

INQUEST submission to the United Nations Special Rapporteur on extrajudicial, summary or arbitrary executions for their report on deaths in custody

March 2023

1. INQUEST is the only charity in the UK providing expertise on state-related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question.
2. Over the past 40 years, INQUEST's work with bereaved families has exposed the UK Government's failures to uphold the right to life, the right to live free of discrimination, and the state's duty to protect life and prevent ill-treatment.
3. Given the remit of the Special Rapporteur's report on deaths in custody, this submission refers only to deaths in prison, police custody, or following police contact and brings together recent INQUEST evidence to outline four key concerns on the investigations into these types of deaths. These are:
 - gaps in data collection on deaths in custody;
 - a failure of post-death investigations to examine possible racism;
 - a lack of support for bereaved families;
 - and, a lack of accountability following post-death investigations.
4. This submission also provides background on how deaths in custody are investigated in England and Wales.
5. INQUEST's work on deaths in custody and their investigation has highlighted many other issues, not all of which will be detailed in this submission. We urge the Special Rapporteur to read INQUEST's previous reports and submissions on deaths in custody,¹ particularly our previous submissions to various UN bodies including the Working Group of Experts on People of African Descent, the International Independent Expert Mechanism to Advance Racial Justice and Equality in the context of Law Enforcement and the Committee against Torture.² Similarly, we

¹ See INQUEST's website for more information, <https://www.inquest.org.uk/Pages/Category/books-and-publications>

² INQUEST, November 2022, Submission of the Working Group of Experts on People of African Descent in advance of the country visit to the United Kingdom, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=9a9d9011-8957-474f-9027-fda3a773d9d6>; INQUEST Submission to the United Nations International Independent Expert Mechanism to Advance Racial Justice and Equality in the context of Law Enforcement on policing data disaggregated by race or ethnic origin, May 2022,

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recommend reviewing the Angiolini Review into Deaths and Serious Incidents in Police Custody³ and Harris Review on Self-Inflicted Deaths in Custody of 18-24 year olds⁴, both of which INQUEST contributed to.

Background

6. Deaths in prison, police custody or following police contact in England and Wales are investigated by independent investigatory bodies. Deaths in prison are investigated by the Prison and Probation Ombudsman (PPO), while deaths involving the police are investigated by the Independent Office for Police Conduct (IOPC).
7. The quality and rigour of the initial investigation into a death in custody has an impact on the subsequent inquest hearing, particularly on the scope of the coroner's investigation (see paragraphs 14 to 16). A flawed investigation can have a detrimental effect on the level of scrutiny a coroner applies to the issues. INQUEST's casework has evidenced how crucial the role of legal representation for bereaved families is (see paragraphs 42 and 43), as we are aware of a number of inquests where lawyers representing families have been able to test and challenge initial investigation reports, resulting in highly critical findings which have prompted re-investigations.

Prison and Probation Ombudsman

8. The PPO investigate every death in prison in England and Wales. At the end of the investigation, the PPO will produce a draft report to explain their findings, including on whether the prison's actions were appropriate and on any recommendations it believes should be implemented to prevent deaths in the future.⁵
9. INQUEST has serious concerns about the PPO's failure to scrutinise possible racism or discrimination when investigating the deaths of racialised people in prison, which is discussed in detail below (see paragraphs 30 to 33). INQUEST also has concerns about the quality of PPO investigations. For example, the PPO rely heavily on clinical reviews to assess the level of care provided to the deceased and whether there were any shortcomings. The quality varies greatly, as does the level of expertise of the

<https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=1939ebb6-78e0-429a-9943-9db7f03cb319>; INQUEST, March 2019, INQUEST submission to the UN Committee against Torture, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=5667368d-35c8-4578-87bc-969368953956>;

³ Rt. Hon. Dame Elish Angiolini, January 2017, Report of the Independent Review of Deaths and Serious Incidents in Police Custody,

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

⁴ The Harris Review, July 2015, Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds,

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/439859/moj-harris-review-web-accessible.pdf

⁵ See the INQUEST handbook for more information on the PPO's process for investigating deaths in prison, <http://info.inquest.org.uk/handbook/deaths-in-prison/>

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clinical reviewers. In INQUEST's experience, some appointed clinical reviewers may not always hold the appropriate, specialist or clinical expertise required.⁶

10. Further, clinical reviewers will categorise deaths as 'foreseeable' or 'unforeseeable'. The danger here is that many apparent 'natural cause' deaths may not receive the appropriate level of scrutiny.⁷ INQUEST's casework and monitoring show so-called 'natural cause' deaths often reflect serious lapses in healthcare.⁸ Applying the term 'natural' is concerning as the classification may influence the coroner in their decision around Article 2 and the scope of an inquest.

Independent Office for Police Conduct

11. The IOPC investigate deaths in police custody, following police contact, deaths resulting from a police shooting or a road accident involving the police in England and Wales.
12. In addition to INQUEST's concerns regarding the IOPC's lack of scrutiny of the role of racism in their investigations (see paragraphs 34 - 40), INQUEST has serious concerns about the inordinate length of time investigations into police-related deaths take, particularly following contentious deaths. In 2021 INQUEST asked 23 families about delays they had experienced during the IOPC investigation process. Only eight told us they had been kept informed about delays, while 15 had not.⁹
13. In addition, there are concerns around the operational independence of the IOPC and its practice of recruiting former police officers. According to statistics from 2019, "about 28% of staff in [IOPC] investigations have previously worked for the police service, with more than one-in-three senior investigators being former officers."¹⁰ As INQUEST have previously evidenced, many bereaved families experience a sense of IOPC bias toward the police.¹¹

The inquest system

14. Following the initial investigations outlined above, deaths in custody will be investigated by a coroner. According to the Coroners and Justice Act 2009, where a person has died and their body is within a coroner's area in England and Wales, if the coroner suspects the death was violent or unnatural, where the cause of death is

⁶ INQUEST, May 2018, Submission to the Health and Social Care Committee Inquiry into Healthcare in Prisons, <https://inquest.eu.rit.org.uk/Handlers/Download.ashx?IDMF=b60fe35b-0e93-40f9-89c6-3ad4718c3538>

⁷ Ibid

⁸ INQUEST, January 2020, 'Deaths in prison: A National Scandal', pg 5, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=bb400a0b-3f79-44be-81b2-281def0b924b>

⁹ INQUEST, Police Action Lawyers Group and INQUEST Lawyers Group, January 2021, Submission of evidence to the Home Affairs Select Committee Police Conduct and Complaints inquiry, <https://committees.parliament.uk/writtenevidence/13061/pdf/>

¹⁰ The Guardian. January 2021, Fewer than one in 10 police officers fired after gross misconduct finding, <https://www.theguardian.com/uk-news/2021/jan/18/fewer-than-one-in-10-police-officers-fired-after-gross-misconduct-finding>

¹¹ INQUEST, Police Action Lawyers Group and INQUEST Lawyers Group, January 2021, Submission of evidence to the Home Affairs Select Committee Police Conduct and Complaints inquiry, <https://committees.parliament.uk/writtenevidence/13061/pdf/>

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unknown or where the person died in custody or otherwise in state detention, the coroner has a duty to investigate the death.

15. Deaths which occur in particular circumstances, such as where the state may be responsible, should result in an 'Article 2' inquest being held.¹² Every death in custody attracts the protections of the procedural duty under Article 2 of the European Convention on Human Rights, i.e. the obligation on the state to protect life and have in place systems to investigate deaths where there is the possibility of state responsibility or involvement in the death.¹³ Inquests are the primary means by which the state discharges its duty to investigate.

16. A coroner must issue a Prevention of Future Death report (PFD) where he or she believes action must be taken by relevant agencies to prevent future deaths.

Scotland

17. INQUEST is currently working on several deaths in custody in Scotland. In Scotland, deaths in custody are investigated through the Fatal Accident Inquiries system. The inquiry into a death is overseen by a judge. The independence, effectiveness and timeliness of investigations in Scotland has been raised by bereaved families and others as a key concern.

Gaps in data on deaths in custody

18. Official statistics on deaths in prison, police custody or following police contact are now routinely published. However, INQUEST have been collating and publishing statistics on deaths in custody prior to the publication of official statistics.¹⁴ Our data is unique as we collect the data from:

- our casework service;
- monitoring of the media;
- and, official sources from the Government and independent investigatory bodies.

19. Below we outline the current available data on deaths in custody and highlight some of the gaps in the official statistics on deaths in custody.

Prison

20. Data on deaths in prison is made available through the Ministry of Justice (MOJ) Safety in Custody bulletin, which is published quarterly. According to the latest MOJ statistics:

- There were 301 deaths in prison in the 12 months to December 2022.

¹² INQUEST: A Practitioners Guide, Leslie Thomas, Adam Straw, Daniel Machover and Danny Friedman, Third Edition, 2014, see section 1.22

¹³ Ibid, see section 19.5

¹⁴ See INQUEST's Statistics and monitoring webpage for more information, <https://www.inquest.org.uk/Pages/Category/statistics-and-monitoring>

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- 293 of these deaths were of men while 8 were of women.
- Of these, 74 deaths were self-inflicted.
- 5 self-inflicted deaths were of women and 69 were of men.¹⁵

21. INQUEST's recent report, '*Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination*' contains in-depth data analysis on the deaths of racialised people in prison covering the seven-year period between 1 January 2015 and 31 December 2021. This information was received through Freedom of Information requests INQUEST made to the MOJ. Key findings from this analysis include:

- During January 2015 to December 2021, 2,220 people died in prison.
- Self-inflicted deaths as a percentage of total deaths were highest amongst people of Eastern European nationality, Mixed Other people, and White Gypsy or Irish Traveller people respectively.
- Of the 2,220 people that died, 97% (2,149) were men and 3% (71) were women.
- Of the 2,220 people that died, 16% (354) were racialised people.
- The 15 deaths of racialised women made up 21% of all deaths of women in prison whilst the 339 deaths of racialised men made up 16% of all deaths of men in prison.¹⁶

22. It is important to note that though the deaths of racialised people are not disproportionate to the prison population, this could potentially be partially attributed to the differences in the average ages of racialised groups. For example, according to the MOJ's 'Ethnicity and the Criminal Justice System' statistics in 2020, the "*ethnicity of prisoners varied across age groups, with a higher proportion of younger prisoners [being] from minority ethnic groups (53% of under 18 year olds). In contrast, 85% of prisoners aged 50 or over were White*".¹⁷ Moreover, while the deaths of racialised people are not disproportionate, INQUEST's casework highlights how they are among some of the most contentious, violent and neglectful.

23. Official data on the deaths of people in prison is limited. The Government only publishes statistics on deaths in prison broken down by broad ethnic categories (White, Black, Mixed or Other) and not by the more detailed racialised groups included in the INQUEST report cited above (including White Irish, White Gypsy or Irish Traveller people and people of Eastern European nationality).

¹⁵ Ministry of Justice, January 2023, Safety in Custody Statistics, <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2022/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-december-2022-assaults-and-self-harm-to-september-2022>

¹⁶ INQUEST, October 2022, 'Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination', pages 22-39, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b7f9a0d0-0f48-48a2-b995-c8870f5a5e6a>

¹⁷ Ministry of Justice, December 2021, Ethnicity and the Criminal Justice System, <https://www.gov.uk/government/statistics/ethnicity-and-the-criminal-justice-system-statistics-2020/ethnicity-and-the-criminal-justice-system-2020>

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24. Further, the Government's ethnic breakdown does not routinely disaggregate deaths in prison by racialised group *and* by type of death. It is therefore not clear to the public exactly who is dying in prison and why. As INQUEST notes in the report cited above, this data "*should already be in the public domain*" as it is "*crucial in order to understand and analyse the patterns and trends in the deaths of racialised people in prison.*"¹⁸

25. INQUEST recommends the MOJ:

- Publish data disaggregated by ethnicity on all types of death in prison.
- Include White Irish people, White Gypsy or Irish Traveller people and people of Eastern European nationality in addition to the existing ethnicity categories they use (Asian, Black, Mixed, Other, White) in any ethnicity analysis.
- Publish its 'Ethnicity and Criminal Justice System' statistics annually.

26. INQUEST is also concerned by the MOJ's failure to publish data on use of force in prison. This includes restraint or use of PAVA incapacitant spray. It is therefore important the MOJ begin routinely publishing data on the use of force in prison.

Police custody or following police contact

27. Data on deaths in police custody or following police contact is made available by the IOPC on an annual basis. According to their statistics for 2021/22 there were 217 deaths of people in police custody or following police contact. Eleven of these deaths occurred in or following police custody. Six of these eleven deaths involved people with mental health concerns and nine were known to have a link to alcohol or drugs.¹⁹

28. INQUEST's own data collection shows there has been 1,850 deaths in police custody or following police contact in England and Wales since 1990.²⁰ Our data also evidences that Black people are dying disproportionately: the 2011 census²¹ showed

¹⁸ INQUEST, October 2022, 'Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination', pages 22-39,

<https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b7f9a0d0-0f48-48a2-b995-c8870f5a5e6a>

¹⁹ Independent Office for Police Conduct, September 2022, Deaths during or following police contact: Statistics for England and Wales 2021/22,

https://www.policeconduct.gov.uk/sites/default/files/Documents/statistics/Annual_deaths_statistics_England_and_Wales_2021_22.pdf

²⁰ See INQUEST's statistics on deaths in police custody, <https://www.inquest.org.uk/deaths-in-police-custody>

²¹ Office for National Statistics, 2011 Census data,

https://webarchive.nationalarchives.gov.uk/ukgwa/20160105160709/http://www.ons.gov.uk/ons/resources/figure1_tcm77-290598.png

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Black people made up 3.3% of the population²² yet from 2011 to 2021 Black people accounted for 13% of all deaths in police custody or following police contact.²³

29. The current way official figures on deaths in police custody or following police contact are published obscures the level of racial disproportionality.²⁴ This is because the definition of custody used by the IOPC means that very similar cases where a person was in direct contact with police prior to their death, but had not officially been arrested or detained, are excluded from the overall 'custody' data, and put in a much broader 'other' category. The result is that significant cases involving deaths following direct police contact, such as those involving use of force and restraint, are lost in the broad 'other' category. The Home Office uses only the 'custody' category to count how many deaths occurred by ethnicity and claims that the numbers are "*not unusual when looking at long-term trends.*"²⁵
30. In INQUEST's recent report '*I can't breathe: Race, death and British policing*', we provide analysis on deaths in police custody or following police contact which involve restraint using never before seen datasets. The most recent relationship between race and the use of restraint can be drawn out from the data that INQUEST obtained through Freedom of Information requests to, and engagement with, the IOPC. From 2012/13 to 2020/21, there have been 119 deaths involving restraint recorded by the IOPC 'in or following police custody' or recorded as 'other deaths following police contact'. Of these, 23 were of Black people, 86 were White, 5 were Asian and 4 were mixed race. Our data shows that Black people are seven times more likely to die than White people following use of restraint in police custody or following police contact.²⁶
31. Despite recommendations made in 2017 in the Angiolini Review into Deaths and Serious Incidents in Police Custody, there is still no public dataset showing the breakdown of all deaths following police restraint disaggregated by ethnicity. INQUEST reiterates the recommendation made in '*I can't breathe*' that the IOPC should monitor and publish data on restraint-related deaths both in police custody and other deaths following police contact, disaggregated by ethnicity and other

²² The 2021 census showed that Black people made up 4% of the total population in England Wales, Office for National Statistics, 2021 Census data, <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021#ethnic-group-data>

²³ INQUEST, February 2023, '*I can't breathe: Race, Death and British Policing*', pg 42, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=edfc7c01-e7bb-4a17-9c33-8628905460e6>

²⁴ Ibid, pg 36; INQUEST, May 2022, INQUEST submission to the United Nations International Independent Expert Mechanism to Advance Racial Justice and Equality in the context of Law Enforcement on policing data disaggregated by race or ethnic origin, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=1939ebb6-78e0-429a-9943-9db7f03cb319>

²⁵ Home Office, 2021, Deaths in police custody: Government Update – 2021. The Department of Health and Social Care and the Home Office, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1003842/Deaths_in_Police_Custody_-_Government_Update_2021_FINAL_CLEAN.pdf

²⁶ INQUEST, February 2023, '*I can't breathe: Race, Death and British Policing*', pages 36 to 54, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=edfc7c01-e7bb-4a17-9c33-8628905460e6>

protected characteristics, in order to “provide improved transparency, and to facilitate better analysis of the relationship between race and restraint related deaths”.

Failure to examine possible racism

30. Of deep concern to INQUEST is the failure of post-death investigations (including PPO, IOPC and coronial investigations) to adequately examine the potential role of racism and discrimination in the deaths of racialised people. Over the past two years, INQUEST has researched this issue and published two reports evidencing the scale of problem.

Prisons

31. INQUEST’s 2022 report, ‘Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination’ highlighted that of the 22 deaths featured in the report, none of the post-death investigations (including the PPO fatal incident reports, Record of Inquests or PFD reports) meaningfully considered the potential role of racism.²⁷

32. As we note in this report:

“[...] there was a near absence of consideration of whether racism or discrimination played a role in the deaths of racialised prisoners in PPO investigation reports, records of inquests and PFD reports. This does not mean that it was not a factor in their deaths, but that there was no examination of its potential impact. Given the evidence of racialised people’s experiences and institutional racism in prison [...] we consider it unlikely that racism or discrimination was not a feature in any of the deaths. Therefore, we consider the current approach by PPO investigations, inquest proceedings and PFD reports to be inadequate: there should be a presumption of relevance in the context of how racialised people die in prison.”

33. INQUEST reiterates its recommendation that the PPO and the coroner’s service ensure they meaningfully consider the race/ethnicity of those who die in prison as well as the potential role of racism or discrimination in their death.²⁸

Police custody or following police contact

34. Similarly, our 2023 report ‘I can’t breathe: Race, death and British policing’, on the deaths of Black men in police custody or following police contact, concludes that post-death investigations (including IOPC investigations, coroner’s inquests and PFD reports) do not meaningfully consider the potential role of racism.²⁹

²⁷ INQUEST, October 2022, ‘Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination’, pages 70-72,

<https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b7f9a0d0-0f48-48a2-b995-c8870f5a5e6a>

²⁸ Ibid, pg 75

²⁹ INQUEST, February 2023, ‘I can’t breathe: Race, Death and British Policing’, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=edfc7c01-e7bb-4a17-9c33-8628905460e6>

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35. INQUEST looked at the extent to which race and racism was examined in the inquests of 12 high profile cases of police restraint-related deaths of Black men that occurred between 2008 to 2018. In each case, we looked at the Record of Inquest, which sets out the findings and conclusion of the hearing and, where relevant, the PFD. INQUEST found not a single record or report mentioned racial discrimination or racism. In fact, in only two of the Record of Inquest's and one PFD is the ethnicity of the Black men who have died stated at all – only for it to never be referred to again.³⁰ As we make clear in our report:

“The result is the possible role race might have had is entirely absent from the official version of these deaths. Moreover, it is often at odds with how their bereaved family and, increasingly, the wider public understand the context of the death.”

36. Moreover, information received through Freedom of Information requests made by INQUEST to the IOPC reveals that in the six years from 2015/2016 to 2020/21 there were seven investigations into a death during or following police contact involving police use of force and a term of reference relating to ethnicity as a potential contributory factor in the police treatment of the deceased.³¹ Of these seven cases, the IOPC found no case to answer for misconduct or gross misconduct in respect to race or ethnic discrimination.

37. Therefore, we recommend³² that the IOPC and the coroner's service ensure they meaningfully consider the impact of the race/ethnicity of any Black or racialised person who dies following police contact, examining the potential role of racism or discrimination. This should be an integral and proactive part of their work to identify, and respond to, systemic issues. This in turn should be central to the work of the Crown Prosecution Service in their response to these deaths.

38. Further, the IOPC should amend their guidelines and practice for handling investigations into racial discrimination to bring them into line with the way allegations of racial discrimination are approached in civil courts. This means explicitly incorporating a shifting burden of proof set out in the Equality Act 2010 and ensuring this guidance is properly applied through specific training of IOPC investigators.

39. Additionally, the Chief Coroner should develop detailed guidance and training on how coroners should approach investigating racial discrimination in inquests to fully reflect Article 2 and the Equality Act.

40. In the context of Scotland, INQUEST believe these recommendations should be considered by the Police Investigations and Review Commissioner, the Crown Office, and in Fatal Accident Inquiry processes.

³⁰ Ibid, pg 52

³¹ Ibid, pg 48, this number includes only those cases where ethnicity was in the terms of reference. It is not the total number of police related deaths where race could have been considered a factor.

³² Ibid, pg 125

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Lack of support for bereaved families

41. INQUEST has previously submitted extensive evidence on the challenges bereaved families face when navigating the investigatory processes triggered following a death in custody.³³ These include delays in investigations and inquests, inconsistencies in the approaches to investigations, and adversarial conduct by state lawyers during inquest hearings.
42. Further, some families whose loved one has died in state custody continue to experience an inequality of arms at the inquest hearing. In January 2022,³⁴ the Government made significant reforms to the funding system for legal representation at inquests by legislating to ensure families involved in inquests which meet the Article 2 threshold are funded for their legal representation at the inquest hearing.
43. While this is a positive step forward for bereaved families, the reforms exclude those families whose loved one died in circumstances involving state agencies, and where those state agencies may have a case to answer, but the coroner determines that the death does not meet the Article 2 threshold. In these cases families may have to crowdfund or pay out of pocket for legal representation, or go unrepresented while state bodies are represented by teams of lawyers at the taxpayer's expense. INQUEST believes all families going through an inquest which involves state bodies must receive automatic, non-means tested public funding for their legal representation.
44. Overall, more work must be done to ensure bereaved families receive adequate practical, emotional and financial support to engage in the complex investigation and inquest system following a death in custody.

Lack of accountability following post-death investigations

45. A striking feature of INQUEST's casework on deaths in custody is the repetition of failures revealed during investigations into a death. For example, INQUEST's two recent reports into the deaths of racialised people in custody cited above reveal a pattern of failings, including excessive or dangerous use of force and poor treatment of mental ill health.

³³ INQUEST, March 2018, INQUEST report of the Family Listening Day for the Independent Police Complaints Commission <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=6df8ac79-3c8a-4fc9-8761-289d1d652558>; INQUEST, December 2019, INQUEST report of the Family Listening Day for the London Clinical Network Health in Justice, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e963cb36-567b-45f8-b51c-7ff756913c96>; INQUEST, May 2016, INQUEST report of the Family Listening Days held to support the independent review into deaths and serious incidents in police custody, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=aa0df9a7-5fc6-410f-9650-f39248b51de6>; INQUEST, September 2020, INQUEST submission to the Justice Select Committee inquiry into the Coroner Service, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e404f863-cdfb-47b6-8e34-a65118520331>

³⁴ Legal Aid Agency, December 2021, Civil news: exceptional case funding for families at inquests, <https://www.gov.uk/government/news/civil-news-exceptional-case-funding-for-families-at-inquests>

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46. When post-death processes work as they should, recommendations arising from inquests, investigations and inquiries are invaluable. They are intended to prevent future deaths.
47. Yet the current system for learning and implementing changes arising from investigations and inquests is not fit for purpose, as there is no oversight of the recommendations made and no mechanism to follow them up. Narrative findings from inquests, which often provide a detailed account of systemic failings, are not published or collated. They remain under used. Further, there is a lack of a coordinated response from existing inspectorate or monitoring bodies to routinely collate or analyse post-death recommendations to better inform their work. INQUEST regularly circulate information about post-inquest outcomes to investigation, inspection and monitoring bodies and without us providing this function it is doubtful these organisations would inform themselves of the essential evidence and recommendations arising from inquests and PFD reports.
48. INQUEST have on occasion had to remind coroners of their own PFD reports in other cases in their own jurisdiction where these are relevant to a case. Some bereaved families have done their utmost to force public bodies to take PFD reports forward, and have proactively monitored actions taken as a result of inquests, but it should not be for bereaved families to provide this role. Further, INQUEST have concerns over the failure of investigation systems to consider broader contextual issues involved in a death, such as whether there have been a series of similar deaths in an institution or within a particular police force.
49. The absence of a framework or coordinated response among public bodies to ensure investigation and inquest outcomes feed into concrete implementation of learning and demonstrable action is a significant failure of accountability that must be addressed.
50. A new framework must be put in place to ensure that organisations are publicly accountable for their actions or decisions on whether to act in response to investigation and inquest outcomes. In this way greater active and accountable learning may be achieved and bereaved people and the public reassured that the conditions and circumstances resulting in a death have not only been scrutinised but that the findings have been acted upon in the hope that future deaths and injuries are averted.
51. INQUEST's proposal is that a National Oversight Mechanism with the duty to collate, analyse and follow-up on learning outcomes and their implementation in relation to all state-related deaths be established. Any new framework should also be accountable to Parliament to enable the advantage of parliamentary oversight and debate. Consideration should be given to its reporting annually to parliamentary select

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committees. The mechanism should provide a role for bereaved families and community groups to voice concerns and provide a mandate for its work.³⁵

52. INQUEST also notes that it is extremely rare for prison officers or police officers to be prosecuted following a death in custody. The lack of accountability for institutional failings must be addressed. For example, full consideration should be given to prosecutions under the Corporate Manslaughter and Corporate Homicide Act, where ongoing failures are identified, and the prison service and health providers have been forewarned.³⁶ The reintroduction of The Public Authority (Accountability) Bill to Parliament would also establish a statutory duty of candour on state authorities and officers and private entities.

³⁵ See paragraphs 23 to 35 of this INQUEST submission for more information, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e404f863-cdfb-47b6-8e34-a65118520331>

³⁶ INQUEST, January 2020, Deaths in prison: A national scandal, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=bb400a0b-3f79-44be-81b2-281def0b924b>