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MOJUK: Newsletter 'Inside Out' No 747 (26/06/2019) - Cost £1

Prisoner's Irreducible Life Sentence Breached Convention on Human Rights

In Chamber judgment1 in the case of Marcello Viola v. Italy (no. 2) (application no. 77633/16) the European Court of Human Rights held, by a majority, that there had been: a violation of Article 3 (prohibition of inhuman or degrading treatment) of the European Convention on Human Rights. The case concerned an irreducible sentence of life imprisonment. The Court reiterated that human dignity lay at the very essence of the Convention system. It was impermissible to deprive persons of their freedom without striving towards their rehabilitation and providing them with the chance to regain that freedom at some future date. Thus, the Court considered that the sentence of life imprisonment imposed on Mr Viola under section 4 bis of the Prison Administration Act (ergastolo ostativo) restricted his prospects for release and the possibility of review of his sentence to an excessive degree. Accordingly, his sentence could not be regarded as reducible for the purposes of Article 3 of the Convention. Nevertheless, the Contracting States enjoyed a wide margin of appreciation in deciding on the appropriate length of prison sentences, and the fact that a life sentence might in practice be served in full did not mean that it was irreducible. Consequently, the possibility of review of life sentences entailed the possibility for the convicted person to apply for release but not necessarily to be released if he or she continued to pose a danger to society.

Stop Jailing Women for Shop-Lifting and Non-Payment of TV Licences

Helen Spector, Justice Gap: The study by the criminal justice consultants Crest notes that since the 2007 Corston review there has been widespread political consensus about the importance of improving the lot of the 3,800 women in prison who are largely serving sentences for low level offences. According to the group: 'But despite the apparent consensus for what is needed and why, women offenders remain trapped by a criminal justice system that fails to identify their needs and circumstances, and which therefore doesn't punish, rehabilitate or break cycles of offending behaviour effectively.' • There are 3,800 women in prison (5% of prison population) • Just 11% of sentences given to women offenders in 2017 were as a result of more serious offence types (indictable or triable either way) • Serious offences accounted for 2% of offences committed by women offenders in 2017 (9% by men) • Over a third of women (34%) of women were first-time offenders in 2017 (21% of men) • About three quarters (72%) are serving a sentence of less than six months for what are overwhelmingly non-violent offences (compared to 56% of men) • Read the report Ending the inertia: a plan to transform outcomes for women offenders>

Baroness Corston's review called for a 'radically different… woman-centred' approach and made 43 recommendations, including the expansion of women's centres, diversion schemes, and replacing women's prisons with smaller local custodial centres. As the Crest paper notes, despite cross-party support including the backing of three successive governments, outcomes for women offenders remain unchanged, the number of women prisoners has 'only decreased marginally' and, of the 43 recommendations, only two had been implemented.

It is well established that vulnerability is both a cause and a consequence of women's offending. As the report notes, almost two-thirds (63%) of women in custody have experienced domestic violence compared to less than one in ten men (7%) and that offending is often linked to grooming or shoplifting to support a partner.

Together with the Police and Crime Commissioners (PCCs), prisons, probation and health services, the police, and charities in Avon and Somerset and the West Midlands, Crest has devised a plan to remove the barriers that prevent effective rehabilitation for women offenders. The report makes three primary recommendations: removing centralised models for rehabilitation, reducing the fragmentation of service provision; and shifting service provision from singularly criminal justice to local government and the NHS.

More specifically, the report highlights that women in need of intervention need to be identified at an earlier date, financial planning support should be offered with fiscal penalties, and more alternatives to custodial sentences should be used. Further recommendations include developing a better understanding of women entering the criminal justice system through non-policing routes (i.e. prosecution by TV licensing) and establishing 'retail-based diversionary schemes' for women committing shoplifting offences.

The report stresses that patterns of offending are generally gender-specific, and gender-informed punishment, rehabilitation and probation services should concurrently be provided, able to address the complex web of vulnerability characterising the lives of women offenders.

GP 'Ghost Patients' to be Investigated by NHS Fraud Squad

BBC News: The NHS fraud squad is investigating GPs in England amid suspicions they are claiming for non-existent patients. Doctors get £150 a year for each patient on their list, but records show there were 3.6 million more patients in the system last year than there were people in England. The discrepancy prompted NHS England to employ a company to start chasing up these so-called ghost patients. The NHS Counter Fraud Authority is now launching its own investigation. Doctors' leaders have always insisted the issue of ghost patients most often has an innocent explanation, such as instances where patients have died or moved without the knowledge of their GP. It is understood the list-cleaning exercise, being carried out for NHS England by the business services company Capita has started to see a reduction in the numbers being claimed for. It has focused on patients who have not visited their doctor for five years. Attempts have been made to contact those patients and where they have not been found they have been deregistered from the practice. But NHS fraud investigators have been carrying out some sample testing of transactions, which the BBC understands has identified some "anomalies" that have raised suspicions. The fraud team will now carry out a full analysis of records held by NHS England and the NHS Business Services Authority, which administer the payments systems to GP practices, to see if doctors have been fraudulently claiming for patients.

Missed Opportunity by Kent Police to Seek Medical Treatment for Carl Maynard

The inquest into the death of Carl Maynard, who collapsed and died in Tonbridge Police Station on 13 October 2017, concluded 0n Tuesday 11th June 2019, afternoon with a critical narrative conclusion. The inquest jury found that 'failing to take Carl directly to hospital' represented a 'missed opportunity to increase Carl's chance of survival'. They also rejected the Kent Police officers' initial justifications for entering his property, which did not meet the legal standards required. The cause of death was found to be acute cocaine intoxication. Carl, 29, was born in Chatham in Kent. His family described him as being 'deeply creative with an abundance of imagination' and was a loving father to his young daughter.

The inquest heard that on 1 October 2017 an allegation of domestic common assault was made against Carl. During the afternoon of 13 October 2017, three Kent Police officers attended Carl's property and a decision was made to force entry to arrest him. The inquest was told that the justification for entering the property must be pursuant to section 17 of the Police and Criminal Evidence Act (1984), which authorises entry for the purpose of arresting for an indictable offence or to save life and limb. Evidence was heard that, on arrest, Carl was seen by an officer pushing two fingers down his throat and gagging. Despite being repeatedly questioned by the officers as to whether he had 'taken' anything, both Carl and his partner denied that he had swallowed drugs and he was taken to custody. At 4.23pm he collapsed in the fingerprint room and revival attempts were unsuccessful. The pathologist found an empty plastic bag within his stomach and concluded that he had died from acute cocaine intoxication.

Returning a narrative verdict, the jury rejected the officers' justification for entering the property as Carl was arrested for common assault, which is not an indictable offence, and there was no evidence that his partner was at risk at the time. They also concluded that "…the arresting officers were plainly suspicious that Carl Maynard had swallowed something and told Carl that they would have taken him to hospital if he had but then accepted his account that he had not swallowed anything, did not seek medical treatment and took Carl to Tonbridge Police Station. The possibility of successful medical treatment was highly unlikely, however the chances of Carl's survival would have been higher in a hospital rather than police custody. Failing to take Carl directly to hospital… represents a missed opportunity to increase Carl's chance of survival". Kent Police's policy at the time of Carl's death was that officers who may suspect a detainee of having swallowed a substance should inform the custody sergeant, and take them to hospital if necessary. During the course of their investigation, the Independent Office for Police Conduct (then under the name IPCC) took the unusual step of issuing a learning recommendation to Kent Police before their report was completed. Kent Police therefore changed their policy shortly after Carl's death to ensure that anyone suspected of swallowing a substance should be taken directly to hospital.

Denise Kelly-Mills, Carl's mother, speaking on behalf of the family including his sister, stepfather and daughter, said: "Ever since Carl died, we have been deeply concerned at the officers' accounts and their apparent disregard for their duties and obligations. We are pleased that on hearing the evidence the jury returned a conclusion which is consistent with the complaints that we have raised from the outset. The jury's conclusion supports our belief that Carl's home was unlawfully entered by the police as a result of which he made a rash decision which cost him his life. We will never understand why the officers didn't take him to hospital. That decision meant that Carl was denied the opportunity to seek medical help and he died on a police station floor. We have also been shocked that none of the officers used their body worn video cameras despite the policy making clear that there was a strong presumption that they should do so. This failure has denied our family the opportunity to really know what happened in that room. Finally, we also feel thoroughly let down by the IOPC who concluded that there was insufficient evidence to find that any of the officers had a case to answer for misconduct. We hope in light of the jury conclusion that they review their decision."

Deborah Coles, Director of INQUEST said: "The jury accepted that the officers suspected Carl had taken something, yet instead of responding to him as a medical emergency, he was left to die on a police station floor. While state bodies, such as Kent Police, receive automatic legal representation at inquests from the public purse, families have to go cap in hand to the Legal Aid Agency for support. Carl's family were denied full funding and were required to

pay a significant contribution to ensure the opportunity to interrogate the facts and ensure that mistakes or harmful practices are brought to light. The inquest function in seeking the truth, as well as exposing wrongful action and unsafe practices, serves a vital public interest in addressing the adequacy of systems for safety and welfare. This is why INQUEST and the families we work alongside are calling on the government to act now and urgently introduce fair public funding for legal representation at inquests."

The family solicitor Sophie Naftalin made the following comments: "Carl's death is a tragedy for his family but this jury's conclusion vindicates many of their concerns about the failures of the officers".

'Systemic Failures' at Heathrow IRC Contributed to Death of Marcin Gwozdzinski

The inquest into the death of Marcin Gwozdzinski today concluded finding serious failings which contributed to his death at Heathrow Immigration Removal Centre (IRC), including missing "significant warning signs" and inadequate risk assessments by untrained staff. Ultimately the jury concluded the main contributing factor to Marcin's death was the premature closure of suicide and self-harm prevention procedures (ACDT) days prior to his death. Marcin died on 6 September 2017, three days after he was found hanging in his room at Heathrow IRC, run by private security company Mitie. Marcin's was one of eleven deaths of immigration detainees in 2017, the highest number on record. Marcin had been in immigration detention for nine months, and the jury also noted that this "prolonged period of detention" was a possible cause of death.

Marcin was a 28 year old Polish national who had been in the UK for five years and was living and working in South West London. His family describe him as a free spirit who loved travel and was a happy person with no known history of mental ill health. On 31 August 2017, Marcin told a Detention Officer at Heathrow IRC that he could not take detention anymore and wanted to die. He was placed on an ACDT (suicide and self-harm prevention procedures) where it was noted that his mood was very low and he was worried about his mental health. Marcin was initially subject to hourly observations and a support plan. The following day on 1 September, after a risk assessment interview lasting just nine minutes and a case review lasting a mere three minutes, the ACDT was closed with detention staff concluding that Marcin's only problem was toothache. No input had been sought from healthcare staff, contrary to national guidance.

On 2 September 2017, Marcin telephoned London Ambulance Service (LAS) numerous times requesting assistance. In one of the confused calls played to the jury, Marcin asked the operator through an interpreter to come to the centre to save his life. He stated that "he could not take it anymore". The LAS operator is heard calling the control room at the IRC and is told Marcin has been making hoax calls. The same day Marcin attended healthcare and asked a nurse for an ambulance. The nurse made a mental health referral noting that Marcin was "extremely irate and threatening" and that he had been unable to placate him. This nurse had been working in the centre for four months but had not received the mandatory training in suicide and self-harm prevention. He had been unaware that Marcin had been on an ACDT the day before. In his evidence, the nurse confirmed that he still had not had training despite over 20 months passing since Marcin's death.

On 3 September 2017, prior to lock up for lunchtime, a detainee took one of the Detention Officers to one side and expressed concern about Marcin. He took the Officer to Marcin's room and showed him he had been smashing things up. The Officer did not think there was any cause for concern and Marcin was locked in his room alone over lunch. Marcin's room was unlocked at 2pm but no one conducted a welfare check. The Officer gave evidence stating that she was unaware Marcin had recently been on an ACDT, and explained she would have looked in had she known. Marcin's fellow detainees found him hanging

in his room at around 2.15pm. Marcin was taken to hospital where he died three days later.

After hearing five days of evidence the jury in a lengthy narrative conclusion noted the following failures probably contributed to Marcin's death; The failure of several detention staff to take due care in following their own suicide and self-harm prevention procedures 'with more than just the minimum administrative effort' The failure of detention staff to consult with healthcare staff whilst Marcin was on an ACDT; The reason for opening an ACDT was not properly addressed during assessments and at the point of closure of the ACDT; Systemic failure of administrative systems to work together and share information between healthcare and detention staff; Despite concerns regarding Marcin's mental health he was never seen by a mental health professional; Failure to sufficiently train healthcare agency staff in ACDT processes especially when it was clear they would be working at the IRC regularly; and A number of significant warning signs were missed on Saturday 2 September which should have been escalated in the context of Marcin's recently closed ACDT.

In addition, the jury found the following failings possibly contributed to Marcin's death; The failure to recognise that a limited grasp of English might be to blame for Marcin not being able to communicate his state of mind Marcin's prolonged period of detention was a contributing factor in his deteriorating mental health; and The handover processes were inadequate as staff were unaware of events during the preceding days. The inquest heard evidence that an internal investigation following Marcin's death, conducted by Mitie, concluded that the notes of the assessment and case review were "poor" and "limited"; and that a quality case review could not be completed in such a short time. They recommended that those involved should not be allowed to have any further involvement in ACDTs until managers were satisfied with the quality of their work. They further recommended the previous Head of Safer Communities who took part in the three minute case review be removed from his role. Extraordinarily, during the course of the inquest it became apparent that the results of the review had not been fed back to those involved, and whilst the previous Head of Safer Communities had been removed from his role another Residential Manager had continued to take part in ACDT case reviews. Staff involved in the ACDT continued to consider the actions they had taken were appropriate. Whilst Marcin was in hospital fellow detainees signed a petition expressing concern that "for a long time he asked for officers, psychologist and doctors for help. He was ignored". In reference to the BBC Panorama documentary about treatment at Brook House IRC, which was shown on BBC on 4th September 2017, the detainees noted "It is a disgrace that nobody has been held accountable for such care we are human beings not animals."

Following the conclusion of his inquest, Marcin's family said: "We are disappointed that many mental health referrals were made but Marcin did not see anyone and we are disappointed that the resuscitation was messed up. There were people without training deciding whether Marcin posed a risk to himself. He was in a cell on his own and no one thought that was a risk. Not only was he stuck in the detention centre but staff did not use an interpreter to communicate with him, I don't believe he would be able to understand or make himself understood. When Marcin died he had no idea when he was getting out and nor did we, it's worse than prison. At least in prison you know there is an end. I am angry that they did not help him."

Clair Hilder of Deighton Pierce Glynn, the family's solicitor said; "They call them Immigration Removal Centres but Harmondsworth was designed as a Category B prison and detainees on Marcin's wing were locked up for 13 hours a day. The inquest revealed serious gaps in staff training, inadequate risk assessments and a lack of care. It is important lessons are learnt however we have little confidence Mitie Care and Custody will make the necessary improvements in light of their failure to follow up on the recommendations they made in their own investigation of the incident completed in November 2017. It is important that the Home Office steps in to ensure detainees are safe."

Taimour Lay of Garden Court Chambers, counsel for the family said: "Marcin had been in immigration detention for over 9 months and repeatedly expressed concern over the effect it was having on his mental health. Whilst it was a private company who failed to keep Marcin safe it was the Home Office who ultimately detained him."

Natasha Thompson, INQUEST caseworker said: "Marcin was desperately crying out for help in the last few days of his life. His pleas, as well as those of other detainees who recognised his distress, were ignored, leading to his tragic and preventable death. Marcin was one of 11 people to die in immigration detention in 2017, a record high. Successive inquests have highlighted fundamental failings in treatment and care as well as unsafe systems and practices. These deaths are evidence of the unnecessary harms caused by immigration detention and illustrate the human cost of UK immigration policies."

Prisoners: Foreign National Offenders - Repatriation

Asked by Lord Hylton: To ask Her Majesty's Government, as a result of international conventions and bilateral agreements on the transfer of sentenced persons, how many people have (1) returned to the UK from any such country, and (2) been repatriated from the UK.[HL16006]

Lord Keen of Elie: Any foreign national who comes to our country and abuses our hospitality by breaking the law should be in no doubt of our determination to punish and deport them. More than 48,000 foreign national offenders have been removed from the UK since 2010, and in the last financial year more than 5,000 were removed from prisons, immigration removal centres, and the community. Prisoner transfer is one of the mechanisms used to remove foreign national offenders. Between 1 May 2014 and 31 May 2019, 464 sentenced prisoners were transferred from England and Wales to other countries under international prisoner transfer arrangements. During the same period 233 sentenced prisoners were transferred to England and Wales. The transfer of prisoners into and out of Scotland and Northern Ireland is a devolved matter.

George Black: Brutal Inside Story Of Full Sutton Prison Segregation Unit

Salutations from Full Sutton segregation unit! I George Black, am writing this with a heavy heart while at the same time another prisoner has set fire to his cell and others are choking on the fumes and banging on their cell doors, trying to attract the attention of staff sitting comfortably in the office. If I wasn't just watching them through the observation pane in my cell door, I could have forgiven them for appearing to be oblivious or deaf to ongoing events. Finally, it has taken 10 minutes for an officer to stroll down the landing and amble back to his colleague to announce there's a fire, before either started to respond to this emergency. Fortunately nobody lost their life this time, although numerous prisoners have reported to me they are having breathing problems.

To bring you up to date with what is going on here at Full Sutton, about two and a half months ago the seg unit moved next door to F wing, while some refurbishing took place in the seg, such as fitting new in-cell smoke alarms and a new computerised cell bell system. Both of which were completely ignored last night. During the four weeks I spent on the makeshift (F-wing) seg and the three weeks we have all been back here in the New Refurbished Seg, I have witnessed over 30 cells being smashed up, numerous dirty protests and at least 20 inmates going on ACCTS (self harm and suicide risk documents). Without accepting one iota of responsibility, the governor must be thinking that it doesn't rain, it pours.

Some inmates in this seg have accumulated outstanding fines of £50,000, £60,000 and

£80,000 [for criminal damage]. Fines they will never be able to pay and which the Prison Rules say will be quashed after two years in any case. Instead of discouraging prisoners from damaging prison property, this system actively encourages it. Furthermore what would possess the prison governor (or perhaps motivate him) to move a bunch of unruly prisoners onto a different wing with porcelain sinks and toilets, wooden furniture and shelves, lino flooring etc, that is in desperate need of refurbishment, at public expense rather than the prison budget. Or perhaps it is just politics, for the Home Office's benefit.

Now I'm not one for complaining or pointing fingers, but it's the governors' fault that these things are happening! All the governors in this prison are guilty of complicity in allowing this situation to fester and continue. The return of a certain canteen culture [among officers] doesn't occur overnight. It needs to be nurtured by bigger fish, within whose protective shadow it can grow. Prison staff are more demoralised, more disillusioned and more desensitised than they have been for a long time. (I suppose my heart wouldn't be able to focus on doing my job properly either if I had all of these frustrations that needed venting.) However, as the governors are always quick to point out [to prisoners] there are no excuses for doing something wrong.

Full Sutton, like no other prison, employs a carrot and stick health care service. If you have a problem with prison staff, almost immediately your health care treatment will be withdrawn (the stick) on the flimsiest of excuses. This especially relates to any pain relief treatment (the carrot) or appointments to see specialists, dentist, doctor, physio etc. This is widely acknowledged by prisoners and certain prison staff, and occurs far too often to be coincidental. The lies they then manufacture to cover up this abuse would leave even Harold Shipman turning in his grave.

The Independent Monitoring Board (IMB) here is not much better, having sadly sunk to new depths, outliving its intended purpose. Apart from giving the ethos of the IMB service a bad name, they also leave a bad taste in prisoners' mouths and memories because they are rotten to the core. If a prisoner reports a serious matter to the IMB, all they do is confer and conspire with a senior member of staff to provide an appropriate response. The only reason for their existence is to present a facade of humanity to conceal the real inner goings-on. They are rather like the last meal offered to prisoners on death row, ultimately pointless – they leave you with a belly ache just before you are about to be killed. When I first came to the seg, with two black eyes and swollen lips, having been accused of assaulting Mufti [riot squad] officers, I did not receive any blankets or sheets for 11 days. I repeated this to IMB members almost daily - to one member on three different occasions. I have since complained to her to confirm this in writing, and that was over four weeks ago. This is a small complaint compared to some prison issues.

Unfortunately for the prisoners here, the chaplaincy is also reluctant to intervene when they witness or are informed of something wrong. Apart from turning the other cheek, they also have a bad habit of turning a blind eye as well. I have personal experience of being fobbed off to numerous legitimate and serious complaints by the governors, IMB, chaplaincy, health care at Full Sutton. It is no coincidence that the majority of prisoners in this seg are telling me the same stories and at the same time there are multiple daily smash-ups and self-harms. I also have irrefutable proof to substantiate my allegations/complaints. Just the fact that the prison does not preserve CCTV evidence when asked to do so (that proves inmates' complaints) should be enough to show what the prison is hiding, or similar acts of destroying/delaying evidence, another sign of guilt. The prison management believes they can continue to cover up these issues by further subjugating inmates. At some point, as all this chaos, the smashing up of cells, dirty protests, acts of self-harming and complaints build up, attracting more attention, some questions will start to be asked outright of

the prison by those out in the real world who abide by higher moral principles.

On 15 May 2019 there were no governors available in the establishment, so they drafted in a governor from Wakefield. Apparently all the Full Sutton governors were called away to a meeting. Could this possibly be the flicker of a spotlight starting to search for the lost forgotten souls abandoned by the legal aid reforms of 2011? Maybe their shouts will be heard.

It is no coincidence that the withdrawal of legal aid from prisoners has led to the gradual and continuous increase of violations against prisoners' rights and most of these ungrateful prisoners smashing up government property and self-harming are part of the post-tariff IPP generation of sentenced prisoners. Some with tariffs of two and three years who have now served 12 and 14 years. Another disturbing commonality they all share is the inevitable deterioration of their mental health caused by a lack of institutional care and a lack of hope.

You can help by complaining and writing to the governor at Full Sutton. Any complaints to Peterborough MPs on my behalf would be much appreciated.

George Black A3887AE, Full Sutton prison, 24th June 2019

Write to the Full Sutton governor Gareth Sands at HMP Full Sutton, Moor Lane, York YO4 1PS

Write to MP Lisa Forbes at Houses of Parliament, London SW1A 0AA

Send copies of any replies you get to George with your solidarity.

Police Forensics Contractor 'Sent Phones to 'Fone Fun Shop'

Hannah Devlin, Guardian: One of the country's largest digital forensics laboratories has been stripped of its accreditation after a former employee reported concerns about the handling of evidence at the business. It was found that the company, Sytech, had inadequate vetting procedures for new staff and police exhibits were being transported in private vehicles at a recent inspection. The Guardian has heard of further concerns from former staff who said that broken phones had been unsealed from evidence bags and sent to a consumer repair shop called Fone Fun Shop. On other occasions phones were sent abroad to be decrypted without the knowledge of the police, a former staff member said.

Sytech, based in Stoke-on-Trent, holds major contracts with more than a dozen police forces, and during a period when police spending on forensics science has fallen precipitously, it is one of the few companies to have expanded. However, concerns have been raised about the chain of custody of evidence entrusted to the company and the case raises broader questions about the outsourcing of forensic work to private labs. One former employee, who wished to remain anonymous, recalled being directly aware of a phone being sent to Fone Fun Shop in Sheffield for repair on one occasion last year. The analyst said they had the impression that at the time the practice was "routine" when data needed to be extracted from phones with cracked screens or defective power sockets. They said they reported this and concerns about the vetting of staff and transport of exhibits to the Forensic Science Regulator last month. "What made me report them to the forensic services regulator was because I couldn't get it out of my head [that] any doubt in a case can get a case overturned or thrown out or even an appeal on a previous conviction," the former Sytech analyst said.

When asked whether phones had been sent to the repair shop, Sytech said in an email: "We have carried out all mobile phone repairs in-house for over 12 months." The company said it was not aware of any cases in which the failure to maintain a chain of custody could risk undermining criminal evidence. A second former employee, who also did not wish to be named, said a police force, understood to be Greater Manchester police, raised concerns with Sytech last year after learning that phones

had been sent abroad to be unlocked by the Israeli-founded, Japanese-owned company Cellebrite.

When asked to confirm this, Emily Burton, the head of forensic services at Greater Manchester police, said: "In October 2018, we became aware of potential issues with the data extraction service provided to us by an external digital forensics company. When this potential issue became apparent, we raised this with the national policing leads for forensics, immediately reviewed current investigations and made alternate arrangements for our data extraction needs whilst the matter was resolved." Currently no investigations had been significantly affected, Burton said. In an email, Sytech said the findings of the recent inspection by the UK Accreditation Service (UKAS) "make no reference to our handling of phones requiring pin-decryption". Currently phones were not sent abroad, the company said, adding that all exhibits sent to external labs for unlocking were transported by a driver with police security clearance in a secure van.

Gillian Tully, the government's forensic science regulator, declined to comment on specific concerns about Sytech. In general, she said, establishing a continuous chain of custody for evidence was a cornerstone of forensic science. "All organisations engaged in work for the criminal justice system should be well aware of those requirements and of adhering to them," she said. "If the continuity can't be established … it could compromise cases." Tully said it would be of concern if private labs were subcontracting "outside of the quality chain".

Nick Baker, the national police lead on digital forensics and deputy chief constable of Staffordshire police, said his force had placed outsourcing to Sytech temporarily on hold while a risk assessment was carried out. "We're going through a process of understanding what the issues are and understanding what our own exposure and risk is and obviously [we'll] make a decision based on that," he said. If forces decided to stop using Sytech for a longer period, Baker said, this could exacerbate an already substantial backlog of phones and computers that need analysing, potentially delaying cases coming to trial. This week, the Home Office contacted alternative private providers to ask whether they would have the capacity to take on extra cases if required. Sytech said it had made police aware of its loss of accreditation "fully and frankly". It said the company completed "internal authentication of staff" and arranged for the police online application to be completed immediately when staff joined the company. "All new employees go through a period of training and strict supervision during their probationary period," Sytech said. In response to the UKAS findings Sytech said it had ceased using privately owned vehicles for the transport of exhibits.

Failings at Hmp Birmingham Contributed to the Death Of Marcus Mcguire

The inquest into the death of Marcus McGuire concluded on 17 June with the jury finding his death was a suicide, with multiple possibly causative failures by HMP Birmingham including a lack of mental health assessment and issues with suicide and self-harm procedures (known as ACCT). Marcus died on 24 April 2018, after being found unconscious in his cell with a ligature. His death was the fifth in seven weeks at the prison, which was at the time privately run by G4S.

In August 2018, HM Inspectorate of Prisons issued an Urgent Notification to the Secretary of State in respect of unsafe conditions at the prison, including poor management of prisoners at risk of suicide and self-harm. The prison was then brought back under the management of HM Prison and Probation Service. An Independent Review of Progress published today (18 June), found insufficient progress has been made and ACCT procedures are still not yet delivered well enough to provide effective care.

Marcus was 35 years old when he died. He comes from a large family, who describe him as having had a fascination with numbers, engineering and physics. Marcus loved the book The Curious Incident of the Dog in the Night-Time and identified with the main character. He was excluded

from school aged 15, but in prison had started a maths degree. He had a history of mental ill health and had previously been detained in hospital under the Mental Health Act. Marcus was recalled to prison in November 2017, shortly after being discharged from a psychiatric hospital where he had been detained after making threats to his life. Following short stints at HMP Hewell and HMP Oakwood, he was transferred to HMP Birmingham in February 2018. Six weeks prior to Marcus' death, the Ministry of Justice sent an improvement notice to G4S in accordance with the terms of their contract to run HMP Birmingham. This related to G4S having fallen below the required standard of compliance with suicide and self-harm prevention procedures since June 2017.

The inquest jury returned a conclusion which found Marcus died by suicide with multiple failings which possibly caused his death, including: the lack of a mental health assessment and inadequate efforts being made to facilitate such an assessment; the lack of action taken in response to his refusal or failure to take prescribed anti-psychotic medication; the inappropriate recording on ACCT documents of Marcus' risk of suicide and self-harm as 'low'; the inappropriate decision to close the ACCT on 5 April, with inadequate post-closure assessment, and; the failure to reopen the ACCT on 13 April after he was seen by a mental health nurse.

In a detailed description of Marcus' death, the jury noted, "Mental Healthcare was not appropriately involved at any stage of Mr McGuire's stay at HMP Birmingham." And that prior to Marcus' death, "there was a shortage of ACCT trained staff leading to case management inconsistencies, repeated failure to check pertinent information and a failure to adhere to ACCT guidance". The jury recorded that, "An inadequate reception screening took place" at HMP Birmingham in February 2018, "with failure to refer Mr McGuire to mental health." This was despite a referral and follow up email from HMP Oakwood requesting he be assessed, which was never actioned. The inquest heard evidence that instead staff decided to "see how he settles at HMP Birmingham". Marcus was discharged from the primary care mental health team without being seen.

In the early hours of 19 March 2018, Marcus seriously self-harmed and was taken to hospital where he required surgery. ACCT procedures were opened immediately. However, the jury found there was a failure to comply with ACCT guidance, with a lack of detail in forms intended to record key concerns. Upon Marcus' return to HMP Birmingham his ACCT was reviewed. Despite recognition of his mental ill health, the input of the healthcare team was not sought nor was a referral to the mental health team initially made.

Whilst in hospital, Marcus had asked the detention staff with him to turn a blind eye whilst he killed himself. An entry to this effect in his ACCT document was never read by those involved in assessing his risk. Marcus was subject to twice hourly observations, though these were not always completed. Marcus' ACCT was reviewed a further three times before it was closed on 5 April. The jury noted that observations were stopped, not reduced as guidance suggests. However, during this time there were several incidents involving Marcus, including signs of paranoia and aggressive behaviour.

Marcus was seen by a mental health nurse on 13 April, when concerns were raised about his behaviour at the medications hatch. She recorded he said he was feeling depressed and paranoid. She incorrectly thought he was still on an ACCT, so could therefore be managed this way until a scheduled mental health appointment on 17 April. The nurse told the inquest that had she known Marcus was not on an ACCT she would have reopened it. A Clinical Reviewer told the inquest that not finding Marcus' ACCT document prior to seeing him was a "major oversight".

From 13 April, Marcus did not take his psychiatric medication. The jury noted he had twice previously asked for it to be amended. They found that Marcus missed his third dose of medication on 15 April, and "there was a failure to notify appropriate channels" in accordance

with policy. Marcus took no further medication except one dose the day before his death, but no action was taken by healthcare staff. The inquest heard evidence that stopping his anti-psychotics “may have increased the risk of further psychotic symptoms developing”. Marcus did not attend the scheduled mental health appointment on 17 April, and a decision was taken that healthcare staff would wait until a GP appointment on 24 April to see him. Marcus was last spoken to by staff at 9pm on 23 April. The following morning a Prison Officer went to collect him for the GP appointment, but found Marcus dead in his cell.

Marcus' family issued the following statement: “Marcus was criminalised for mental ill health, and throughout his life was failed by the systems in place to protect him. In prison, both G4S and mental healthcare services made serious failings which we know contributed to his death. Exposing the failings in Marcus' care will not bring him back, however we hope another family will not have to go through what we have been through.

Our family know that prevention is better than cure. We have lost two brothers, who were both excluded from school. As we know thousands of working class boys are excluded or off rolled from school; many with Special Educational Needs and many vulnerable. Many will end up in prison. Education, and crime and punishment for the middle class bears no resemblance to how we the working class experience them. This needs to change.”

Clair Hilder of Deighton Pierce Glynn, the family’s solicitor said: “Marcus’ family have sat through a significant amount of evidence about improvements to the care prisoners at risk of suicide and self-harm now receive at HMP Birmingham. It is an insult to them and to Marcus' memory that in contrast HMIP, in following up their recommendations in this area during a review of progress completed in May 2019, has found insufficient progress has been made. Ending the G4S contract to run HMP Birmingham is not a magic wand. Public scrutiny needs to continue to ensure further progress is made and the failings identified in Marcus’ care are not continuing.”

Deborah Coles, Director of INQUEST, said: “Marcus was let down by the state throughout his life, by education, mental health and criminal justice services, in a society that punishes those in most need of support. His family have now been let down by a failure to make sufficient changes since his death, to protect others.

The systems for learning in prisons have been exposed as fundamentally flawed, as the lamentable failings found at this inquest reflect the issues well known to both G4S and the Ministry of Justice. Ultimately, responsibility for Marcus’ death rests with their complacency and indifference in response to potentially lifesaving recommendations. It appears that complacency continues to this day.”

Judged Under the Influence

Thousands of criminal cases are being reviewed after the family of a judge said he had been going to work drunk. The allegations were made in guardianship papers filed by the family of Judge William T. Marshall, 62, an elected judge in southern Ohio. A total of 2,707 cases which he heard and which involved prison time or court supervision are now being reviewed under the oversight of the state public defender's office. Judge Marshall's family, who are seeking control of his personal and financial affairs, claim that the judge regularly "either failed to appear for work as a common pleas judge or showed up to work while under the influence". Without a guardian, they say, he would "return to drinking and continue his self-inflicted death sentence", Fox News reports. According to the documents, Judge Marshall has been hospitalised at least three times since 2013 in connection with his alcoholism and was also ordered to attend a rehab clinic following a drunk driving conviction.

Scotland: Automatic Pardon For Gay and Bisexual Men to Come Into Effect in October

Scottish Legal News: Men prosecuted for same-sex sexual activity which is now entirely legal will be able to apply to have their convictions erased from October. Legislation passed unanimously by the Scottish Parliament last year will grant an automatic pardon to every man in Scotland criminalised for breaching homophobic laws which have now been repealed. Following preparatory work with police and other justice agencies, regulations have now been laid which MSPs will be asked to scrutinise and approve. These regulations will bring the legislation into force on 15 October, from when men can apply to have convictions removed from central criminal records under a ‘disregards’ scheme.

Justice Secretary Humza Yousaf said: “We have been working with Police Scotland and other partners to ensure we have a clear and effective system in place as we bring this important legislation into force. Subject to Parliament approving the necessary secondary legislation, in October the Act will enable people convicted of these offences to apply to have them disregarded so they will never show up on any form of disclosure or criminal records check. And it will provide an automatic pardon to all men convicted of same-sex sexual activity that is quite rightly now legal. There are people in Scotland who were criminalised simply because of who they love under laws which fostered homophobia, ignorance and hatred. The Scottish Government absolutely understands the distress that this has caused and we have worked across the Parliament to address this historical injustice.”

Tim Hopkins, director of the Equality Network, said: “We welcome the news that the Act will come into force on 15 October. “On that date, everyone who was convicted for one of the discriminatory offences that targeted relationships between men will receive an automatic pardon. “Shamefully, those convictions were for things that were legal between a woman and a man, in some cases no more than a kiss in a public place. “The damage done by Scotland’s homophobic past can never be undone, but the wrong has now been recognised and acknowledged. Those who have such convictions on their record will also be able to apply to have them removed, and that will go some way to relieve a burden and stigma that they have carried for decades.”

Prisoners Denied Access to a Computer & Internet Access - Violation of Article 2

In Chamber judgment1 in the case of Mehmet Reşit Arslan and Orhan Bingöl v. Turkey (application no. 47121/06) the European Court of Human Rights held, unanimously, that there had been: a violation of Article 2 of Protocol No. 1 (right to education) to the European Convention on Human Rights. The case concerned the right to education of two convicted prisoners. Having been sentenced to life imprisonment and wishing to continue their higher-education studies, which had been interrupted by their conviction, the applicants had asked the prison authorities to allow them to use a computer and access the Internet. Their requests were denied. They appealed to the courts but were unsuccessful. Having examined the circumstances, the Court found that the domestic courts had failed to weigh up the applicants’ interests on the one hand and the imperatives of public order on the other.

Father Not Allowed to Regain Contact With His Young Daughter - Violation of Article 8

In Chamber judgment1 in the case of Haddad v. Spain (application no. 16572/17) the European Court of Human Rights held, unanimously, that there had been: a violation of Article 8 (right to respect for private and family life) of the European Convention on Human Rights.

The case concerned the placement of the applicant’s youngest child in foster care. The applicant’s three children, including his daughter, then aged one and a half, were placed in a res-

idential centre in Madrid, at their mother's request, and declared abandoned. The children were later placed in centres in Murcia. The applicant was not informed of their placement. As criminal proceedings were pending against him for domestic violence, based on a complaint filed by his wife, he was not allowed to have contact with his children or to approach them. He was ultimately acquitted. Currently having regained the custody of his two sons, he has been seeking to recover custody of his minor daughter.

The Court found that the Spanish administrative authorities should have envisaged other, less radical measures than pre-adoption foster care for the minor daughter and should have taken account of the applicant's requests to re-establish contact with her, at least after the criminal proceedings against him had been terminated. They had not made appropriate or sufficient efforts to ensure respect for the applicant's right to live with his daughter, together with her brothers.

Serious Concerns Remain Over Treatment of Immigration Detainees In UK Law

Gherson Immigration: Immigration detention is the practice of holding foreign nationals in custody for the purpose of immigration control. Its use is limited to administrative purposes. In most cases the reason is to effect an individual's removal from the UK. But detention can also be used to establish someone's identity, or where there is reason to believe they will abscond, and even when release is not considered to be 'conducive to the public good'.

A key feature of immigration detention, however, is that it is not a criminal procedure (it is an administrative one) and, therefore, should not be punitive. In this sense, immigration detention is completely different to imprisonment and public authorities can only resort to detention in cases where it is necessary or a specific lawful purpose (such as facilitating removal) and there are no reasonable alternatives to detention.

According to the Home Office's own polices, immigration detention "must be used sparingly, and for the shortest period necessary". These policies are designed to reflect the state of the law in the UK in relation to administrative detention, which requires a 'strict and narrow' interpretation of the phrase 'the shortest period necessary'. Such an interpretation requires that that detention must always be strictly confined to the time required to meet a permitted statutory purpose. In the now infamous Hardial Singh case, for example, the court held that where there is no prospect of removing someone within a reasonable timeframe, "detention becomes arbitrary, and consequently unlawful… and the deportee must be released immediately".

Despite this emphasis on the short-term nature of any detention, the UK remains the only EU member state which does not set an explicit limit on the period of time that a person can be held in immigration detention. The reasoning is that the risks of arbitrary and prolonged detention are sufficiently minimised by the legal principles enshrined in UK law, described above. Rather than being automatically released after a fixed statutory period, detainees under UK law must, in theory, be released as soon as their detention is no longer necessary for a specified purpose, which could be earlier than a statutorily fixed period.

That's the law. However, the Home Office has the discretionary power to detain a person at any point of their immigration process and there is little to no judicial oversight when the initial decision is taken. However, in practice, people are being wrongfully detained, held in immigration detention when they are vulnerable and detained for too long, contrary to the Home Office's own Guidance and, in many cases, in breach of their human rights.

While immigration offices and ports of entry are supposed to have an absolute detention time limit of 5 consecutive days, immigration removal centers ("IRCs"), such as the Heathrow

Immigration Removal Centre, has no limit on the duration of a person's detention. Recent reports have given examples of detainees being held at Heathrow IRC for 12 months, two years, and even up to four years and six months before being released on bail. It is difficult to conceive such lengthy periods of detention as 'reasonable' and serious questions arise as to just how the Home Office can argue that a period of over two years in detention could ever be the 'shortest period necessary' to facilitate removal.

According to the Independent Monitoring Board for Heathrow IRC, the frequent inappropriate use of immigration detention has a damaging effect on the mental health and wellbeing of detainees and can amount to 'inhuman and degrading treatment'. However, the duration of detention is only part of the issue. Heathrow IRC has been condemned for the conditions in which detainees there are kept. Designed for 'short term detainment', there have been reports on the worsening health conditions of detainees at the IRC, resulting in gang crime, psychoactive drug problems, mental and physical harm and insufficient access to medical treatment.

Around 30,000 people are held under Immigration Act powers every year, for a range of reasons. In 2018, 24,748 people entered detention. As of April 2019, there are seven IRCs (Brook House, Colnbrook, Dungavel, Harmondsworth, Morton Hall, Tinsley House, Yarl's Wood), two STHFs (Manchester Residential STHF, formerly Pennine House, and Larne House), one pre-departure accommodation facility, and 30 holding rooms. There are also short-term units within some IRCs, including at Colnbrook and Yarl's Wood.

The systemic failure of the immigration detention regime in the UK can be seen in the statistic that out of the 10 main detention facilities in the UK, each housing 2,000-3,000 people at a time, the nationwide removal rate for those held is less than 50%. The remaining 50% of detainees are eventually released after overturning 'incorrect' Home Office decisions. Such figures highlight the continuing and growing problems of immigration detention, with numbers of detainees increasing, and the release statistics remaining stagnant. Changes are required, and in this context the growing Parliamentary pressure for the 28–day detention limit is encouraging.

Whatever the circumstances, being held in prison-like conditions for people who in most cases have not committed a crime, without a time limit, causes extreme anxiety and distress. Many detainees already have traumatic backgrounds, and the psychological impact of being held is highly and potentially permanently damaging. The 28-day detention plan being advocated by both Parliament and the Independent Monitoring Board for the Heathrow IRC may be a step in the right direction, but is little comfort to those currently enduring years in detention. In the short term and at the very least, urgent and decisive measures must be put in place to address the weak administrative process and the serious lack of judicial oversight of the decision to detain which currently affects the UK immigration regime and blemishes the reputation of the UK as a fair and compassionate society as a whole.

HMP & YOI Foston Hall Women's Prison - Self-harm Incidents Very High

HMP & YOI Foston Hall, a women's prison situated between Derby and Uttoxeter, was found to be a "very positive institution" with reasonably good outcomes across all four HM Inspectorate of Prisons' healthy prison tests. Peter Clarke, HM Chief Inspector of Prisons, said most women in Foston Hall felt safe. "Violence was rare and incidents minor. Work to investigate incidents when they did occur and the support offered to victims and perpetrators did, however, need to be better." The incentives scheme was not very effective, and the number of adjudications and the use of force by staff were both higher than expected, although

incidents when force was used were not normally very serious.

A dedicated social worker led work to support adult safeguarding effectively, but needed better support from other staff. "Support for those with needs was not sufficiently proactive or always in line with prisoner care plans. The case management of those at risk of self-harm was variable," Mr Clarke said. Self-harm incidents were very high and despite two self-inflicted deaths since 2016, when the prison was last inspected, not all the recommendations made by the Prisons and Probation Ombudsman, who investigated these incidents, had been implemented.

Inspectors found the general environment to be excellent and most accommodation was good. Most women were positive about their relationships with staff. New work to promote equality and diversity had begun and was encouraging, with new arrangements for consultation now in place. Health care had improved considerably since 2016. Most prisoners experienced very good time out of cell and some good joint working between education providers and the prison had led to improvements to the curriculum on offer. The management of resettlement was improving, but would have benefited further from a better analysis of the distinct needs of women in the prison. Mr Clarke said: "Work to support offender management was good but more could have been done for the many prisoners serving indeterminate sentences." Inspectors noted some impressive initiatives, such as the Family Bonding Unit established to encourage stronger family ties.

Overall, Mr Clarke said: "This is a good report about a good prison. Foston Hall is well led, with energy and creativity evident among the senior team. Themes that emerged from our inspection were the need to refine strategies so that initiatives were better coordinated and delivered more effectively, and to ensure that the staff group was more proactive in focusing on the needs of prisoners and their well-being. We were, however, confident that managers could use the platform they had created for further improvement and we leave the prison with several recommendations which we hope will assist this process."

Landmarks in Law: the Case That Shone a Spotlight on Domestic Violence

Catherine Baksi, Guardian: Thirty years ago, a jury found Kiranjit Ahluwalia guilty of murdering her husband. Her subsequent appeal changed the way that the concept of "provocation" was applied, and helped shift the attitude of English courts and the public on the impact of domestic violence on women who kill. It led to the later freeing of two other women – Emma Humphreys and Sara Thornton – and was also relied on in the recent case of Sally Challen, who this year successfully appealed against her conviction for murdering her coercive and controlling husband. At the age of 23, Ahluwalia was pushed into an arranged marriage. She gave up studying law and moved to England from India with her husband, Deepak, in 1979. For 10 years she endured violence, rape and sexual abuse from her controlling husband who treated her like a slave. When she could stand it no longer, she set fire to his bedclothes while he slept. Although she had not intended to kill him, he died 10 days later and she was charged with his murder. Her plea of manslaughter due to provocation was rejected. The jury found her guilty of murder and she was sentenced to life in prison. Ahluwalia recalls: "When I got my life sentence and my trial solicitor said there were no grounds of appeal, that was a big blow. I had no lawyer, no family, I ended up with a life sentence. I lost everything."

After a couple of days, she wrote to Pragna Patel, director of the campaigning charity Southall Black Sisters, which this year celebrates its 40th anniversary of fighting for women's rights. The group, backed by Justice for Women, won an appeal in 1992 on the grounds that expert evidence and psychiatric reports had not been presented at the original trial. After a retrial, Ahluwalia was found guilty of manslaughter due to diminished responsibility. She was sentenced to three years and four months in prison – the time she had already served – and was released immediately. Her story was made into the 2006 film Provoked, starring Aishwarya Rai and Miranda Richardson. At the time of her trial, her plea of provocation – which is a partial defence to murder – failed because the law demanded an immediate incident of provocation that acted as a trigger to a loss of self-control. In her case, a few hours had elapsed between her husband's last attack and her act of retaliation, which was deemed to be a "cooling down" period and not a "boiling over" period, as her defence suggested. Ahluwalia's case, says Harriet Wistrich, director of Justice for Women, was one of a series of important cases in the early 90s that brought to the fore the issue of victims of domestic violence who kill. "In legal terms these cases brought changes to the defence of provocation by introducing such concepts as slow-burn provocation and cumulative provocation," she says. Wistrich explains that they highlighted the fact that the provocation defence had been designed to assist men who lost control and responded with anger. Meanwhile, women were more likely to endure abusive conduct over a longer period, which would accumulate to a stage when they would ultimately lose control.

As Patel explains: "The discriminatory law was based on male standards of behaviour and did not allow for the examination of the abusive, coercive, controlling and constraining context in which abused women kill. Nor did it allow for the very real social, cultural and economic reasons that can prevent exit from abuse." The case, says Patel, was not just about differences in physical strength and ways in which anger or rage is built up. It was about the social and political realities in which men and women find themselves, and the failure of state agencies to take domestic violence and abuse seriously. "We were not asking for a licence to kill, but for the contexts in which abused women kill to be better understood," she says. The groundbreaking case, says Patel, "shone a spotlight on domestic violence in South Asian communities and helped to create awareness of how the patriarchal concepts of honour and shame silence South Asian women".

The Coroners and Justice Act 2009 abolished the defence of provocation and replaced it with loss of control, which, says Patel, "better reflects women's reality while not being lenient on men who claim that they lost self-control due to adultery or in anger". Despite an improved awareness and response to abused women, Patel insists that the criminal justice system continues to reflect gender bias in the laws of self-defence. But, she adds, the recent case of Challen has helped to develop an even greater judicial and societal awareness of the concepts of coercion and control as a form of domestic abuse. As Wistrich points out, a lot of the facts of Ahluwalia's case were mirrored in Challen's. "If the words and framework were there at the time, [Ahluwalia's case] would also have been described as a coercive and controlling relationship," she suggests. Thirty years on, Ahluwalia reflects: "It all seems like a bad dream … People now understand more about the abuse that goes on. Women have started coming out because they know now that there is help."

Hostages: Sally Challen, Naweed Ali, Khobaib Hussain, Mohibur Rahman, Tahir Aziz, Roger Khan, Wang Yam, Andrew Malkinson, Michael Ross, Mark Alexander, Anis Sardar, Jamie Green, Dan Payne, Zoran Dresic, Scott Birtwistle, Jon Beere, Chedwyn Evans, Darren Waterhouse, David Norris, Brendan McConville, John Paul Wooton, John Keelan, Mohammed Niaz Khan, Abid Ashiq Hussain, Sharaz Yaqub, David Ferguson, Anthony Parsons, James Cullinene, Stephen Marsh, Graham Coutts, Royston Moore, Duane King, Leon Chapman, Tony Marshall, Anthony Jackson, David Kent, Norman Grant, Ricardo Morrison, Alex Silva,Terry Smith, Hyrone Hart, Glen Cameron,Warren Slaney, Melvyn 'Adie' McLellan, Lyndon Coles, Robert Bradley, John Twomey, Thomas G. Bourke, David E. Ferguson, Lee Mockble, George Coleman, Neil Hurley, Jaslyn Ricardo Smith, James Dowsett, Kevan & Miran Thakrar, Jordan Towers, Patrick Docherty, Brendan Dixon, Paul Bush, Alex Black, Nicholas Rose, Kevin Nunn, Peter Carine, Paul Higginson, Robert Knapp, Thomas Petch, Vincent and Sean Bradish, John Allen, Jeremy Bamber, Kevin Lane, Michael Brown, Robert Knapp, William Kenealy, Glyn Razzell, Willie Gage, Kate Keaveney, Michael Stone, Michael Attwooll, John Roden, Nick Tucker, Karl Watson, Terry Allen, Richard Southern, Jamil Chowdhary, Jake Mawhinney, Peter Hannigan.