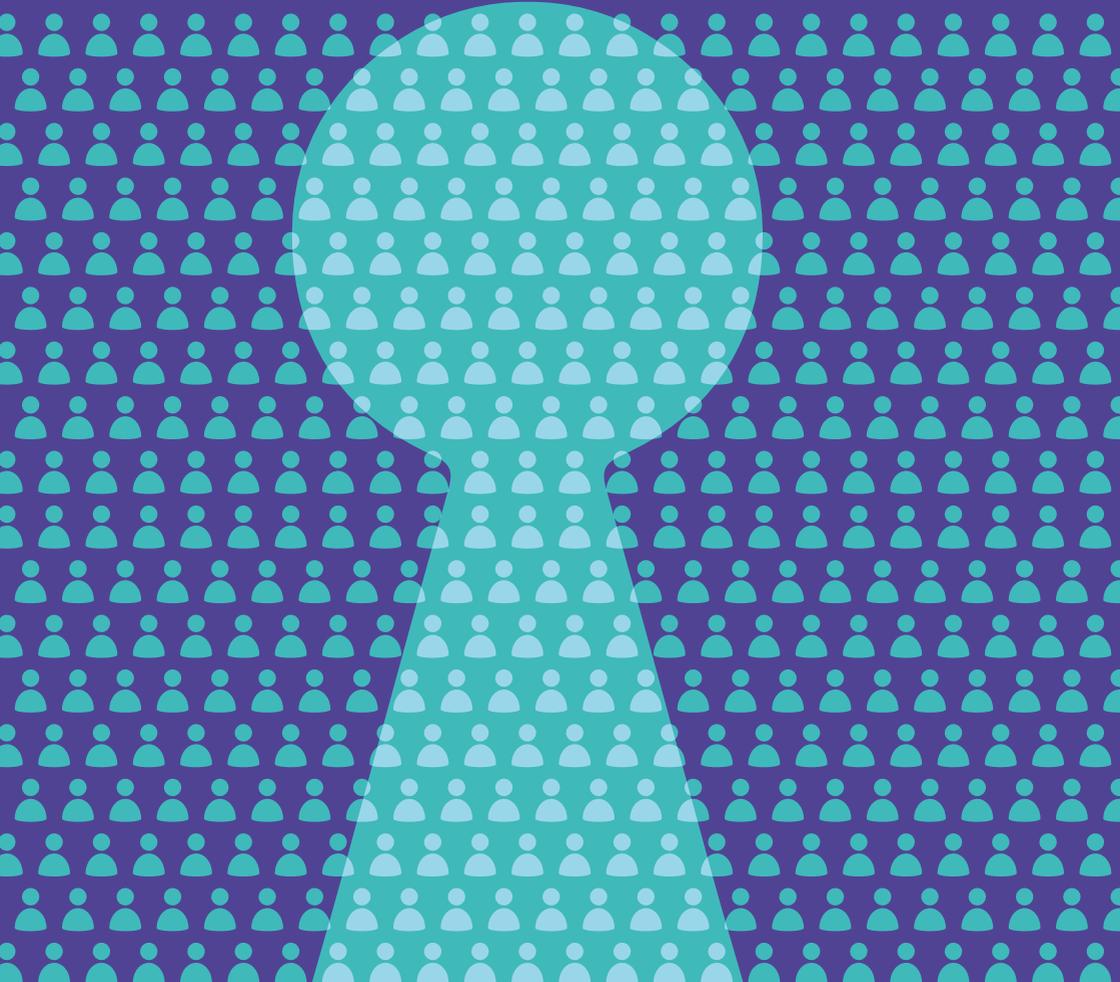




# Evidencing Truth to Power

THE WORK AND IMPACT OF INQUEST 2016 – 2018  
MAY 2019



**INQUEST is the only charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Its specialist casework includes death in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question, such as the deaths following Hillsborough and Grenfell Tower. This impact report provides a snapshot of the work INQUEST does. To find out more visit [www.inquest.org.uk](http://www.inquest.org.uk)**

This report details the impact of the work of INQUEST and our incredibly dedicated and professional staff team. Working closely with families and lawyers for almost forty years, INQUEST has been at the forefront of improving practice and policy following state-related deaths.

INQUEST is a hugely influential and well respected organisation with an unwavering commitment

to speaking truth to power and ensuring that bereaved families are central to the battle for long term systemic change to prevent future deaths.

INQUEST is operating in challenging circumstances as we are seeing the impact of deepening inequality born out of austerity in the increase in demands for our advice and support. Demand for our expertise and input has also increased both nationally and globally. In an era witnessing the rise of the far right, the hostile environment and of the politics of othering, it is our duty and responsibility to stand tall and challenge head on discrimination and racism, as well as their root causes.

INQUEST has transformed and politicised the investigation of contentious deaths, the defence of human rights and access to justice. Alongside bereaved families we have placed these issues firmly on the policy and public agenda and will continue to in the struggles for truth, justice and accountability.

**Deborah Coles,**  
**INQUEST Executive Director**

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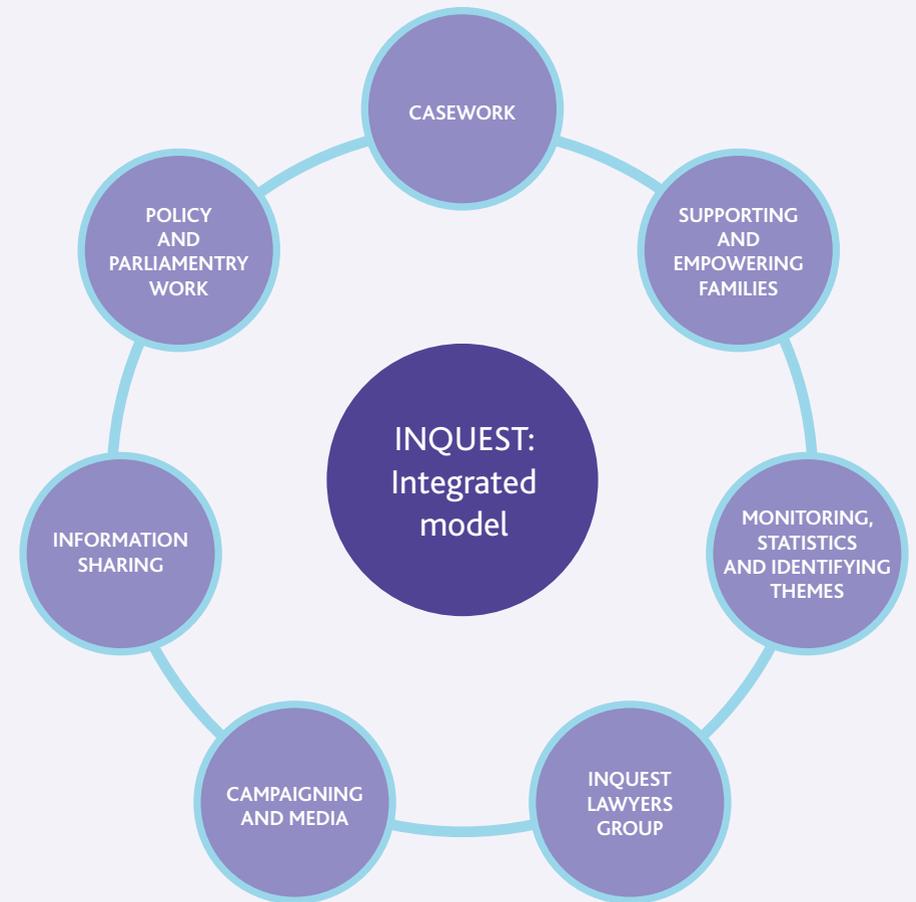
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**In the six and a half years since Seni's death, INQUEST has been with us every step of the way, giving us the strength that we needed to persevere and find out what happened to Seni. Like other families before us, we have found that INQUEST has been there for us in our time of need, to cope with all the challenges that we never thought we would have to face and we do not know what we would have done without this small but effective organisation. So, thank you, INQUEST: love and respect!**

(Aji Lewis – Seni's mother)

## HOW DOES INQUEST MAKE AN IMPACT?

INQUEST's policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people. Employing an **integrated model**, this brings together casework support, family participation, identification of thematic trends, statistics and analysis that feeds into the organisation's work on campaigning, information sharing and policy and parliamentary work. At the heart of this unique model are the experiences and needs of bereaved people. INQUEST ensures the family voice is heard by those with power and influence, and ultimately aims to hold the state to account for individual deaths and to bring about meaningful policy and practice change to prevent future deaths.



**Underpinning values:** INQUEST works to empower bereaved people, often excluded from exercising their legal rights. This involves challenging racism, sexism and discrimination and raising concerns about the systemic discrimination, inequality and poverty behind many deaths in custody and state care. INQUEST is committed to the values of social justice, is independent of government and its work is collaborative and non-judgemental in relation to the background or actions of an individual who has died.

# INQUEST'S STRATEGIC PRIORITIES

## FAMILIES

- Increased opportunities for family participation and empowerment
- Better treatment of bereaved people by the investigation and inquest process.



## DEATHS INVOLVING MASS FATALITIES AND STATE/CORPORATE ACCOUNTABILITY

- Hillsborough inquests and implementation of 'Hillsborough Law' – 'The Public Accountability Bill'
- Grenfell Tower fire disaster.



## POLICY

- Reform of the inquest and investigation systems related to detention and contentious deaths
- Better mechanisms and systems to ensure learning and accountability following deaths
- Monitoring deaths in custody.



## ORGANISATIONAL DEVELOPMENT AND PROFILE

- Capacity building with an emphasis on staff numbers
- International work and profile
- Web-site development and creation of a new Legal Database
- Strengthening communications and media profile.



# CASEWORK JULY 2016 TO JUNE 2018 IN NUMBERS

OVER THE LAST **02** YEARS INQUEST HAS WORKED ON **1,101** NEW CASES

OF THESE CASES



<b>49%</b> INVOLVED PRISONS	<b>3%</b> WERE IN WERE IMMIGRATION RELATED
<b>25%</b> WERE MENTAL HEALTH RELATED	<b>3%</b> RELATED TO LEARNING DISABILITY
<b>17%</b> WERE INVOLVED POLICE CONTACT	<b>7%</b> INVOLVED OTHER ISSUES, SUCH AS MEDICAL CARE, CARE HOMES AND DEATHS ABROAD

THE INVESTIGATIVE AND INQUEST PROCESS CAN BE SLOW AND INQUEST WORKED ON A FURTHER



**520** ACTIVE CASES FROM PREVIOUS YEARS, WORKING ON **1,621** CASES IN TOTAL

OVERALL THERE WAS A **29% INCREASE** IN INQUEST'S NEW CASELOAD WHEN COMPARING THE TWO-YEAR PERIODS JULY 2014-JUNE 2016 WITH JUNE 2016-JULY 2018

Our Casework Team of five provided confidential and independent specialist support to more families than ever before, linking families with skilled lawyers from the INQUEST Lawyers Group (ILG) specialising in investigations and inquests. It enabled families to engage in a complex legal process armed with information and confidence. Families reported feeling less isolated and more supported. Practical examples of support included supporting families access funding, advice around post mortems, assisting families navigate legal documents, letter writing and work with the media, accompanying families to meetings with lawyers, pre-inquest hearings and during the inquest itself.

**INQUEST's help has been priceless in so many ways, from finding good legal representation and giving vital information, to excellent emotional support and care throughout the inquest process and the investigations.**

(Family member)

#### HOW THE CASEWORK TEAM SUPPORTED THE ORGANISATION'S KEY PRIORITIES:

- Families have improved understanding of their rights and choices
- Independent, confidential, non-judgemental
- Delivered information and advice on the inquest process
- Directing families to specialist legal representation
- Funding options for legal costs
- Working with family lawyers on thematic issues or concerns
- Help with contacting a MP
- Media advice
- Information on other sources of help and support
- Thematic policy issues and wider action
- Family Forums and Family Listening Days

## IMPACT

In 2017, families were asked how they felt following contact with the organisation. This is what they said:

**100%** felt more informed, thus enabling meaningful participation in the investigation and inquest process

**99%** had received the support they needed

**83%** felt more able to face the challenges ahead

**66%** felt less isolated, a crucial element of the work as previous INQUEST research highlighted the negative impact of a state related death on relationships, mental and physical health.

INQUEST regularly consults with families on service delivery and effective engagement. The impact of informative, experienced and targeted support is evident. INQUEST saw considerable success in its work on key priorities, delivering unparalleled levels of support, advice, information and impact on cases. It also responded to two major reviews into state related deaths; The Angiolini Review and the Bishops Review. Outlined below is a snapshot of the type of casework the organisation engaged in, the families it worked with and the difference it made.

## FOCUS ON

# DEATHS FOLLOWING CONTACT WITH THE POLICE

INQUEST, long recognised as a leading voice in identifying the urgent crisis around policing and mental health, experienced a **20% increase in casework relating to deaths following contact with the police.**

INQUEST provided unequivocal evidence for the need for the government to commission a major independent review into deaths and serious incidents in police custody (The Angiolini Review).

INQUEST has drawn attention to the systemic issues of racism and discrimination in the use of force and restraint and the disproportionate number of deaths of people from BAME communities and those with mental ill health.

The **summer of 2017** saw an unprecedented spike in the deaths of black men following the use of force by police, with the **four men dying in just over four weeks.**

INQUEST previously advised on, contributed to or, participated in, the 2014 **Home Affairs Select Committee** review of policing and mental health, the **Independent Advisory Panel on Deaths in**

**Custody** and **Ministerial Board on Deaths in Custody, Her Majesty's Inspectorate of Constabulary's** review of the treatment of vulnerable people in police custody, **Lord Victor Adebowale's** review of mental health and policing and the 2013-14 **Casale Review** (the IPCC commissioned independent review of the investigation of Sean Rigg's death).

The last two years saw one of the most **significant outcomes in INQUEST's** history with the publication of the ground-breaking **Angiolini Review.** Announced in late 2015 by Theresa May (in her former role as Home Secretary) following a meeting with INQUEST and the families of Sean Rigg and Seni Lewis, this was the first ever wholesale review into all aspects of the policing system, practises and structures of justice and accountability following a police custody death. Deborah Coles was appointed as special advisor to Dame Elish Angiolini QC and INQUEST provided support, expertise and thematic analysis. The organisation helped to direct the review's focus and scope, ensuring family voices and experience sat at its heart.

## ANGIOLINI REVIEW

- INQUEST Director appointed advisor to the review
- INQUEST facilitates meetings with bereaved families and family lawyers
- INQUEST 's written submissions highlight the need for practical changes
- INQUEST holds two Family Listening Days
- The review, published in October 2017, is welcomed by families and cross sector organisations alike
- Media coverage includes national and regional TV and Radio
- The review contains many of INQUEST's recommendations for change
- Home Office Minister and MPs gave personal thanks to INQUEST and the families in parliament



September 2017 saw the publication of the IPCC's unprecedented "Six Missed Chances". Jointly produced by the IPCC, the family of James Herbert and INQUEST, the report pinpoints six key opportunities for learning and change which may have prevented James Herbert's death with national recommendations on policing and mental health. James' father Tony has given powerful testimony to police conferences around the country. The report has now been accepted and endorsed by the National Police Chiefs Council and College of Policing.

Responding to a recommendation made in the Angiolini Review, a new information leaflet for families has been co-produced by INQUEST, the IOPC, the Ministry of Justice and the Home Office. This will be given in the immediate aftermath to all families, bereaved families also contributing to it. It

**I think the Angiolini review went far beyond what most of us expected. INQUEST has had a huge impact on how deaths in custody are perceived. I believe it is the starting point of a change of perspective on the issue.**

(David Baker – Senior Lecturer in Criminology, Coventry University)

includes valuable information on sources of advice and support and we hope it will facilitate greater access to justice.

The Angiolini Review's 110 recommendations contained much of what INQUEST has long advocated:

- Non-means tested public funding for legal representation of families
- Strengthening systems and structures of accountability

and holding the police to account at an individual and corporate level

- National Oversight and learning from deaths, such as through an 'Office for Article 2 Compliance' which would monitor and report on recommendations arising from deaths
- An end to delays - Article 2 cases should be dealt with in the same time scales as civilian homicide cases
- Recognition of the disproportionate number of deaths of people from Black, Asian and minority ethnic communities who die following the use of restraint, and the need to tackle racism and discrimination in IPCC investigations and police training
- National policing policy, practice and training must reflect the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life threatening risk

- Phasing out of ex police officers as lead investigators within the IPCC (now IOPC)
- Better treatment of vulnerable people including through proper healthcare facilities to divert people from police custody and an end to the use of police cells as a 'place of safety'.

**My heartfelt thanks go to the many families who attended the INQUEST Listening days or individual meetings with me and who allowed me to hear their personal experiences of the system. Sadly, too many of the family members have become unwilling experts on the issues and at great emotional and personal cost.**

(Dame Elish Angiolini QC)

## THE DEATH OF OLASENI LEWIS

**The co-ordinated and sustained joint efforts of INQUEST, the families and ILG contributed to a review and change across systems and practises, particularly around the policing of people with mental ill health. INQUEST's work highlighted the need for reform and supported by specific cases the organisation had worked on, helped inform policy and practice change:**

### THE DEATH OF OLASENI LEWIS

**23 year old Seni Lewis** died as a result of prolonged restraint by Metropolitan Police Service officers, while medical staff stood by, at Bethlem Royal Hospital on **31 August 2010**. He was admitted to the hospital for assessment following a serious and sudden decline in his mental health. Police were called to attend and 11 officers were involved in holding Seni down over a period of 30-40 minutes, his legs and hands bound, until his complete collapse. Following advice from the family of Sean Rigg, the Lewis family contacted INQUEST who helped to secure specialist legal representation for the family.

Almost seven years passed before Seni's inquest, a period characterised by failures of all aspects of the system required in responding to and investigating the circumstances of his death. In **May 2017**, an inquest jury unanimously condemned the actions of police and healthcare staff, criticising the decision to call in the police and the excessive and unjustified force used against Seni which they found contributed to his death. Significant national media work followed and prompted the family's MP to put down a private members bill in July 2017.

Following Seni's inquest, six officers involved in his restraint were cleared of misconduct. INQUEST continues to support the family.

## IMPACT

- Seni's case led to a change in the London Metropolitan Police policy around police attendance in healthcare settings. The Lewis family contributed to Family Listening Days organised by INQUEST for the IAP, IPCC, Angiolini Review.
- Part of Seni's legacy will be 'Seni's Law', formally titled the **Mental Health Units (Use of Force) Bill: a Private Members Bill brought by the family's MP Steve Reed**. The bill addresses the use and oversight of restraint in mental health settings.
- INQUEST worked closely with the MP, helping to draft the bill and providing briefings on the issues surrounding it.
- INQUEST conducted significant media and policy work on the Bill.
- It received Royal Assent in December 2018.

**I am grateful for the practical support I have received from INQUEST, in particular its director Deborah Coles, and from Raju Bhatt, the widely respected solicitor who has represented so many bereaved families following deaths in custody.**

Steve Reed MP on the Bill's second reading, House of Commons, 3rd November 2017

## FOCUS ON

# DEATHS IN PRISON

**The 2016 Ministry of Justice 'Safety in Custody' figures revealed the highest number of self-inflicted deaths on record: Prison deaths were up 38% overall, self-inflicted deaths were up 32% (a total of 354 deaths, 119 of which were self-inflicted – over double the number seen in 2012). INQUEST provided analysis of the broader patterns and humanised the stories behind the statistics.**

The self-inflicted deaths of 12 women in 2016 was the highest number on record since 2004; with the overall number the highest since the organisation began its monitoring. This prompted INQUEST to conduct research for its report **Still Dying on the Inside** in May 2018.

INQUEST gave evidence to five parliamentary committees on the issues arising from deaths in prison; the Joint Committee on Human Rights, the Justice Committee, the Welsh Affairs Committee, the Health and Social Care Committee and the All Party Parliamentary Group on Women in Prison. It also submitted evidence to the Independent

Advisory Panel on deaths in custody looking at underlying issues affecting deaths of women in prison.

INQUEST campaigned around the recommendations made in **Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds** – Lord Toby Harris' 2015 review commissioned following INQUEST's work on the issue.

INQUEST highlighted the long term failure of successive governments to act on the recommendations arising from investigations, inquests and independent reports into prison deaths.

INQUEST's call for a **national oversight mechanism to learn from repeated deaths** remained a key campaigning message over the last two years. This was brought into focus by the events at HMP Liverpool, where there were 14 deaths since 2015 and HMP Woodhill.

## CASE STUDY

# THE DEATH OF DIANE WAPLINGTON

**INQUEST continued to draw attention to the overuse of prison and inadequate treatment and care of people experiencing mental ill health in prison. INQUEST remains frustrated at seeing the same failings in the quality of care and treatment repeated time and time again and the criminalisation of people with mental ill health.**

## THE DEATH OF DIANE WAPLINGTON

In 2014 Diane was found unresponsive in her cell having suffocated herself whilst remanded in HMP Peterborough. She had been in and out of mental health institutions for more than 14 years and was remanded in custody for setting fire to her hospital bed. INQUEST argued that, had the recommendations of Baroness Corston's 2007 report been implemented, Diane and many other women who have died in prison would never have gone to prison in the first place. INQUEST worked closely with the family and their legal team, providing context

and sharing previous inquest findings. Initially the family was not interested in making a press statement as they wanted details of Diane's death to be kept private. When the jury came back with strong findings specifically criticising the reason why Diane was sent to prison in the first place, the family was encouraged to speak out. The INQUEST caseworker, Selen Cavcav and Director, Deborah Coles, accompanied Diane's mother Sheila Waplington and her sister to give evidence to the Joint Committee on Human Rights' Inquiry on Mental Health and Prisons. The family drew further attention to this issue by giving their first ever interview to Channel 4 news alongside INQUEST.

**Prison is not a place for mentally ill people; it's a trigger**

(Sheila Waplington addressing the JCHR)

## CASE STUDY

# WOMEN IN PRISON

Working alongside bereaved families, INQUEST was instrumental in drawing attention to the deaths of women in prison. Cases such as Diane's highlighted the inappropriate use of prison for women in crisis. Following on from its previous reports **Dying on the Inside (2008)** and **Preventing the Deaths of Women in Prison (2014)**, in May 2018, INQUEST published **Still Dying on the Inside: Examining deaths in women's prisons**. This evidence based report told the stories of some of the women who had died in prison; monitored trends;

identified serious safety failures inside prisons around self-harm and suicide management, inadequate healthcare provision and the lack of action on recommendations arising from post-death investigations and inquests. It also called for abolition of prison for women and the redirection of resources into community services.

INQUEST utilises its media and parliamentary contacts to use individual cases to highlight the need for systemic change.

## IMPACT

Following the report's publication which generated media disquiet about the delays in producing its Female Offender Strategy, the government finally published it in June 2018. INQUEST broadly welcomed the proposals, not least its commitment to *"divert the most vulnerable women in the criminal justice system away from custody through provision of tailored support"* and the abandonment of building more prisons. However INQUEST has serious concerns about the lack of resources earmarked for community alternatives. INQUEST will continue to monitor the strategy and its impact on the number of women who die in prison.

## CASE STUDY

# THE DEATH OF DEAN SAUNDERS

Dean Saunders, 25, was found dead in HMP Chelmsford on 4 January 2016 after electrocuting himself. He had been remanded in prison, rather than a hospital, after an episode of mental health crisis when he injured his family members who were trying to stop him stabbing himself. The casework team was in touch with Dean's family within days, explaining the process, securing an expert legal team, and providing context and details of previous deaths in the same prison. The jury found, in January 2017, that Dean and his family were "let down by serious failings in both mental health care and the prison system" and that neglect contributed to his death. INQUEST coordinated national media coverage focusing on why Dean was ever in prison in the first place. Within days, INQUEST's briefing to Parliamentarians resulted in parliamentary questions, a meeting with the Justice Secretary and Prisons Minister and a subsequent parliamentary debate on suicide and self-harm in prison. Dean's family are now part of the Family Reference Group.

- In March 2017, families, including those of Dean Saunders and Diane Waplington, gave oral evidence to

the Joint Committee on Human Rights for their inquiry on mental health in prisons. Drawing on evidence from INQUEST and other families the JCHR highlighted the lack of an independent oversight mechanism to monitor and implement recommendations, accepting that the government's current learning from deaths was not fit for purpose.

- Subsequent work saw INQUEST give evidence to Lord Farmer's Review, highlighting the importance of family contact on the well-being of prisoners. Following the publication of this review in August 2017, the Justice Secretary accepted that families play a significant role in supporting prisoners.
- INQUEST gave written and oral evidence to the Parliamentary Health and Social Care inquiry – its report, published in November 2018, highlighted government failings in its duty of care towards people detained in England's prisons and stated that addressing health care needs for prisoners should be at "least the equivalent to that of the general population" a point long argued by INQUEST and the families it works with.

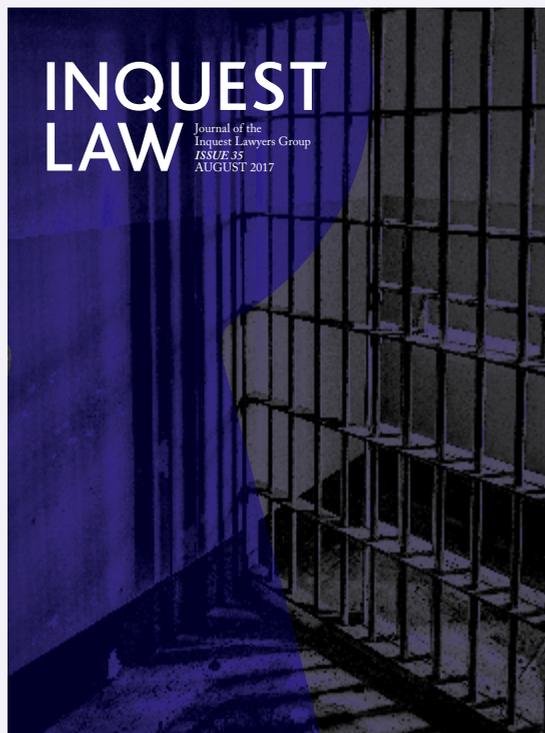
## CASE STUDY

# HMP WOODHILL

## HMP WOODHILL

HMP Woodhill had the highest number of self-inflicted deaths (7) in prison in 2016, and 18 deaths between 2013 and 2016. INQUEST was aware that the situation at HMP Woodhill was just one example of a much wider national problem in relation to failures to act on learning from repeated deaths. It referred the cases to the same legal team who developed expertise around this particular prison. INQUEST intervened in the Judicial Review proceedings and provided a detailed witness statement, illustrating that repeated failures to act on recommendations made following previous deaths resulted in further deaths. A well planned and co-ordinated media and policy campaign put Woodhill right at the centre of the debate on the prison crisis. Although unsuccessful, the Judicial Review helped draw inspection and monitoring boards' attention to the lack of a national oversight mechanism to report on action taken in response to post death investigations. The government commissioned an

independent review which concluded that staffing difficulties resulted in a completely unacceptable situation at Woodhill and change was required. A full edition of INQUEST Law magazine was dedicated to self-inflicted deaths in prison, featuring a main article on the Woodhill legal challenge.



## FOCUS ON

# MENTAL HEALTH DETENTION AND DEATHS OF PEOPLE WITH LEARNING DISABILITIES

## CONTEXT

INQUEST's casework team saw a **41% increase** in mental health related cases over the last two years.

Publication of INQUEST's ground-breaking 2015 report **Deaths in Mental Health Detention: An Investigation fit for Purpose?** provided unique evidence about the inadequate system of post death investigations.

The pivotal **Mazars Review** published in 2015 following the **preventable death of Connor Sparrowhawk in July 2013**. It reported that Southern Health Trust had failed to properly investigate the deaths of more than 1,000 patients with learning disabilities or mental health problems over four years.

INQUEST reported this was a systemic problem and not isolated to one Trust. This work has impacted on the policy landscape.

INQUEST dealt with an increasing number of significant cases involving deaths of people in mental health detention and those with learning disabilities. By highlighting the systemic failings in care, the lack of candour and meaningful engagement with bereaved families, INQUEST, along with other campaigners, forced the Care Quality Commission (CQC) to act and review how NHS trusts investigated deaths.

April 2016 saw the CQC set up a national review of investigations into deaths in NHS Trusts providing a unique opportunity to raise concerns about these deaths and the treatment of bereaved families. INQUEST played a key role at all stages of the review; formed part of the advisory working group, organised and facilitated a Family Listening Day during which families shared powerful testimonies. The resulting FLD report formed central and powerful evidence in the CQC's final report and recommendations, as did INQUEST's detailed written submission which also drew in evidence from the INQUEST Lawyer's Group.

## CASE STUDY

# CONNOR SPARROWHAWK

**Connor Sparrowhawk was 18 years old. He had autism, learning disabilities and epilepsy. On 19 March 2013, he was admitted to hospital (Slade House Assessment and Treatment Unit run by Southern Health NHS Foundation Trust).**

107 days later, on 4 July 2013 he drowned in the bath, an entirely preventable death. INQUEST started working with Connor's family shortly after his death. Initially his death was dismissed by the Trust as 'natural causes'. The truth only came about as a result of the family's fight for it. This took place against a background of Trust secrecy, denial and resistance to effective scrutiny. Southern Health argued against the Article 2 inquest with a jury. It was this process, at which the family were legally represented, that enabled the systemic failings and neglect to be exposed. INQUEST facilitated meetings with the family's MP and the Secretary of State for Health. After a three-year struggle by Connor's family and the #JusticeforLB campaign the Trust admitted negligence and that it had breached Connor's human rights. A health and safety prosecution saw

the biggest ever fine of an NHS Trust in March 2018 for what the Judge called "unnecessary human tragedy".

Connor's mother Sara wrote an article for INQUEST Law detailing the inequality of arms facing families at inquests involving the state.

INQUEST was incredibly proud to be named joint winners of the 2016 Liberty Human Rights with Connor's family (Justice for LB), and ILG member Charlotte Haworth Hird for "their tireless efforts to improve the standards of care provided to people with mental health and learning disabilities". This case highlights the impact INQUEST has by adopting a truly integrated approach to its casework, policy and campaigning work.

Over the past five years INQUEST have worked alongside us, offering support, expertise and information with a calm reassurance. Any family experiencing the preventable death of a loved one in public sector 'care' is catapulted into grim, unknown territory at a time intense distress. INQUEST provide a 'safety net' in terms of enabling families to gain accountability and work with families to influence wider policy and practice.

(Sara Ryan)

Image: Sara Ryan



## IMPACT

**In March 2017, following the CQC report new guidance was published on Learning from Deaths and Deborah Coles spoke at the NHS 'Learning from Deaths' conference about the lack of candour and meaningful engagement with bereaved families.**

**In April 2017, the Healthcare Safety Investigation Branch (HSIB) was established to offer support and guidance to NHS organisations on investigations. Deborah Coles was on the expert advisory group that established the HSIB.**

**In October 2017, the Government announced its Independent Review of the Mental Health Act 1983 as part of its stated drive towards parity of esteem between mental and physical health to which INQUEST has submitted evidence and met with the review team.**

**From July 2017 to June 2018 during the passage of Seni's Law ('Mental Health: Use of Force Bill'), INQUEST briefed Parliamentarians**

about the lack of independent investigations into deaths in mental health settings, and this was raised in the debates.

**In February 2018, Deborah Coles met with the Minister for Mental Health about ongoing concerns about the investigation process.**

**In June 2018, INQUEST submitted evidence to the review of the Serious Incident Framework about ongoing concerns with the investigation of learning disability and mental health deaths.**

**In July 2018, a new information leaflet was produced for families following a bereavement with details of support groups including INQUEST and guidance for NHS Trusts on working with families.**

INQUEST's media and parliamentary/policy work has seen an increasing number of families impacted by learning disability and mental health deaths coming to the organisation for specialist advice and support.

## DEATHS OF CHILDREN IN MENTAL HEALTH SETTINGS

INQUEST saw a disturbing rise in casework on children who die whilst receiving in-patient mental health services. It identified serious difficulties in ascertaining the extent of these deaths in NHS and private health settings, highlighting the failure of systems for monitoring, investigation, and oversight.

Through casework and an extensive Freedom of Information exercise INQUEST established that no single body is responsible for recording the deaths of children who die as mental health in-patients. This crucial information is neither independently investigated, analysed nor made public by any one body or government department.

INQUEST made this a strategic priority following three significant cases: Amy El-Keria who was 14 years old when she died in a private Priory run mental health setting in 2012. In June 2016, four years after her death, an inquest jury found that the Priory Group's neglect contributed to her death. With INQUEST's help the family had a more wide-ranging Article 2 jury inquest, resisted by the Priory Group, which uncovered serious failings and neglect in the treatment and care of a vulnerable child. The publicity

surrounding the inquest outcome resulted in a criminal investigation by the Health and Safety Executive.

This resulted in a prosecution being brought against the Priory Group for offences relating to Amy's death under Section 3 (1) of the Health and Safety Act. It is understood to be the first prosecution of its kind and is a historic moment in terms of accountability following deaths of children in private mental health settings.

The case of Sara Green, a 17-year-old who died in a Priory Hospital in March 2014, also raised concerns around the Priory's systems of practice and care. Christopher Brennan was 15 years old when he died in the Bethlem hospital under the care of the South London and Maudsley NHS Foundation Trust. The coroner concluded in September 2016 that cumulative failures in risk assessment and management meant neglect contributed to Chris' death.

The deaths of these children, failed by the child and adolescent mental health services, prompted INQUEST to develop this work as a strategic priority. Alongside this, we continued our calls for an independent investigation body for deaths in mental health settings.

## CASE STUDY

# BETHAN SMITH

When Bethan Smith, known as Beth, died in 2011, her family were faced with an obstructive and defensive NHS Trust. The original investigation into her death was described as a 'travesty of the truth'. Seven years on, Beth's family have found that *"positive and healing things can emerge out of a terrible darkness"*. In the years before her death, much to their dismay, Beth effectively estranged herself from her family. They repeatedly tried to contact the hospital where she was an inpatient, but the first time they heard back was a call to tell them that Beth was in intensive care. She had been found hanging and later died. The initial Serious Untoward Incident (SUI) report into Beth's death, conducted with no family input and by the same Trust that was responsible for the hospital where she died, contained mistakes and little detail on the care and Beth received.

In November 2016, Beth's parents came to an INQUEST Family Listening Day to share their experiences with the Care Quality Commission (CQC). *"Meeting other families at that powerful day was inspirational for us. We did not feel alone anymore."* A conversation

between the family, the CQC and their INQUEST caseworker led to them getting in touch with the NHS Trust again. Her family were astonished when they received a response saying the case was to be re-examined. The resulting action saw her parents invited to re-write the original SUI, subsequently used as an example of good practice in the Trust's training, contribute to an information leaflet for families and help the Trust re-think the way they communicate with bereaved families. Beth's mother told INQUEST *"We know that there would have been no change at all without your Family Listening Day and the opportunities it offered."*

**This little victory is for all of us, for you at INQUEST, and for those who have no voice or strength to fight.**

(Parents of Bethan Smith)

## IMPACT

- In April 2016 INQUEST's casework and findings formed the basis of BBC Panorama's hard-hitting programme "I'm Broken Inside: Sara's story". INQUEST collaborated on the programme throughout its making. Politically embarrassed by the Government's lack of correct information concerning child deaths, Alistair Burt the then Health Minister met with INQUEST immediately after the programme for urgent discussions of the issues raised.
- In June 2016, the UN Committee on Rights of the Child recommended in its report to the UK the introduction of automatic, independent and public reviews of unexpected deaths or serious injuries occurring in custody, care and mental health care institutions. The recommendation reflected evidence provided by INQUEST.
- In January 2017 Nicola Blackwood (Parliamentary

Under-Secretary of State for Health) updated Parliament detailing action taken by Alistair Burt to increase oversight of child deaths with the introduction of reporting requirements to the Minister for mental health and the Secretary of State for Health. She acknowledged gratitude on behalf of previous and current Ministers for INQUEST's role in bringing the matter to light.

- The treatment and care of people in mental health settings and their investigation has received a high political and media profile during this reporting period including interviews on Newsnight, the Today programme and Channel 4 News. This profile has led to more families of children and young people who have died in receipt of mental health services contacting us for advice and support, an area which remains a strategic priority.

## FOCUS ON MASS FATALITIES

INQUEST has driven the campaign to hold public bodies to account when state or corporate interests are at stake. Two significant events took place in the last two years: the conclusion of the Hillsborough inquests and the terrible fire at Grenfell Tower. In their different ways, they demonstrated the breadth and depth of INQUEST's work and the importance of the integrated model as a vehicle for mobilising the different facets of the organisation's work; from being able to respond immediately with legal advice and support in the aftermath of Grenfell to the long term mobilisation of policy and lobbying work that has been a facet of the Hillsborough families' campaign for justice and accountability.

### HILLSBOROUGH

In April 2016, the Hillsborough inquests concluded, with jury findings that were a powerful expose of state and corporate failings. An inquest jury of ordinary men and women confirmed the truth about what happened; the 96 football fans who died in the 1989 Hillsborough stadium disaster were unlawfully killed, and the fans were exonerated of any blame.

### CONTEXT

INQUEST has supported the Hillsborough families for over 25 years:

- Relatives of those who died spoke at an INQUEST AGM just months after the disaster.
- The publication of '*Hillsborough: the Truth*' by Phil Scraton, one of INQUEST's original founders and notable for his investigative work into the context and aftermath of the disaster, led directly to the establishment of the Hillsborough Independent Panel – tasked with re-examining all the relevant information from the original inquests and subsequent literature. Raju Bhatt, a member of the ILG was also an integral part of that panel.
- INQUEST has campaigned tirelessly to highlight how such deaths do not operate in a vacuum but are part of a larger question surrounding state accountability and how public bodies are held to account.

Once the decision was taken to re-open the inquests, INQUEST provided on-going support for the Hillsborough families and their lawyers.

- Acted as a contact point for unrepresented families, helping them find specialist legal support.
- Facilitated a family workshop to support families in what to expect from the inquests.
- Attended some of the hearings.
- Made the evidence gathered by the organisation on jury narrative/ conclusions from its casework available to the families' lawyers, all of whom were ILG members.
- Produced an INQUEST Law dedicated to the families which shared the key aspects of the legal legacy, opportunities for coronial reform and made the case for the introduction of a "Hillsborough Law".

Throughout the Hillsborough inquests it (INQUEST) supported the bereaved and their legal teams and has been significant in the development of the Hillsborough Law which will impose a 'duty of candour' on public institutions and their workers regarding investigations, court proceedings and coronal inquests. From the outset INQUEST placed the interests of the bereaved at the centre of its work.

(Professor Phil Scraton  
School of Law,  
Queen's University, Belfast).

## FOCUS ON MASS FATALITIES

INQUEST was also instrumental in two key pieces of work that followed the Hillsborough inquests; the publication of the Rt. Reverend James Jones' review of the experiences of families affected by Hillsborough (The Bishop's Review) and the subsequent call for the Public Authority Accountability Bill known as the "Hillsborough Law".

The Bishop's Review, titled *'The patronising disposition of unaccountable power: A report to ensure the pain and suffering of the Hillsborough families is not repeated'* was published in November 2017. The author, Reverend James Jones, a former Bishop of Liverpool and chair of the Hillsborough Independent Panel met with Deborah Coles following which INQUEST were commissioned to hold a Family Listening Day and put in a detailed submission. The FLD was attended by a broad cross section of families bereaved following state related deaths. Many of the concerns raised by INQUEST and the families were reflected in its recommendations. These included:

- A 'Charter for Families Bereaved through Public Tragedy' in which public bodies would commit to placing the public interest above their reputation and approach inquiries and inquests with candour.
- 'Proper participation' of bereaved families at inquests, including non-means tested, publicly-funded legal representation for bereaved families at inquests
- Public bodies are not able to use public money to fund legal representation more advantageous than that which is available to families.
- Cultural change at inquests which would ensure the process is not adversarial, but inquisitorial as intended, upheld by relevant Secretaries of State who should make clear how public bodies should approach inquests.
- Bereaved families put at the heart of inquests, through training of coroners that includes bereaved families, and renewed guidance from the Chief Coroner.

The 'Hillsborough Law' is supported by families and drafted by family lawyers who represented them at the Hillsborough inquests and is an important legacy.

The Bill aims to make it a legal duty for public authorities and public servants to tell the truth, requiring authorities and officials to act at all times *'with transparency, candour and frankness'* and to assist court proceedings, inquiries and investigations. It also makes it a criminal offence for public servants to cover up their actions. Crucially it imposes parity of funding for bereaved families faced with Inquiries and inquests so they are not 'outgunned' by public bodies.

In March 2017, the Bill was initially presented in Parliament, attended by families and INQUEST, as a Private Members Bill by Andy Burnham MP and received cross party support. It was to move to the next stage, a second reading, in May 2017 but parliament was dissolved for the election and the Bill dropped off. However INQUEST will continue to push for its passage into law.

**'I took the opportunity at a recent meeting with the Secretary of State to hand these to him personally. As well as specific comments from family members I also gave him the full report from the family listening day' (Bishop James Jones in a letter to INQUEST on the impact of the families' contribution.)**

(Rt. Rev. James Jones)

## FOCUS ON

# GRENFELL TOWER FIRE

The tragic and preventable fire at Grenfell Tower on 14th June 2017, resulting in the death of 72 people, was deeply shocking. The organisation's expertise, experience of contentious deaths and the needs of bereaved people meant it immediately began working to assist those affected by the fire.

### IN THE IMMEDIATE AFTERMATH WORK INCLUDED:

- Copies of the INQUEST Handbook and posters were sent to the Westminster Coroner's Office to be distributed to bereaved families.
- INQUEST worked quickly to inform the debate as to whether a public inquiry or inquest would be the best forum for a proper investigation into the tragedy and produced an **information leaflet** which was then translated into **20 languages**, distributed and uploaded onto the website.

### SUBSEQUENTLY:

- **33 Grenfell cases** have been opened on the INQUEST database including bereaved families, survivors and local residents. A further **9 cases** have been opened.

- INQUEST staff have been present at **35 key meetings** including community meetings with North Kensington Law Centre, Kensington CAB, Grenfell legal support, Grenfell United (GU), Justice 4 Grenfell, Humanity for Grenfell BMELAWYERS4GRENFELL, the Law Society, the Mayor's office, the Equality and Human Right Commission, public meetings with the Inquiry team and been in communication with the Office of the Prime Minister, Government and Shadow Cabinet.
- INQUEST drafted a detailed submission outlining matters it thought the inquiry should consider as part of a call for evidence on the terms of reference and published a short version of this on the website to assist others in making their submissions. INQUEST also attended and addressed a meeting of bereaved families about the work that INQUEST have been doing and the importance of Pen Portraits.
- INQUEST wrote to the Inquiry team about the necessity of beginning the Inquiry with Pen Portraits to help ensure effective participation.
- Meetings have been coordinated amongst the ILG, chaired by INQUEST director Deborah Coles.

- Worked on the parliamentary briefing with Grenfell United and attended the briefing event on 8th May 2018 – 80 MP's in attendance.
- Deborah Coles addressed the rally outside Parliament and then attended the parliamentary debate on 14th May 2018.
- INQUEST was present at every day of the pen portraits (21st May – 30th May 2018) to support those giving their commemorations.
- INQUEST staff attended the first anniversary memorial at the base of the tower in the morning and the silent walk in the evening.
- INQUEST wrote a letter to the Grenfell Tower Inquiry about ongoing concerns including with the venue, disclosure and the examination of witnesses on 22 August 2018. It was signed by Grenfell United, Justice4Grenfell, and Relative Justice Humanity for Grenfell.
- On 10th October 2018 INQUEST wrote a letter to the Prime Minister, about the importance of appointing an independent and diverse panel for the Grenfell Public Inquiry as soon as possible.
- INQUEST's Grenfell Project Coordinator spoke about Dignity and Defiance after Disasters for TEDx UCL Women, discussing why grieving and traumatised people should never have to fight for their right to truth and justice.

- The Grenfell Page on the INQUEST website is regularly updated.
- INQUEST attended phase one of the public inquiry at least once a week and kept a watching brief

Underpinning all of INQUEST's work is the commitment to supporting families. Integral to this work over the last two years was an on-going commitment to sharing information, resources and ideas with families so they could effectively engage with both INQUEST and the broader areas of campaigning, participation in events and parliamentary hearings, training, mutual support and active participation in the investigation and inquest process. INQUEST's response to and development of policy is also underpinned by family input. This work successfully encouraged families to become their own collective advocates for systemic change.

### SUPPORTING AND ENGAGING FAMILIES

- Inquest Handbook; a guide to the inquest process
- Skills and Support Toolkit; available in hard copy and on-line, available to all bereaved families
- INQUEST website
- Family Forum
- Family Listening Days
- Supporting families develop on-line support networks
- Family Reference Group
- Meetings with MPs and other influencers

# IMPACT

- INQUEST was able to appoint a **Grenfell Project Coordinator**, whose role includes keeping a watching brief on the public inquiry and other legal processes, community outreach work and ensuring the voice of the bereaved is heard.
- The INQUEST Director conducted significant related policy and media work.
- Survivors and bereaved families had improved understanding of investigative procedures e.g. applying for **Core Participation status** and obtaining legal representation from specialist ILG lawyers. By producing the accessible information and attending meetings, INQUEST ensured there was a greater opportunity for families to participate in the process of finding out what happened in the face of much grief, mistrust and a lack of confidence in the process..
- In February 2019 INQUEST held a family consultation day with families bereaved by deaths in Grenfell Tower to hear

about their experiences of the inquiry process to date and their recommendations for change.

**The Grenfell Action Group would like to thank INQUEST for their assistance to our community at a time of dire need. The experience and specialist knowledge provided by Inquest gave clear and vital information to a traumatised community that allowed residents and bereaved family members to make informed choices about accessing proper legal support.**

## FOCUS ON FAMILY SUPPORT

### INQUEST HANDBOOK

**The Inquest Handbook, available online and in hard copy, offers a comprehensive guide to the coroners' inquest system in England and Wales. It was revised in 2017 and is offered free to all families and friends affected by a sudden death involving an inquest. 2,140 handbooks were sent out over the last two years.**

**The Skills Toolkit**, produced with the help of families, is an on-line resource to help bereaved people develop the practical skills they might need while also coping with the aftermath of a death in state care.

INQUEST held **4 Family Forums**, involving nearly **200 family members** over the two years. Facilitated by caseworkers, these events enabled families to share experiences of their individual cases, seek and offer mutual support, share strategies for coping with the process, campaigning ideas and a social element; a chance to "catch up" with other families.

INQUEST further developed its **Family Listening Day model**; designed to enable families to "**speak truth to power**". These

facilitated events are commissioned by public bodies and reviews and allow those responsible for policy or practice implementation to hear directly from families affected by bereavement following state related deaths. We held 5 Family Listening Days over the period.

**The inquest handbook is used by our caseworkers who work with families who have been bereaved by murder and manslaughter. The inquest is a complicated process and this handbook provides our caseworkers with a valuable tool to try and guide and support the families through this process.**

(Victim Support Homicide Worker)

## FOCUS ON THE FAMILY VOICE

### FAMILY LISTENING DAYS 2016-2018

CQC Review of Investigations into Deaths in NHS Trusts – commissioned by the Care Quality Commission (October 2016)

Independent Police Complaints Commission (March 2017)

Bishop's Review of Hillsborough Families' Experience – commissioned by the Rt Rev. James Jones (April 2017)

Independent Review into Deaths and Serious Incidents in Police Custody – commissioned by Dame Elish Angiolini QC (May 2017)

London Clinical Network commissioned a FLD in order to hear from families regarding deaths in prison involving health care staff (July 2018)

The 'family voice' was central to the recommendations in the reports that followed these events including calls for;

- non-means tested public funding for legal representation
- parity of resources and funding
- specialist information and support for bereaved people
- strengthening systems and structures of accountability,
- national oversight and learning from deaths,
- tackling discrimination, through recognition of the disproportionate number of deaths of BAME people
- better treatment of vulnerable people, especially for those in urgent physical or mental health need
- timely, family centred, independent and rigorous investigations
- greater family involvement with relatives held in both custodial and health settings
- Charter for bereaved people.

The **redesigned website**, launched in November 2017, provided improved access and space dedicated to family input. The new family blog section has already seen more families sharing their thoughts and experiences than ever before.

As a result of INQUEST's support, families were enabled to become active citizens and advocates for change. Over the last two years families gave **evidence to Select Committees**, attended **parliamentary hearings**, visited the **House of Commons** to witness the reading of Bills, met with **MPs and policy makers**, convened and attended **campaign meetings**, participated in **Family Listening Days**, wrote for the web-site, supported other families, participated in the **Family Reference Group** and contributed to INQUEST meetings and events.

INQUEST is always seeking to further improve the ways it engages with families; recognising their need for accessible, convenient and flexible

platforms to ensure they remain a strong part of the organisation's campaigning and work for meaningful change and reform.

### STRENGTHENING THE FAMILY VOICE, BUILDING FOR THE FUTURE

Through the evaluation of INQUEST's work and consultation with the bereaved families it supports, the organisation identified a need for a brand new role dedicated to engaging even more effectively with families. In December 2017, INQUEST appointed a new Family Participation Officer. The new role will develop and strengthen the work with families, building capacity and support through the inquest process. It will support and develop INQUEST's work providing families with platforms to raise issues and draw public focus to family experiences and concerns and to strengthen the support and guidance for families. Practical developments, following family suggestions at the Family Forum, has seen two meetings in 2018 of the **revitalised Family Reference Group**

## FOCUS ON

# THE FAMILY VOICE

– working with families to identify new opportunities for engagement and ways to support INQUEST’s work including, new systems of **mutual support** e.g. **on-line support forums** a new **“buddy-up system”** which will include training for families, **a photography project**, **#SoulsINQUEST**, and opportunities for families to support INQUEST fundraising initiatives.

**INQUEST creates a community and then new little communities develop as people find out they have things in common and make friends.**  
(Family Member)

## IMPACT

Improving engagement opportunities had a significant impact on the work of the organisation and the experience of families. These include:

- Greater access to information and legal knowledge ensuring more active and informed decision making during the investigation and inquest process
- Improved opportunities to engage with the process of reform, based on collective experience and resolve
- More accessible ways of sharing legal and emotional support
- New opportunities and ways of developing skills training for families
- Enhanced and developed family input and involvement into INQUEST’s work and strategic planning.

## ACCESS TO JUSTICE

INQUEST has maintained a long-standing belief that for human rights to be enforceable, they must be accessible and not least in cases involving the state. Key to this is the recognition that without parity of funding for bereaved people, ensuring legal expertise and representation at inquests, there is an uneven playing field in the process of investigating contentious deaths. The last two years have seen unprecedented public and parliamentary scrutiny of the ‘inequality of arms’ that characterise many inquests. Central to that scrutiny has been INQUEST’s work in bringing the issue to the attention of parliamentarians, the media, those conducting reviews and encouraging families to share their experiences.

- With the Secretary of State for Justice outlining the inherent inequality in the legal aid funding system.
- Continued to lobby and brief parliamentarians and relevant government departments.
- Used its place on the Ministerial Board to keep funding for inquests on the political agenda.
- Facilitated a meeting of the ILG with the Legal Aid Agency (LAA).

- Caseworkers have written to the LAA in support of individual families’ funding applications.
- Briefed the media on the ongoing unfairness of the current funding arrangements.
- Encouraged families to speak at Family Listening Days, providing unique insight into the financial challenges they have faced.
- In March 2018 Connor Sparrowhawk’s family and the family of Joseph Phoung (a 32-year-old man who died following contact with the police and mental health services in West London), lawyers and INQUEST gave evidence to the Joint Committee on Human Rights Inquiry into Enforcing Human Rights and made written submissions in support of reform.
- Alongside the ILG, INQUEST submitted detailed evidence to the Ministry of Justice review of legal aid for inquests and held meetings with their new team.

These are significant steps in delivering a long held organisational strategic priority and INQUEST will continue its work to broaden access to justice for bereaved people.

## FOCUS ON MEDIA

Information sharing plays a huge part in the success of INQUEST and the organisation punches well above its weight. Between the summers of 2016 and 2018, it shared information and analysis with various audiences, from lawyers, parliamentarians and policy makers to families, the media and other voluntary sector organisations. Its reach is extensive for a small organisation.

### COMMUNICATIONS AND INFORMATION SHARING

- Website
- Press releases
- E-newsletter
- Parliamentary Briefings
- TV and radio contributions
- Newspapers and 'non traditional' print journalism
- Social media; Facebook, Twitter and YouTube
- INQUEST Law
- Conferences, seminars and events

### INFORMATION SHARING IN NUMBERS

- Produced over **200** press releases.
- Secured over **200** mentions and quotes in national news outlets including the Guardian, the Independent, The Times, The Daily Mail, The Observer, the Telegraph, the Voice, Private Eye as well as significant reporting in local newspapers.
- Regular broadcast media appearances by INQUEST staff, director Deborah Coles and families on national and local **BBC news programmes, Channel 4 News, Sky News, ITV, Channel 5**, and others.
- Expert commentator for special radio broadcasts including **BBC Radio 4, BBC 5 Live** and many **BBC local and commercial stations**.
- Increased profile with 'non-traditional' news outlets including articles for **Buzz Feed, Vice magazine and the Huffington Post**.
- **28% increase** in Twitter followers (currently **8,756, up** from the **6,101** in 2016), and over **314K** Tweet impressions, an eight fold increase since 2016.

- Facebook likes rose by **58%** over the two years
- The web-site was viewed on average **6,500 times** a month, the bulk of which were from the UK but also accessed in 58 countries, including the USA, Australia, Ireland and India.
- **Published 11 editions** of its e-newsletter (available to supporters, families and subscribers) and provided information on individual cases, campaigns, parliamentary and policy work and organisational news.

INQUEST's work with families can extend over many years, with some of the longest running and highest profile cases receiving considerable media interest, giving INQUEST a platform from which to raise awareness of the broader issues running throughout its casework.

Media publicity drives an increase in self-referrals to INQUEST when isolated families realise they are not alone in their experiences and there is somewhere to go for help. INQUEST works with the media and families to represent the voices of all those bereaved and ensuring these are not reported as 'one-off' deaths but seen as part of a broader, systemic problem.

Journalists use INQUEST's expertise and statistics to help them track patterns and trends and place deaths in their broader social and political context.

Social media has helped isolated families to connect as a community, offering mutual support and help whilst at the same time raising the profile of individual family campaigns. Family support groups have transformed the way INQUEST engages with support networks and directly informed the decision to appoint a Family Participation Officer.

INQUEST's statistical analysis and evidence gathering provides unique oversight of the investigative and inquest process and improved communication strategies have broadened its influence nationally and internationally.

INQUEST is also looking to develop new ways of communicating information, creating accessible resources to as broad an audience as possible and from using new crowdfunding opportunities to innovative legal developments.

## IMPACT OF INQUEST'S POLICY WORK ON SPECIALIST MEDIA COVERAGE

### Alongside the terms of reference produced by INQUEST for the Grenfell Inquiry, INQUEST utilised the media to put the recommendations onto the political agenda.

In December 2017 the Guardian ran an article; '*Grenfell victims' families* 'should be placed at heart of inquiry'. This article gave a platform to many of INQUEST's recommendations in the terms of reference and in particular INQUEST's recommendation to include 'pen portraits' of all those who died to broaden public confidence in the investigation, and for more advisory panel member to reflect the diverse, cultural and religious makeup of the community.

Different journalists across the departments at the Guardian recognised INQUEST as providing expertise around key areas of the Grenfell Inquiry, and Deborah Coles was invited on to the 'Guardian UK: Politics Weekly' podcast in the week before the inquiry began taking evidence (16 May 2018). Other media coverage, including comments from Deborah, on the

success of the pen portraits helped acknowledge the importance of humanising the inquiry process. These included:

### Intimate, harrowing Grenfell testimonies make victims real, not just a number

(Guardian, 25 May 2018)

*"The bereaved, the lawyers and Inquest, the charity representing the families, had to fight for the right to humanise the victims, just as they did at the Hillsborough inquest in 2014. If they had not done so, the inquiry would have dispensed with the dead, and lurched straight into the technicalities of refurbishment and combustible cladding."*

### I feared the Grenfell tributes would be mawkish. I was wrong

(Guardian, 26 May 2018)

After the success of the pen portraits, Guardian articles centred around INQUEST's comments 'All inquiries should use Grenfell's tributes model, charity says' (30 May 2018) and in a Guardian editorial from 31st May 2018 'The Guardian view on the

Grenfell inquiry: cultural change and procedural model' recognised INQUEST's influence:

*"Inquest's calls for pen portraits of the individuals who lost their lives to be at the centre of the process and for descriptions of the gaps they have left behind in the lives of families and friends to be heard at the outset have been well heeded."*

INQUEST also supported and contributed to diverse media events: a Q and A session at the screening of George Ampomah's documentary film '*The Hard Stop*', which followed two friends of Mark Duggan following his shooting. In August 2017 INQUEST staff attended the **Edinburgh Festival** where a number of comedians, including Mark Thomas, Sarah Pascoe, Stephen K Amos and Shazia Mirza performed to a sold out crowd to raise funds for INQUEST and the North Kensington Law Centre to aid their work with the families affected by the fire at Grenfell Tower. Deborah Coles spoke at the event.

At the end of 2017, Sara Ryan launched her book '*Justice for Laughing Boy: Connor Sparrowhawk - A Death by Indifference*'. Deborah Coles spoke at the London book launch at Doughty Street Chambers alongside Caoilfhionn Gallagher QC, who represented the family, and Baroness Helena Kennedy QC, who commended INQUEST's work.

## FOCUS ON

# FOCUS ON INTERNATIONAL WORK

### INTERNATIONAL WORK

INQUEST is regularly contacted by international human rights organisations, NGOs and others, seeking advice about best practice in working with bereaved people after a state related death, and securing an effective investigation.

In November 2017 Deborah Coles spoke at a UN meeting as part of the International Decade for People of African Descent. She told the delegates from Europe, Central Asia and North America about the over-representation of black people in the UK criminal justice system, and the disproportionate number of restraint related deaths. She also spoke at a conference in Brazil on state accountability following police related deaths about best practice in working with bereaved people and investigation. Deborah was then asked back to Brazil in November 2018 to address the Women of the World Festival (Festival Mulheres do Mundo) in Rio de Janeiro, the first time it has been held in Latin America. She spoke on two panels specifically focusing on the incarceration of women in the UK and Brazil and the social and political context of racism,

sexism, poverty and inequality. She then met with a community organisation, the Redes da Maré, in the Maré favela and spoke with the mothers of those who died as a result of state violence. This included the mother of Marielle Franco, who was a Brazilian politician, feminist, and human rights activist who was assassinated earlier in the year. Whilst in Brazil Deborah also presented a paper via video link opening the University of Sydney Critical Death Investigation Lab conference in Australia.

In May 2018, Deborah joined experts from across the world on the Greek island of Lesbos to develop a protocol outlining the rights of and duties toward all those who experience suffering as a result of the disappearance or death of a loved one as a result of a migrant journey. She was one of the co-signatories of 'The Mytilini Declaration for the Dignified Treatment of all Missing and Deceased Persons and their Families as a consequence of Migrant Journeys'. The Last Rights Project aims to ensure the standards within the Declaration are adopted as a matter of urgency.

The last two years also saw Deborah Coles visit in Scotland, working alongside both the family and lawyer in the case of 31 year old Sheku Bayoh who died after being restrained by five police officers on 3 May 2015, in Kirkcaldy, Scotland. She also assisted the family of 21 year old Katie Allan, who died in Polmont Youth Offender Institution, sharing our expertise on deaths of women in prison. In November 2018, she met with the Scottish Government's review team and panel of experts conducting a review of the investigation of

deaths in mental health settings to share INQUEST's expertise. She also met NGOs working on issues related to prisons and policing. She was also interviewed for a BBC Scotland documentary on Sheku Bayoh's death that aired in December 2018.



Hands Up for INQUEST 2018, Notting Hill, with guest of honour, Patrisse Cullors, Co-Founder of Black Lives Matter.

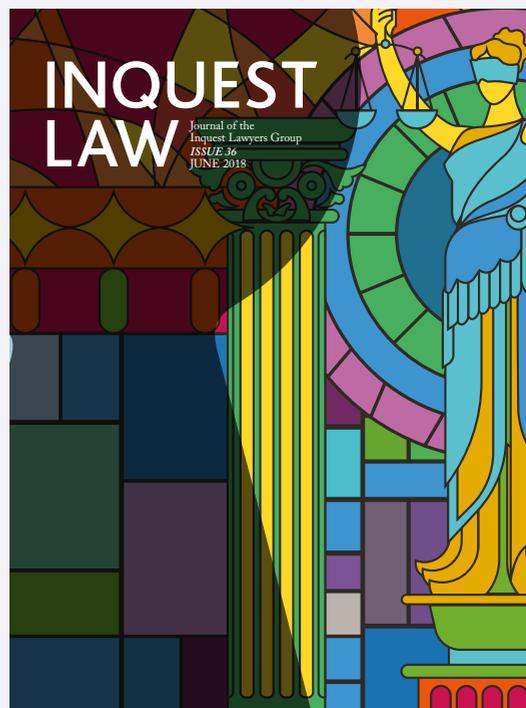
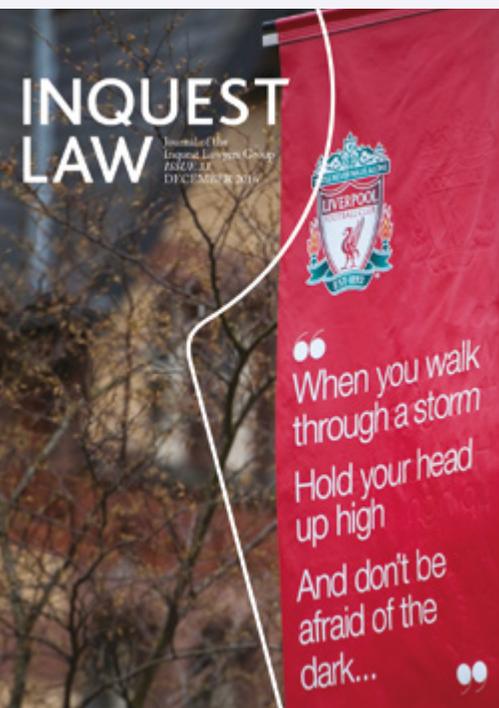
Photo: Sarah Booker

## FOCUS ON

# INQUEST LIBRARY ONLINE (ILO)

INQUEST has devised a unique, searchable database with a focus on collating inquest outcomes, coroner recommendations and jury findings for INQUEST lawyers (in the first instance) to access and further help their clients, by drawing on broader issues that could be relevant to the individual inquest. Designed to respond to searches such as case

type (women, mental health etc.) or institution, this innovative platform will include regular case law updates, a searchable database of relevant articles and case studies, statistical information, and opportunities for lawyers to start discussion threads online. The work on this project took place during 2017 and the resource went live in March 2019.



## FOCUS ON

# INQUEST LAWYERS GROUP

**Representing families, influencing the law and practice**

## CONTEXT

The INQUEST Lawyers Group (ILG), made up of **314 solicitors and barristers**, is a national network of lawyers providing specialist representation to bereaved people.

The ILG promotes and develops knowledge and expertise in the law and practice of inquests by acting as a forum for the exchange of ideas and delivery of training.

## INQUEST LAWYERS GROUP SUPPORT

**Campaigns for coronial reform** - Lawyers met with Bishop Jones and Dame Angiolini and shared powerful accounts of the obstacles faced by their clients when negotiating the inquest system.

**Strategic policy work** – INQUEST coordinated meetings for members to meet with the IPCC, the new CEO of the IOPC, the PPO, Chief Coroners, including the new Chief Coroner HH Judge Mark Lucraft, and with the Legal Aid Agency to discuss families' needs regarding funding for inquests.

**Legal advice and support** – ILG members offer specialist legal representation to families during investigations and inquests and work alongside INQUEST on legal interventions and evidence based submissions. ILG members assisted INQUEST's intervention in the Judicial Review of the high rates of self-inflicted deaths in HMP Woodhill, and helped in the immediate aftermath of Grenfell with legal representation for families, helped frame the Terms of Reference for the Inquiry and met with the community to support their legal needs.

- Sharing skills and expertise - INQUEST Law is a magazine written by ILG members and invited contributors. It informs practitioners about legal developments relating to the inquest system and the investigation of sudden deaths, with extensive case notes written by the leading lawyers in the field.
- Members also delivered training in Manchester and London on topics such as Legal Aid Funding and the lessons from Hillsborough.
- The ILG helps support a pool of specialist lawyers who understand traumatic bereavement and the complexities of the investigative and inquest process.

