to other types of corporations as well, such as those incorporated under statute like local authorities and the YJB.<sup>129</sup>

There have been no prosecutions arising from a death in custody to date. Only private sector companies have been convicted, generally in relation to employee deaths. The decision as to which legal entity to prosecute in such circumstances is usually straightforward. The position in relation to a death in custody, whether of an adult or a young person, is potentially far more complex. A number of different public bodies have roles to play in the youth custody system and sometimes services are contracted out. Even in the event that contracting out is not relevant to the case, the prosecution could still face a dilemma in deciding which specific public body to indict. A charge of corporate manslaughter in relation to a death in custody is unprecedented, so a prosecutor would have no previous cases to refer to for guidance. The relevant parts of the 2007 Act listing the organisations to which the offence applies make no mention of HMPPS, HM Prison Service, or the YCS.<sup>130</sup> The MoJ is specifically noted as an organisation to which the offence applies though<sup>131</sup> and the discussion in the House of Lords referred to the MoJ's potential liability, although this is not necessarily conclusive. Doyle and Scott discuss the potential liability of HM Prison Service<sup>132</sup> but also imply the possibility of a specific YOI<sup>133</sup> or prison<sup>134</sup> being prosecuted. They state: 'by virtue of Schedule 1, the offence of "corporate manslaughter" not only applies to private companies but also in some

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<sup>123</sup> House of Commons, *Report of the Zahid Mubarek Inquiry*, HC1082-I (2006).

<sup>124</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 2(a).

<sup>125</sup> *Ibid*, s 1(2)(b).

<sup>126</sup> *Ibid*, Sch 1.

<sup>127</sup> *Ibid*, s 1(2).

<sup>128</sup> For the purposes of the Act a corporation does not include a corporation sole: Corporate Manslaughter and Corporate Homicide Act 2007, s 25.

<sup>129</sup> This is acknowledged in the relevant Crown Prosecution guidance – see: [www.cps.gov.uk/legal/a\\_to\\_c/corporate\\_manslaughter/#as03](http://www.cps.gov.uk/legal/a_to_c/corporate_manslaughter/#as03) (accessed 2 November 2017).

<sup>130</sup> See the list of bodies and departments in Corporate Manslaughter and Corporate Homicide Act 2007, Sch 1.

<sup>131</sup> *Ibid*.

<sup>132</sup> Doyle and Scott, n 6 above, at 302.

<sup>133</sup> Created under the Criminal Justice Act 1988.

<sup>134</sup> Doyle and Scott, n 6 above, at 295.

measure to all the public bodies the performance of whose functions are most likely to cause deaths ... these include, inter alia, the Ministry of Defence, the Department of Health and HM Prison Service'.<sup>135</sup> The comment is misleading, as whilst the Ministry of Defence and the Department for Health are listed in the Schedule, HM Prison Service is not and never appears to have been so listed. Doyle and Scott appear to have unquestioningly referenced Horder, who also erroneously refers to HM Prison Service in his 2012 book.<sup>136</sup> Matthews suggests in his guide to the Act that the offence will extend to fatalities caused by executive agencies because executive agencies fall under the responsibility of the relevant parent department<sup>137</sup> and HM Prison Service and HMPPS are both executive agencies falling under the responsibility of the MoJ. No further explanation is provided by Matthews though, and it is presumed in such circumstances the proceedings would be brought against the MoJ rather than either executive agency.

The position is potentially even more confusing in the youth justice context because there are additional bodies involved: the YJB (pre-1 September 2017) and now the **YCB** (post-1 September 2017). Although the YJB is not specifically listed in the relevant schedule of the Act, it could presumably be indicted in relation to a child custody death on the basis that it is a statutory corporation. However, the usual position would be for the Crown Prosecution Service (CPS) to 'pursue the body that currently has responsibility for the functions connected with the death'.<sup>138</sup> It is the YCS which now has responsibility for placements, but the status of the YCS as an organisational body within the meaning of the Act is unclear. Whilst it has been confirmed as a 'distinct arm' of HMPPS, further details are scarce and it does not appear to be a body corporate like the YJB.

The position becomes even more unclear when services are contracted out to private sector companies. The MoJ has stated that the offence applies to all custody providers, whether public or private (that is, contracted service providers).<sup>139</sup> This issue was raised in the House of Lords by Lord Thomas of Gresford when considering the relevant commencement order: 'in relation to private ... prison facilities, what is the relationship between those private facilities and the [MoJ]? Could the department resist a charge under the ... Act on the basis that the responsibility has been contracted out?'.<sup>140</sup> The written response of Lord McNally, on behalf of the MoJ, did little to clarify matters. Whilst noting that the MoJ could not 'contract out' of criminal liability, he went on to opine that 'the liability of any particular organisation will depend on all the relevant circumstances ... such as what the contract might say about the parties' obligations'.<sup>141</sup> He concluded that it would be 'for the courts to determine where the responsibilities lie and so whether the elements of the offence are made out'. This is of course correct, but of little use to a prosecution team which must decide at the outset which organisation to pursue. Whilst a prosecution could be brought against both

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<sup>135</sup> Ibid.

<sup>136</sup> Horder, n 8 above, at 117.

<sup>137</sup> R Matthews, *Blackstone's Guide to the Corporate Manslaughter and Corporate Homicide Act 2007* (Oxford University Press, 2008), 161.

<sup>138</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 16(3)(a). See also Crown Prosecution Service, *Corporate Manslaughter Legal Guidance*, available at: [www.cps.gov.uk/legal/a\\_to\\_c/corporate\\_manslaughter/#as03](http://www.cps.gov.uk/legal/a_to_c/corporate_manslaughter/#as03) (accessed 2 November 2017).

<sup>139</sup> See Ministry of Justice, *Corporate Manslaughter and Corporate Homicide Act 2007 Commencement (No 3) Order 2011 and Corporate Manslaughter and Corporate Homicide Act 2007 (Amendment) Order 2011* (Circular 2011/07).

<sup>140</sup> House of Lords Library, Letter dated 8 July 2011 from Lord McNally to Lord Thomas of Gresford, available from: [www.parliament.uk/depositedpapers](http://www.parliament.uk/depositedpapers) (accessed 19 October 2017).

<sup>141</sup> Ibid.



organisations in such circumstances, this would of course involve more time and expense, and there is a risk that both prosecutions will not be successful.

In summary, if a child dies in a private sector YOI or STC, it is possible that a prosecution could be brought against the relevant private contractor who had day-to-day control of operations. However, given the comments made in the House of Lords about contracted service provision, the prosecution might also need to consider a public sector charge and would be faced with the various issues discussed above when deciding which specific body should be indicted. In relation to a death in a public sector YOI or Medway STC (currently under public sector control), indicting HM Prison Service would appear to be an obvious choice but it is not clear that it is an organisational body within the meaning of the Act. Accordingly, the prosecution might need to consider whether to indict another public body such as the MoJ, the YJB or the YCS (although as noted above it is not clear whether the YCS is an organisational body either). Should a fatality occur in a SCH, a charge could be brought against the relevant local authority. Given that public bodies cannot contract out of criminal liability, a charge could also be considered against the MoJ, the YJB or the YCS.

### C. Establishing a duty of care

It is a requirement for the organisation to have owed the deceased a ‘relevant’ duty of care as defined within the Act. No new duties of care are created by the Act, rather the Act confirms which duties owed under the law of negligence are relevant for the purposes of the offence.<sup>142</sup> The State also has wider obligations to protect the right to life as discussed above, but the wording of the Act does not suggest these will be taken into account when considering duty of care precepts and liability under the Act. A list of relevant duties, applicable since the Act’s commencement, are listed in section 2 and include, amongst others: a duty owed to employees or other workers; a duty owed as an occupier of premises; and a duty owed in relation to the supply of goods or services.<sup>143</sup> A relevant duty of care was extended to custody arrangements pursuant to the addition of sections 2(1)(d) and 2(2). Accordingly, since 1 September 2011, a duty of care owed to a person who is detained in a custodial institution or secure accommodation will be a relevant duty of care for the purposes of the Act.<sup>144</sup> Custodial institution is defined as including YOIs and STCs.<sup>145</sup> Secure accommodation is defined as meaning accommodation, not constituting or forming part of a custodial institution, provided for the purpose of restricting the liberty of persons under the age of 18.<sup>146</sup> This means that a duty of care owed to a resident of any of the three types of secure accommodation for young people should fall within the Act’s remit.

These provisions appear fairly clear and this might lead to the conclusion that establishing duty of care precepts will not be one of the major obstacles to establishing liability for a death in custody. However, there are some additional factors to consider: what is the exact extent of the duty and might the duty fall within one of a number of exclusions in the Act? It is well established that any organisation which is responsible for the detention of a person owes that

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<sup>142</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 2(5).

<sup>143</sup> *Ibid*, s 2(1).

<sup>144</sup> Note that the provisions also cover a range of other places of custody including: custody areas of courts, police stations and customs premises; service custody premises; removal centres; and prison escort vehicles: Corporate Manslaughter and Corporate Homicide Act 2007, s 2(2).

<sup>145</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 2(7).

<sup>146</sup> *Ibid*, s 2(7).



person a duty of care to take reasonable care of that person's health and safety.<sup>147</sup> However, the extent of the duty is less clear.<sup>148</sup> In relation to suicides, the courts have held that there is a duty to take reasonable preventative steps but only where it is known or ought to have been known that the individual was a suicide risk.<sup>149</sup> Doyle and Scott note that case law<sup>150</sup> suggests that there is an obligation to take reasonable steps to identify whether a prisoner might present a suicide risk and concluded: 'th[is] would suggest that the ... Act may only be applicable where the prisoner was being monitored ... or where appropriate measures had not been taken to identify the known risk factors'.<sup>151</sup> The same would presumably apply to a child in custody. Doyle and Scott also highlight that there has been no judicial consideration of the scope of the duty of care to prevent prisoner deaths at the hands of other prisoners.<sup>152</sup> If the scope of this duty was held to be similar to the scope of the duty in relation to suicides, a breach of duty would presumably occur where appropriate measures had not been taken to segregate a violent detainee, or where a specific detainee should have been identified as being at risk.

Public policy decisions are expressly excluded from being a 'relevant' duty of care for the purposes of the Act. Section 3 of the 2007 Act states that a duty of care owed by a public authority in respect of a decision as to matters of public policy (including in particular the allocation of public resources or the weighing of competing public interests) is not a relevant duty of care. Ormerod and Taylor have noted that the exclusion is seeking to draw a distinction between public policy decisions and operational decisions in the law of tort: 'the manner in which a public authority implements its duty in practice has been justiciable in negligence, but the way it exercises its statutory discretion is not'.<sup>153</sup> This provision indicates that public policy decisions relating to cutting staff numbers or reducing investment in mental health support services which leads to an increase in suicides should not expose a public body to prosecution for corporate manslaughter. However, the distinction between public policy and operational decisions often becomes blurred. For example, a public policy decision to cut staff numbers in YOIs could lead to operational negligence in the supervision of a detainee deemed to be a suicide risk. Ormerod and Taylor highlight that the courts have continually struggled with the dividing line and that it has been recognised that the test is very difficult to apply in practice.<sup>154</sup>

Section 3(2) of the Act creates another type of exclusion: 'any duty of care owed in respect of things done in the exercise of an exclusively public function is not a relevant duty of care *unless* it falls within section 2(1)(a)(b) or (d)' (emphasis added). 'Exclusively public function' is defined in the Act as a function that falls within the prerogative of the Crown or something that is exercisable only with authority conferred by the exercise of that prerogative or under a statutory provision.<sup>155</sup> Whilst imprisoning individuals seems very likely to fall

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<sup>147</sup> R Matthews, *Blackstone's Guide to the Corporate Manslaughter and Corporate Homicide Act 2007* (Oxford University Press, 2008), 66.

<sup>148</sup> *Ibid.*

<sup>149</sup> *Ibid.*

<sup>150</sup> *Orange v Chief Constable of West Yorkshire Police* [2001] EWCA Civ 611, [2002] QB 347.

<sup>151</sup> Doyle and Scott, n 6 above, at 302.

<sup>152</sup> *Ibid.*

<sup>153</sup> Ormerod and Taylor, n 7 above, at 605.

<sup>154</sup> *Ibid.*, 606.

<sup>155</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 3(4).

within the definition of an exclusively public function,<sup>156</sup> the exclusion only applies to the extent a public function is not expressly included in section 2, and since 2011 a duty of care in relation to custody has been included in section 2(1)(d). The public function exclusion should not therefore prevent a prosecution being brought in relation to a death in custody provided the fatality occurred after the death in custody provisions were effected.

#### D. Establishing gross breach and senior management involvement

Gross negligence is required to establish liability and this means a defendant must have fallen far below what could have reasonably been expected in the circumstances.<sup>157</sup> Section 8 sets out the factors that the jury must and may consider. It is clear that section 8 was not designed with deaths in custody in mind as there is no mention of factors which are specific to the custody context. Section 8(2) provides that the jury must consider whether the organisation failed to comply with any relevant health and safety legislation and, if so, to consider how serious a failing this was and how much of a risk of death it posed. Health and safety legislation is defined as ‘any statutory provision dealing with health and safety matters’ and the only examples provided are the Health and Safety at Work etc Act 1974, the Health and Safety at Work (Northern Ireland) Order 1978 and Part 3 of the Energy Act 2013.<sup>158</sup> None seem particularly relevant to, for example, a suicide or murder in custody. Whilst health and safety legislation might be more relevant to a death caused by an accident in a custodial institution, Doyle and Scott have noted that the Health and Safety at Work Act 1974 is largely inapplicable to prisons (and a fuller discussion of accidental deaths of this type is outside the scope of this article).<sup>159</sup> In a death in custody trial, the prosecution would likely need to rely on section 8(4) which allows (but does not require) the jury to have regard to ‘any other matters they consider relevant’. It seems reasonable to assume a jury would consider things like any failure to follow suicide prevention procedures or MMPR as relevant, but the failure to explicitly address the custody context is symptomatic of the careless way in which the death in custody provisions were added to the Act.

#### E. Prove senior management was a substantial element in the breach

Securing a conviction in relation to a death in custody is made even more difficult by the necessity of also demonstrating that the way in which the organisation’s activities were organised or managed by its senior management was a substantial element in the breach.<sup>160</sup> The senior management ‘test’ element of the offence attracted vociferous criticism.<sup>161</sup> ‘Senior management’ is defined in the Act as persons who play significant roles in the making of decisions about how the whole or a substantial part of the organisation’s activities are to be managed or organised, or the actual managing or organising of the whole or a substantial part of those activities.<sup>162</sup> Whilst ‘senior management’ is a defined term, the concept is otherwise ‘low on definitions’,<sup>163</sup> and ‘vague’.<sup>164</sup> Despite the Act having been in force for nearly ten

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<sup>156</sup> Ormerod and Taylor opine that they believe this to be the case, n 7 above, at 606.

<sup>157</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 1(4)(b).

<sup>158</sup> *Ibid*, s 25.

<sup>159</sup> Doyle and Scott, n 6 above, at 303.

<sup>160</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 1(3).

<sup>161</sup> House of Commons Home Affairs and Work and Pensions Committees, *Draft Corporate Manslaughter Bill, First Joint Report of Session 2005–2006, Volume 1: Report*, HC 540-I (2005), para 132.

<sup>162</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 1(4)(c).

<sup>163</sup> L Trevelyan, ‘Fatally flawed?’ (2005) *Law Society Gazette* 6 May 2005.

years, we have had little judicial guidance on how the courts should interpret the senior management test. In the case of *R v Dr Errol Cornish and Maidstone and Tunbridge Wells NHS Trust*<sup>165</sup> it was suggested that the prosecution did not necessarily have to name the relevant senior managers involved in the breach, rather it should be required to identify the ‘tier’ of management that it considers to be the lowest level of senior management within the organisation that is culpable for the offence. However, the prosecution in the case ultimately failed and it is not clear this approach will be followed in later cases. Whilst the senior management definition will likely include a wider class of persons than would have been the case under the identification doctrine,<sup>166</sup> and allows aggregation of a number of individuals’ actions,<sup>167</sup> the senior management concept stands accused of redirecting focus back to individual culpability as opposed to systematic failure alone.<sup>168</sup>

Doyle and Scott consider the senior management element of the offence to be the most significant barrier to securing a death in custody corporate manslaughter conviction: ‘the senior management test may nullify the intent of section 2(1)(d) and undermine the capacity of the ... CPS to convict a prison for an avoidable death in custody’.<sup>169</sup> They note that the death in custody provisions fail to acknowledge the complexity of the organisational structure within HM Prison Service which now involves many levels of management.<sup>170</sup> They also remark that day-to-day implementation of procedures to prevent deaths in custody is usually at a non-managerial level and therefore unlikely to satisfy the senior management test.<sup>171</sup> The difficulties Doyle and Scott anticipate could also be envisaged in relation to a death within an HM Prison Service operated YOI or STC. The secure youth estate is just, if not even more, organisationally complex than the adult secure estate. Whilst it should be possible to charge a local authority with corporate manslaughter in relation to death in a SCH, a local authority’s senior management may have no real involvement in SCH placements, managed by a separate team, making it impossible to satisfy the test. The problem could also be exacerbated if it is necessary to indict, for example, the MoJ because it cannot be established that HM Prison Service or the YCB are organisational bodies within the meaning of the Act. Trying to prove that the senior management of the MOJ played a substantial role in any death at a public custodial institution run by a separate agency (and itself having its own organisational structure) is likely to be a very difficult task.

## F. Causation

The prosecution must be able to prove that the way in which the organisation managed its activities caused the deceased to die.<sup>172</sup> No further guidance is included in the Act itself but the accompanying explanatory notes state: ‘the usual principles of causation in the criminal law will apply ... this means that the management failure need not have been the sole cause of death; it need only be a cause (although intervening acts may break the chain of causation

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<sup>164</sup> See House of Commons Home Affairs and Work and Pensions Committees, *Draft Corporate Manslaughter Bill, First Joint Report of Session 2005–2006, Volume 1: Report*, HC 540-I (2005), para 39.

<sup>165</sup> [2015] EWHC 2967 (QB).

<sup>166</sup> See, for example, the opinion of Ormerod and Taylor, n 7 above, at 60 and Gobert, n 112 above, at 428.

<sup>167</sup> Gobert, n 112 above, at 427.

<sup>168</sup> A Roberts, ‘Corporate liability – Ireland’ (2006) 5 *Criminal Law Review* 465, at 465.

<sup>169</sup> Doyle and Scott, n 6 above, at 295.

<sup>170</sup> Doyle and Scott, n 6 above, at 304–307.

<sup>171</sup> *Ibid.*, at 305–307.

<sup>172</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 1(1)(a).

in certain circumstances)'.<sup>173</sup> At a death in custody trial, it is easy to imagine a defence team arguing that causation, and therefore the corporate manslaughter charge, is not proven. They could do this a number of ways. Firstly, Ormerod and Taylor have posited that if the 'but for' test cannot be made out then the defendant's guilt cannot be proven: 'if the death would have occurred in any event even if there had not been the management failure which constituted the gross breach, the offence would not be made out'.<sup>174</sup> Secondly, even if the breach contributed to the death but only in a minimal way, this is not enough to establish liability. CPS guidance confirms that the prosecution will have to prove that the breach was a more than minimal contribution to the death.<sup>175</sup> Lastly, a defendant might argue that an intervening act of the deceased, or perhaps another detained young person, broke the chain of causation. This would be particularly relevant in suicide or homicide cases. Causation is accordingly another potentially problematic barrier to securing a death in custody corporate manslaughter conviction.

## G. Sentencing

If a public body or private sector company was to be convicted of corporate manslaughter in relation to a death in custody, the primary sanction would be a fine.<sup>176</sup> Updated sentencing guidelines were introduced on 1 February 2016 (the Sentencing Guidelines).<sup>177</sup> There is no upper limit on the fine that can be imposed, the indicative fine range is £180,000 – £20 million.<sup>178</sup> The Sentencing Guidelines confirm there is a nine-step sentencing process and link the starting point for a fine to the turnover or, in the case of a public body the annual revenue budget (ARB), of the organisation.<sup>179</sup> The Sentencing Guidelines indicate that large organisations (turnover/ARB of over £50 million) and medium sized organisations (turnover/ARB of between £10 million and £50 million) can expect multi-million pound fines.<sup>180</sup> If a death in custody were to be successfully prosecuted, the convicted organisation could therefore potentially face a very sizeable fine. The average fine across all 26 prosecutions to date is £324,826.<sup>181</sup> The average fine under the updated Sentencing Guidelines has risen to £490,625.

A public body convicted of corporate manslaughter would have any fine reduced in light of step 4 of the Sentencing Guidelines.<sup>182</sup> This provides that any fine should normally be substantially reduced if a public body defendant can demonstrate the proposed fine would have a significant impact on its provision of services. As no public body has ever been

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<sup>173</sup> Crown Prosecution Service, *Prosecution Policy and Guidance on Corporate Manslaughter* (CPS, Year), available at: [www.cps.gov.uk/legal/a\\_to\\_c/corporate\\_manslaughter/#as01](http://www.cps.gov.uk/legal/a_to_c/corporate_manslaughter/#as01) (accessed 13 November 2017).

<sup>174</sup> Ormerod and Taylor, n 7 above, at 605. For discussion of the 'but for' test more generally see D Ormerod, K Laird, *Smith and Hogan's Criminal Law* (Oxford University Press, 2015), at 91.

<sup>175</sup> Crown Prosecution Service, *Prosecution Policy and Guidance on Corporate Manslaughter* (CPS, Year), available at: [www.cps.gov.uk/legal/a\\_to\\_c/corporate\\_manslaughter/#as01](http://www.cps.gov.uk/legal/a_to_c/corporate_manslaughter/#as01) (accessed 13 November 2017)

<sup>176</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 1(6).

<sup>177</sup> Sentencing Council, *Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences Definitive Guideline* (Sentencing Council, 2016).

<sup>178</sup> *Ibid*, 21.

<sup>179</sup> *Ibid*, 22–28.

<sup>180</sup> *Ibid*, 24.

<sup>181</sup> As at March 2018.

<sup>182</sup> Sentencing Council, *Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences Definitive Guideline* (Sentencing Council, 2016), 26.

convicted of corporate manslaughter, it is unclear how the courts will interpret the meaning of a 'substantial' reduction. Whilst some commentators regard the imposition of any fine on a taxpayer funded, public body as somewhat futile,<sup>183</sup> one of the purposes of sentencing is to reduce offending through deterrence<sup>184</sup> and the threat of a fine could be a powerful disincentive to negligent practices in custodial institutions. In addition to a fine, a court can impose a publicity order requiring the organisation to publicise details of the conviction in a specified manner.<sup>185</sup> A conviction will also generally lead to a prosecution costs order being made against the organisation.<sup>186</sup> The court can also, in theory, make a remedial order requiring the organisation to take specified steps to remedy the breach which led to the death, although such an order has never been made to date.<sup>187</sup> Thus, the 2007 Act potentially has an important role to play in encouraging safer custody practices.

## Conclusion

The inclusion of the death in custody provisions in the Act is symbolically significant. It publically affirms the value we, as a society, place on the sanctity of life of all our citizens. Other methods of accountability for deaths in custody have their role to play too, but appear to have a limited ability to change a broken system which is one of the reasons for also having a criminal sanction. However, despite a significant number of adults dying in custody every year<sup>188</sup> and four children dying in custody since the Act was extended to apply to deaths in custody, there has never been a custodial corporate manslaughter prosecution. The Act is all bark and no bite, at least in relation to deaths in custody. As Slapper noted in 2013, when there had been very few convictions under the Act, 'Justice is mocked if an important law is unenforced'.<sup>189</sup>

To have a real deterrent effect the organisations within the youth justice system must believe that the threat of a corporate manslaughter prosecution is real. Nor is it really surprising that there has never been such a prosecution given the lackadaisical way in which the death in custody provisions were added to the Act; an ill-advised attempt to distil the myriad complexities of our justice system into nothing more than a few additional sections. This article has explored the impediments to prosecution this approach has engendered. The Act's provisions in this regard are vague and this has led to uncertainty. This is an area which warranted greater statutory consideration and guidance. It is likely that only the most tenacious of prosecutors would consider bringing an indictment and, if a prosecution ever were to be brought, there would be a significant risk of failure.

The death in custody provisions of the Act should be reviewed and amended. The most helpful clarification would be the inclusion of guidance about which organisation a prosecution should normally be brought against: the MoJ, HMPPS, HM Prison Service, the

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<sup>183</sup> J Harris, 'The Corporate Manslaughter and Corporate Homicide Act 2007: unfinished business?' (2007) 28 *Company Lawyer* 321, at 322.

<sup>184</sup> Sentencing Council, *Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences Definitive Guideline* (Sentencing Council, 2016), 25.

<sup>185</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 10.

<sup>186</sup> A costs order has been imposed in the majority of the cases to date.

<sup>187</sup> Corporate Manslaughter and Corporate Homicide Act 2007, s 9.

<sup>188</sup> In the 12 months to June 2017, 97 prisoners committed suicide and two were murdered, see: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/632625/safety-in-custody-quarterly-bulletin-mar-2017.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/632625/safety-in-custody-quarterly-bulletin-mar-2017.pdf) (accessed 2 October 2017).

<sup>189</sup> G Slapper, 'Justice is mocked if an important law is unenforced' (2013) 77 *Journal of Criminal Law* 91, at 91.



YCS or the YJB (as relevant). The position in relation to contracted service provision should also be demystified. These things would give prosecutory teams more confidence to consider bringing proceedings in relation to both child and adult deaths. It would also assist the prosecutors to weigh up the merits of a particular case knowing they were applying the various elements of the offence to the correct legal entity. For example, conclusions as to whether senior management played a substantial element in the breach might differ significantly depending on whether the organisation in question is the MoJ or the YCS. Given the plethora of statutory provisions, rules, regulations and policies that govern how young people in custody are treated, it would also be useful for section 8 of the Act to be amended to acknowledge the custody context and to refer to suicide prevention procedures, MMPR or anything else considered to be key in helping a jury determine if a gross breach occurred.

As Lord Hunt of Wirral eloquently declared during the parliamentary debates on the death in custody provisions, ‘the power lawfully to deprive an individual of his or her liberty must be one of the most serious responsibilities there can be. The duty of care owed to an individual in detention, where he cannot act freely in his own interests, is onerous and profound’.<sup>190</sup> This is even more true when the individual is a child, vulnerable and at the formative stage in life. It is a scandal that in the 21st century children still die in the care of the State and that the Act provides mere lip service to accountability, rather than a meaningful reform of the law. In order to comply with its Article 2 obligations, the government should review and amend the death in custody provisions within the Act.

A successful prosecution under the Act in relation to a death in custody would allow for the complete exposure of the underlying systemic issues which deny children in custody the same protection afforded to children in the wider community and which have cost children their lives – namely a youth custodial system that is poorly resourced and ill-equipped to respond to the complex needs of the most vulnerable children. The ‘institutional process of regulation’<sup>191</sup> frequently loses sight of children’s best interests as they are often in conflict with the best interest of adults and of the State more generally.<sup>192</sup> A conviction might therefore help to re-direct the youth custodial estate towards a normative framework better equipped to accommodate the realities of the difficult, deprived backgrounds and serious multiple problems which characterise the lives of young people in custody. We must not forget that children in custody are children with rights. We must move away from attitudes, policies and accepted practices which generate the routine and systematic degradation of children in custody, towards a reconceptualised philosophy which places the best interests of the child at the heart of the justice system.

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<sup>190</sup> *Hansard*, HL Deb, vol 688, col GC187 (15 January 2007).

<sup>191</sup> M Foucault, *Discipline and Punish: The Birth of the Prison* (translated by A Sheridan) (Penguin, 1995).

<sup>192</sup> B Howe, K Covell, *Empowering Children: Children’s Rights as a Pathway to Citizenship* (University of Toronto Press, 2005).