

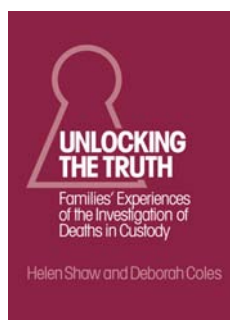


UNLOCKING THE TRUTH

Families' Experiences
of the Investigation of
Deaths in Custody

by Helen Shaw and Deborah Coles

Executive Summary & Recommendations



Unlocking the Truth is essential reading for researchers, policy makers, penal reformers, family liaison officers from the police, Prison Service and those working for the independent investigation bodies, human rights specialists, legal professionals, coroners, voluntary sector bereavement agencies, bereavement counsellors, academics, students and all those with an interest in the mechanisms that follow contentious deaths.

Helen Shaw and **Deborah Coles** are co-directors of INQUEST, the only non governmental organisation in England and Wales that works directly with the families and friends of those who die in custody.

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Executive Summary

This report traces the political, legal and recent historical context of deaths in custody and families' experience from the time of death to the conclusion of the investigation and inquest. It makes 80 recommendations and two key proposals which we believe would significantly improve the current system.

It describes the issues to emerge in the last 25 years that have shaped public, family and state perceptions of deaths in custody. The evidence-based chapters describe families' experiences of investigations and inquests and outline their suggestions for changes in practice. It shows the crucial role that all agencies should play in supporting bereaved people through provision of information and appropriate referral to specialist support and demonstrates the failings of the current system.

Since 2000, post-death processes have been subject increasingly to reform. Sustained campaigning by bereaved families and their representatives, and reactions to the Marchioness and Hillsborough disasters, high profile deaths in custody and the murders of Stephen Lawrence and Zahid Mubarek contributed to widespread public concern about the investigation and inquest system and provisions for holding those responsible to account. Reforms and legal cases also modified policy and practice in the investigation and inquest systems. At the time of writing further changes, in particular to the coroner service, are ongoing.

As new processes evolve so families' descriptions of previous practices indicate quite clearly what can go wrong. Any new process will present teething problems. The challenge to a reformed system is that its response to these problems must be open, innovative and consistently reviewed and revised. It is vital that past cultural and systemic failings that undermined public confidence are not simply recreated.

Chapter One – Introduction

Introduces the report, its purpose and structure, the motivation behind it and thanks those who contributed to it – in particular the families who shared their experiences with us.

Chapter Two – Social and Political Context

This chapter shows how INQUEST's work since the early 1980s with families bereaved after deaths in custody revealed serious shortcomings in the mechanisms of legal and democratic accountability and led the organisation to develop a critical analysis of custodial deaths. Families were marginalised and excluded from debate but their tenacity and strength was instrumental in drawing national and international attention to the lack of independence in the investigation process, abuse and neglect by custodians and institutional indifference to the deaths.

The evidence based chapters

In chapters 3 to 6 we examine each stage of post-death procedures, following the timeline of families' experience: immediately after the death, the investigation process, the inquest, and after the inquest.

We present comments from the families affected and put forward practical suggestions for immediate improvements to the system on their behalf. At the end of each chapter we list the recommendations argued for in the text.

Chapter 3 – Immediately after the death

This chapter describes what happens immediately after a death in detention from bereaved families' perspective, outlining the relevant human rights standards and what happens to the body of the deceased person. We discuss how families are supposed to be treated, their actual experiences and suggestions for change.

Chapter 4 – The Investigation

We consider what bereaved families expect from the investigation following a death in custody and what the investigation bodies are obliged to provide. We underline the importance of early legal representation for families. We outline the stages of investigations following deaths in prison and police custody and consider the provision of information to families about the process. Continuing the timeline of families' experiences of interaction with the system, we discuss problems arising from the role of family liaison officers and the conduct of investigators' interviews with families. We then examine problems with families' access to information about the ongoing investigation and the release of documentary information. As we highlight concerns about the shortcomings of the current system, we present evidence from experienced practitioners together with the families' and our own recommendations for change.

Chapter 5 – The Inquest

In this chapter we discuss families' experiences of the inquest system, how the inquest system works and the law and procedures that govern it. We outline the problems families face and make suggestions for better practice. We look at the issues that arise following the conclusion of the investigation and in preparation for the inquest hearing; we discuss the experience of the hearing itself and what happens after it is over. We present families' perceptions of the whole process and the views of the lawyers who represent them. It is accepted that custodial deaths should be subjected to public and judicial scrutiny and that there should be public inquests into all deaths in detention – deaths that involve the police, prisons, immigration detention and psychiatric detention. We argue that these cases merit a specialist approach both in relation to the resources available to all involved and to the experience and expertise of the coroner presiding over the public inquest hearing.

Chapter 6 – The impact of a death in custody and inquest

In this chapter we discuss how a death in custody and the associated legal procedures impact on family members. We consider the specific nature of this kind of bereavement and how it involves both complex grief and legitimate anger. We discuss the options available to meet families' emotional needs. We consider how for some families getting

involved in working for change can help.

Official procedures, while failing to recognise grief following traumatic death, at the same time often exacerbate it by failing to take account of the perspectives of the bereaved whose needs and feelings as those most seriously and enduringly affected by the death should be the starting point of any investigation.

Chapter 7 – Key Proposals and Concluding Remarks

Despite the changes brought about as a result of legal reform, parliamentary lobbying and campaigns fought over the conduct of investigations and inquests into deaths in institutions, the current system is still insufficiently resourced and is failing to perform its preventative function which is to ensure a decline in preventable deaths. The process does not allow for discussion of wider policy issues; does not ensure accountability of those responsible at an individual and institutional level; and does not enable an honest and open approach to ensuring changes are made to prevent future deaths in similar circumstances.

Monitoring the investigation and inquest process has demonstrated that a significant number of cases reveal clear evidence of individual and systemic failings. Inquests repeatedly highlight the failure to implement existing guidelines on the care of ‘at risk’ detainees. Recommendations made by inspection bodies alerting state authorities to the potential risks to the health and safety of people in custody are often not implemented and can result in death or serious injury. Despite critical investigation reports and detailed narrative verdicts returned at inquests highlighting systemic failings, action is rarely taken either at an individual or senior management level.

The vital contribution the coroner service can make to the prevention of further fatalities is hindered because of the failure to take action based on the findings and reports that emerge from the investigations. We propose that coroners should be allowed to inquire broadly into matters arising in these cases that are likely to result in recommendations conducive to public health and safety. To reduce the number of preventable deaths, the wider environment in which the death occurred needs to be analysed. Broader issues need to be explored than are currently permitted by the narrow remit of the inquest. Analysis of thematic issues could lead to important changes and save lives.

Our key proposals

A. Improving the processes following the conclusion of the investigation and inquest into custodial deaths.

The new system must produce a systematic way of learning from the investigations and inquests into custodial deaths. Currently the findings of inquests are not published or shared and recommendations and responses are not monitored.

Any proposals for legislative reform need to include a clause that provides that the purposes of an inquest are:

(a) to conduct a public investigation into a death which occurred in contentious circumstances in order to provide public accountability for the death;

- (b) to provide an effective mechanism for eliciting and challenging evidence; and*
- (c) to provide a forum for interested persons to contribute to the development of coronial recommendations for the prevention of similar deaths.*

Follow up action after an inquest is a fundamental part of an effective investigation and the state has a proactive role to play in effecting change when deaths occur in its custody.

- i. Where a coroner believes that action should be taken to prevent the recurrence of similar fatalities, he or she should be under a duty not discretion to report the matter to both the person who may have power to take remedial action and the Chief Coroner.¹
- ii. There should be a duty on coroners to make recommendations whenever appropriate about preventing further deaths in similar circumstances and on any matter connected with the death including public health and safety or the administration of justice.
- iii. The office of the Chief Coroner should prepare detailed guidelines and training for coroners in relation to the formulation of such recommendations
- iv. All coronial recommendations should be made publicly available and coroners should be empowered to refer findings and/or recommendations to any individual or agency and require that individual or agency to provide, within six calendar months, a written response including a report as to whether any action has been taken or is proposed to be taken in response to the recommendation.
- v. The coroner should then be required to provide a copy of the response referred to in the recommendation above to: the senior next of kin of the person whose death is mentioned in the coroner's findings, or their representative; a witness who appeared at an inquest into the death who is the subject of the findings; and any other person who the coroner considers has sufficient interest in the inquest or investigation.
- vi. The office of the Chief Coroner should have the power to call for such further explanations or information as he or she considers necessary, in relation to the implementation of recommendations.
- vii. The office of the Chief Coroner to include in its annual report to Parliament: (a) a summary of all coronial investigations in which recommendations have been made; and (b) a summary of responses to the recommendations made in the previous year, including a list of those recommendations which are still awaiting implementation or response.
- viii. Parliament should then ask the relevant government department to report on what action has been taken. There should be a statutory obligation on departments to respond within agreed time limits. They should be required to present an action plan.
- ix. A National Coroners Information System should be created to enable data on all inquests and their findings to be collated and available for all to access. It should be complemented by a research unit established within the Chief Coroner's office with the

1. Coroner Reform: The Government's Draft Bill 2006 section 56.1

capacity to properly utilise the National Coroners Information System database to conduct research relevant to individual cases on behalf of coroners, and to identify trends and clusters of deaths requiring further investigation.

- x. The Chief Coroner should also notify investigation and inspection bodies of coroner's reports and jury findings as they happen and ensure they receive the annual report.
- xi. There should be an obligation for those who receive reports to respond not only to the coroner, but to the investigation bodies and the family concerned. Consideration should be given to a mechanism whereby such reports must be acted upon or explanations published for why reasonable action has not been taken.
- xii. The investigation bodies should be required to incorporate any coroner's reports and jury findings into their final report on each individual case. Both the IPCC and PPO should collate relevant reports and jury findings, publish and circulate them and use them to monitor outcomes and improve practice.

B. Establishing a Standing Commission on Custodial Deaths.

A well-resourced overarching independent body with specific statutory powers – a Standing Commission on Custodial deaths – should be established which could:

- bring together the experiences from the separate investigation and inspection bodies where shared features of the deaths go beyond the remit of specific government departments, state and custodial agencies;
- identify key issues and problems and monitor the outcomes and progress of investigation and inquest findings;
- look at serious incidents of self-harm or near deaths in custody where there is a need to review and identify action to be taken to prevent similar incidents;
- develop policy and research, disseminate findings where appropriate and encourage collaborative working, with best practice established in one institution being promoted in the other institutions;
- act as a check and balance on the investigation bodies themselves;
- play a key role in the promotion of an ethos of human rights promoting measures to prevent or minimise the risk of future violations of article 2 of the Human Rights Act;
- have an active interventionist role and be empowered to hold a wider inquiry into broader thematic issues as well as issues of democratic accountability and redress over systemic management failings that fall outside the scope of the inquest;
- be empowered statutorily to intervene in individual inquests or court cases where appropriate as an interested party particularly where there is no traceable or interested next of kin.

The principal advantage of the Standing Commission over existing remedies is that its power and scope would not be limited to individual deaths in custody. Its focus could also contribute to wider policy considerations as many of the deaths are part of a pattern which impact on policies on drug and alcohol use, homelessness, mental health, crime prevention, combating racism, penal policy and policing.

Conclusion

These two key proposals, if implemented alongside reform of the inquest system and the practice changes suggested below, could make a significant contribution to improving families' experiences, preventing further fatalities and achieving greater accountability.

Bereaved families tell us that what they want is for the process to result in changes which will ensure another family does not have to endure the same distressing experience. Where there has been wrongdoing or mistakes have been made families want an admission, an apology and to see those responsible brought to account.

Unlocking the truth about deaths in custody sheds light on the way we treat some of the most vulnerable men, women and children in society. It is important that we recognise, scrutinise, criticise and argue for reform of the way the state deals with deaths in custody as these processes are an indicator of the condition of its democracy.

Recommendations

Immediately after the death

Notification of the Death

1. There should be agreed protocols and standards about notification of death across the police and prison service to ensure:
 - a. it is a priority for all institutions to notify the family as soon as possible after a death;
 - b. those delivering the news should be accompanied by a Family Support Worker from the coroner service;
 - c. no information is released to the media until the family has been notified;
 - d. that there is a transparent process for the release of information;
 - e. there is mandatory basic training for anyone who may be involved so they can notify with accuracy, clarity and sensitivity;
 - f. staff receive proper and professional support;
 - g. training is updated at regular intervals.

2. Families should be:
 - a. told face to face about a death where possible by someone who can give information about the death and about what will happen next and who else will be involved;
 - b. offered the opportunity to meet the relevant senior official and to visit the scene of the death if they wish.

3. Staff should ensure:
 - a. that the relative has appropriate support mechanisms available;
 - b. that all information about the death and subsequent procedures given orally is duplicated in writing;
 - c. that a direct phone number and contact name that can be reached out of hours is left for the family;
 - d. that they give only accurate information about the circumstances of the death so that families are told the truth, however painful.

In the short term co-ordinating a unified approach to notification and provision of information involving multi-disciplinary groups could be addressed in the Forum for Preventing Deaths in Custody .

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Access to the body and the post mortem examination

4. The coroner service needs to ensure that bereaved families:
 - a. are told as soon as possible that the post mortem examination is mandatory;
 - b. are given clear and accessible oral and written information about the post mortem examination and their options regarding retained tissue before it takes place;
 - c. receive written confirmation that the body is preserved according to an agreed protocol, either directly or through their legal representative;
 - d. are able to view the body as soon as they wish and particularly before the post mortem examination;
 - e. are informed of the time and location of the examination and have time to consider and act on their options within an agreed period of time before the examination goes ahead;
 - f. have the initial draft post mortem report released to them, setting out what examinations have taken place and early findings (excluding toxicology or other reports that may take some time to complete) as a matter of urgency;
 - g. are informed if organs are removed and not replaced before the time of the funeral;
 - h. are automatically made aware that they are entitled to a copy of the post mortem report and the fee for provision of the report is abolished.

5. Those working with bereaved families must:
 - a. be aware that some faiths have post death rituals that will be interrupted if physical access to the body is prevented and understand that it can cause additional distress;
 - b. understand the impact of the issue of ownership of the body.

In the longer term coroners rule 7 should be amended to require the coroner service to inform families of the time and location of the post mortem examination and their right to have their own representative present; and to allow the examination to be delayed until the family has instructed their own representative if that is their wish.

Provision of Information

6. The coroner service should ensure that bereaved families:
 - a. receive a copy of the leaflet *When Sudden Death Occurs*;
 - b. receive a copy of INQUEST's information pack;
 - c. have access to one named person in the Coroners Court who can answer their questions throughout the duration of their contact with the service.
7. In the long term:
 - a. the service provided by INQUEST should be complementary to a properly resourced and comprehensive support service provided by the coroner service ensuring that families receive all the basic support they require;
 - b. the Ministry of Justice should provide a new national coroner service with a comprehensive information pack for families;

- c. the independent publications of the voluntary sector should be made available alongside this pack;
- d. a new post of Family Support Worker (FSW) should be established which is distinct from the coroner's officer;
- e. the FSW in each jurisdiction could assist with notification of local families irrespective of location of death, provide support and advice and be available on an ongoing basis to answer queries about any aspect of the procedures that follow a sudden death;
- f. the FSW would be trained and knowledgeable about the needs of bereaved families and about specialist, complementary services available;
- g. the FSW would have a social work qualification and experience in working with bereaved people.

The Voluntary Sector

- 8. The sector needs more resources to co-ordinate and ensure seamless delivery of its services.
 - a. Voluntary sector groups should meet regularly to ensure good communication, appropriate referral and understanding of each group's remit and expertise.
 - b. Consideration should be given by the Ministry of Justice to funding such an initiative.

The Investigation

- 9. The Independent Police Complaints Commission and the Prisons and Probation Ombudsman must:
 - a. recognise that the expectations of families are very different from those of the state institutions involved;
 - b. understand that in the immediate aftermath of the death there can be tension between the need to proceed with the investigation and the potential and actual intrusion into the human experience of the aftermath of a sudden and unnatural death;
 - c. put in place clear, coherent and consistent national protocols for the structure of the relationship between the investigating officials and all others in direct contact with bereaved people;
 - d. ensure that investigations follow an agreed basic protocol;
 - e. ensure investigators are explicit about the purpose of their initial meeting with the family and approach it as a two step process: first to provide families with information about themselves and the investigation process and second to get information from families about their relative to provide background to the investigation;
 - f. complete investigations within agreed time limits;
 - g. offer a meeting with the family and their lawyer to discuss the investigation report;
 - h. update investigation reports following the inquest to take into account inquest evidence, jury findings and any coroner's comments or rule 43 reports prior to publication;
 - i. publish the reports and the authorities' responses to them;
 - j. use the reports and findings both to inform subsequent investigations and to promote better practice.

- 10. IPCC Commissioners, PPO managers, all investigators and Family Liaison Officers and Family Liaison Managers should:

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- a. receive training on the specific needs and concerns of families bereaved by deaths in custody;
- b. receive such training with specific input from those organisations working with such families;
- c. ensure there is clear demarcation between meetings at which the family are an equal stakeholder and interviews where the families are required to provide information to assist the investigation process.

11. Bereaved families should be entitled to:

- a. an oral explanation of and a letter about the investigation process from its beginning outlining their rights and the role that they can play including reference to legal representation, proposed timescales for disclosure of information and completion of the investigation, sources of support and advice including information about INQUEST, advice on funerals, expenses, etc;
- b. clear explanations about the purpose of any meetings;
- c. funding to enable them to attend meetings with the investigators and/or their lawyers;
- d. information about progress of and full involvement in the process;
- e. a choice as to how they receive information gathered as part of the investigation;
- f. receive information about the investigation irrespective of whether they are involved in it or not;
- g. adequate time to absorb findings of the investigation in order to raise any concerns they might have about the draft report;
- h. mandatory disclosure of the investigation report.

A reformed inquest system

12. The Coroners Act and any secondary legislation and codes of practice should be amended² to require:

- a. an inquest to be held with a jury where there is a death of a detained patient, of a child imprisoned in a secure training centre or of a detainee in an immigration detention centre;
- b. an agreed mechanism to ensure that the jury is made up of peers of the deceased and that different parties can make representations on jury selection;
- c. full mandatory disclosure of all information irrespective of whether the coroner intends to call witnesses, and clear rules about when and how it will be made;
- d. a regional structure for the coroner service with the regional coroner having sufficient experience and knowledge to preside over all deaths in detention cases;
- e. compulsory continuing training for all coroners;
- f. provision of regular updates on changes in coronial law;
- g. a casework management approach in inquests into deaths in custody with clear timetables set out at the initial opening of the inquest, subject to regular review;
- h. a mechanism to implement, monitor and subject to public scrutiny action taken in response to coroners' findings and inquest juries verdicts and to inform all parties involved in the inquest of progress.

2. These are discrete recommendations that arise directly from the report. For INQUEST's response to the draft Coroners Bill see www.inquest.org.uk

13. In the short term complex and controversial custody death inquests should be heard before a judge sitting as a coroner.

Consideration should also be given to allocating additional resources in the form of full time deputies to coroners' jurisdictions with the most prisons and other places of detention to address the problem of delay.

Administrative issues

14. Inquests should be held in accessible well-equipped buildings to ensure:

- a. families have access to a private room;
- b. sufficient space in the court to seat all properly interested persons on different rows;
- c. access to office facilities for all legal representatives;
- d. collation and numbering to enable everyone to work from the same bundle of documents at the hearing;
- e. standardised recording of proceedings with free transcripts available to all properly interested persons.

Legal representation for families

15. In the long term:

- a. there should be an automatic right to non means tested public funding for legal representation of bereaved families;
- b. the Law Society should consider setting up an accredited panel in conjunction with the INQUEST Lawyers Group (ILG).

16. In the short term decision makers at the Legal Services Commission Special Cases Unit should:

- a. be trained by relevant organisations to understand the context and impact of a death in custody on a bereaved family;
- b. be required to shadow a solicitor from the ILG in order to gain a better understanding of the nature of an inquest case and the type and quantity of work involved.

Support for bereaved families

17. The coroner service should ensure:

- a. bereaved families are referred to appropriate legal, social and health service providers, including those in the voluntary sector;
- b. mental health professionals and bereavement counsellors should be recognised partners within the coronial system;
- c. the court has an index of suitable counsellors, psychologists and social workers with the skills to deal with the complicated grief that follows a death in custody;
- d. adequate and accessible information is provided about the inquest process;
- e. families receive follow-up communication about action being taken where the coroner has made a report under Coroners Rule 43;
- f. Family Liaison Officers, Family Support Workers, counsellors, psychologists and social workers working with bereaved people should be trained to understand the inquest system and the complex responses of bereaved people to a death in custody and an inquest.