

INQUEST

Truth Justice Accountability

Family Listening Day

Families' experiences of the coronial process following deaths in police custody or prison

September 2023



Unlocking
the truth for
40 years

INTRODUCTION

INQUEST was commissioned to hold a Family Listening Day (FLD)¹ as part of a wider study of bereaved peoples' experiences of inquests, being conducted by Birkbeck's Institute for Crime & Justice Policy Research (ICPR)² in partnership with the Centre for Death and Society at the University of Bath.³ The wider study, *Voicing Loss*, involves interviews with individuals who have personal or professional experience of the coronial process.⁴ The focus of the FLD was to hear from families who had experienced the inquest system and Coroner's Service following a death that occurred in state care: police custody or prison.

INQUEST's FLD model involves a facilitated conversation around a pre-agreed theme in a safe, empathetic environment and this was the 12th such commissioned event. The FLD took place on Wednesday 23 of November 2022 at the National Council for Voluntary Organisations' offices in London. Seven family

members attended, outlining their experience of seven different deaths and the subsequent coronial process. This report was written by Chris Tully, an independent consultant, who assisted INQUEST in developing the FLD model.

Families discussed the themes arising from the deaths of their loved one in police custody or prison. There was a consensus on key issues and these are outlined in this report. Families described delays and inconsistent relationships with the Coroner's Service, coroners and the investigatory bodies. The FLD highlighted predominantly negative experiences but there were examples of good practice too including empathetic coroners, supportive Coroner's Service staff and the vital role played by INQUEST caseworkers and specialist, experienced inquest lawyers. Important contributions were made on the significance of context; whereby a death in state care has the potential to influence subsequent events and experiences. Families also wanted to discuss the paucity of information and lack of independent advice, the need for support to engage effectively with the process, and the vital role legal representation plays in securing successful

¹ <https://www.icpr.org.uk/>

² <https://www.bath.ac.uk/research-centres/centre-for-death-society/>

³ <https://www.inquest.org.uk/family-listening-days>

⁴ <https://www.icpr.org.uk/voicing-loss>

outcomes. Families also considered the nature of the inquest itself, including the role of coroners, state lawyers and the importance of juries. Finally, the FLD considered what changes could be made to encourage greater family engagement in a process that requires more empathy, consistency and a greater emphasis on placing families at its heart, rather than as bystanders with limited faith in its potential to prevent future deaths.

CHAPTER ONE

INITIAL ENGAGEMENT

The families present had all experienced a sudden bereavement where the death took place in institutions where the state had a duty of care. As such the conversation inevitably began with families' experiences of the notification of death. For many, this initial contact set the tone for much of what followed: the information offered by the Coroner's Service and coroners, the information and advice made available to them and the lack of consistency in how families were supported in the days, weeks and months following their bereavement.

1.1 Notification of death

For some, the notification of death and information regarding the need for an inquest was an impersonal and unsympathetic experience. This had a negative impact on families' experiences and the grieving process. How families were notified lacked consistency - a visit from the police, a phone call or in one case, by letter. There were some common features: the absence of details as to how

their loved one had died, little or no advice on how to engage with the Coroner's Service or specific details on practical matters such as viewing the body, post mortem arrangements or who to turn to for emotional support. Families were not told about INQUEST.

Some families received a visit from the police, and in worst case examples, this proved extremely traumatic,

"When the police came to tell me my son died, I was in the bath, I thought it was about something else. He just said your son has died in prison. I asked how he died, and he said, 'drug overdose' [the cause of death had not been determined at this point]. Everybody was shouting. My children were in shock. The officer just took out his baton and handcuffs and started telling people to calm down – so I snapped out of it as I could see what could happen and they left."

For others, the timing of the notification meant that they were left in limbo and unable to glean information or an explanation as to what had happened,

"In the beginning it was really difficult. We were told in the evening, he died on 2 January, which was difficult, people were on holiday. The prison told us that

the body was going to the mortuary, we tried to contact them the next day because I wanted to see my brother's body but nobody answered. INQUEST helped and put me in touch with a lawyer."

The participant received this information after she had been ringing the prison regularly because she was so concerned about her brother's wellbeing.

Another participant was present when her son's life support was switched off, following restraint by 11 police officers, in a hospital. She had no idea what was going to happen next and only by chance met someone with experience of the process who pointed her in the direction of INQUEST.

All those present were keen to outline how these initial notifications were traumatic and lacked empathy and concrete information on next steps.

1.2 First contact with the Coroner's Service

Participants had no prior understanding as to what the role or purpose of the Coroner's Service was and felt that information about this needed be clear, concise, accessible and independent. Participants raised concerns that no one was specifically tasked with outlining what the Coroner's Service does, with explaining how families could interact with it, or indeed with clarifying its key functions and in whose interests it operates.

Families also described the lack of practical information regarding the coronial process: i.e. in relation to viewing the body, post mortems, time scales and crucially, legal representation.

Families said this meant they already felt "separate" from the process as soon as it

began and were essentially forced onto the "backfoot" regarding meaningful participation.

1.2.1 Information and advice

Families described inconsistent experiences regarding the advice and information they received. Some were offered limited information whereas others felt overwhelmed. Where information was made available, families highlighted the difficulty with interpreting what information was relevant to their needs, especially when they were in shock,

"We got this handbook and had to go through it. No one told us about the fact that we will get an inquest."

Others reported that they were handed a leaflet but were unsure who it was produced by. They noted that in the hours and days following a bereavement, weighed down by grief and confusion, it was another bit of information without context or meaning, allied to limited opportunities to meet with Coroner's Service staff to explain the process more fully,

"I was given a booklet but didn't know who it was from, didn't want to read it at the time."

One person described how,

"We got a leaflet through the door saying there would be an inquest, you're thrown into a new world all of a sudden."

In another case a participant felt that balancing the amount of information for families following a death was important, especially when families are vulnerable,

"The package sent to you is way too much, the folder was overwhelming."

However, the majority of participants felt the paucity of information had a negative impact on their initial experience of the inquest process.

One person believed,

“Unless you’re a celebrity you don’t get anything.”

Someone else suggested that families are,

“Put on the shelf, nobody cares.”

One participant described their first contact with the Coroner’s Service as deeply frustrating because,

“The coroner’s officer gave the impression of being overworked and underpaid.”

They also expressed anger that after requesting a temporary death certificate, there were mistakes in the document,

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THEY DIDN’T HAVE THE RESOURCES TO DO IT CORRECTLY, IT’S A JOKE.

No apology was made for the mistakes. Others suggested that the Coroner’s Service failed to acknowledge diversity in their dealings with families,

“Coroners don’t respect people’s religion. In Islam you must be buried in 24 hours. They were not respectful. A comment was made by the prison staff that my brother had converted to Islam, but he was born a Muslim, just because he is white does not

mean he was not a Muslim.”

Independent advice and information is vital for grieving families because they are trying their best to do the right thing for their relative,

“For [them] it’s a process, but for us it’s our loved one.”

Families described operating in “a void”, and feeling “anxious” and “frightened” by the sheer magnitude of what they were facing. For some these feelings were exacerbated by having to act as the single point of contact between the Coroner’s Service and extended family. This placed a burden of responsibility on them that proved stressful and complicated,

“It was my sister that they told [about my brother’s death] and she had to tell the rest of the family. It made her ill.”

Others agreed,

“The coroner would only speak to one of us, telling me and then I had to relay to all the others.”

Another participant pointed out that this had an impact on the rest of the process,

“The inquest just focuses on one family member so brothers and cousins for example do not have a space to reflect.”

The group’s initial experiences of the Coroner’s Service gave the impression that it lacked independence. Asked if they felt the Coroner’s Service fulfilled the role of being independent and impartial, families felt it did not. Some suggested that there should be an independent body tasked with working with families. In the absence of information, they said that they were existing in a state of uncertainty, leaving them “going over [the death] again and again.”

None of the families were given INQUEST’s

details. This meant that all but one, who already knew of the organisation, relied on luck, personal research, or word of mouth before accessing the organisation's services. Having no specialist advice to hand proved disadvantageous,

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WE DIDN'T GET
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As will become clear later in this report, participants believed that INQUEST's specialist casework team and family support model had a significantly positive impact on both their wellbeing and their capacity to engage with the Coroner's Service and investigators. Access to information and independent advice was crucial to effective participation in the investigation and inquest process.

1.3 Trust

In the absence of independent advice and following negative experiences of initial contact, families found it difficult to establish trust, both with individuals and the process more broadly. There was an added layer of complexity and stress with regards to

how investigations were carried out by the Independent Office for Police Conduct (IOPC) or the Prisons and Probation Ombudsman (PPO).

No one was given information on how these other investigations impacted the coronial process. Some participants felt that information was being intentionally withheld or things were happening behind “closed doors” that were “secret” and explained away because of potential criminal proceedings. As a result, one of the key themes explored by the group was trust,

“Knowing who to trust is one of the biggest things.”

The context of these deaths, behind closed doors, amplified the families' concerns around trust. Some families were inevitably suspicious because the advice offered often came either from employees of the institutions involved in the death or from those tasked with investigating it. Underpinning this was a sense that time spent with families had as much to do with information gathering as information sharing.

Relationships with police Family Liaison Officers (FLO) were complicated,

“We thought the police constable was being helpful but realised [he] was just trying to find out what you know.”

Families suspected that the closeness of these relationships blurred impartiality, and their self-serving nature possibly contributed to delays,

“There needs to be a disconnect with police and coroner. More speedy process, six or seven years, it is unacceptable.”

“Police should not have any involvement with things.”

Another participant highlighted a potential conflict of interest inherent in investigations into police conduct,

“IOPC is all ex-police officers so how can they be unbiased?”

CHAPTER TWO

LEGAL REPRESENTATION

Legal representation was identified as being hugely important to meaningful participation and it was not until families had secured specialist legal advice that they felt better able to engage effectively with the investigation and inquest process. This was in part due to the realisation that the process is more complicated than they had initially been told, that the state institutions involved were all legally represented and that the amount of complex information and paperwork provided required an experienced, professional eye to explain technical legalese. This was especially true for families who experienced long, drawn-out investigations.

Many families said that INQUEST's support in helping them secure specialist lawyers was valuable. There was unanimous concern about the obstacles to accessing Legal Aid which, at the time these deaths occurred, involved a complicated and intrusive means tested application that resulted in two of the participating families being left unrepresented.

2.1 Importance of legal representation

All too often families were not made aware of the significance of legal representation; in some cases, they were told it was either unnecessary, or “*up to you.*” In hindsight, having experienced how adversarial the inquest process is, families wanted the Coroner's Service, the IOPC and/or the PPO to acknowledge the need for legal representation.

Families who contacted INQUEST were given independent advice and their cases were referred to specialist lawyers, members of the INQUEST Lawyers Group (ILG), with experience of cases involving state related deaths. Securing funding and an experienced legal representative led to more effective participation and greater clarity around what to expect from the investigation and inquest process. In part, this also acted as a counterbalance to the publicly funded legal resources enjoyed by the police, prisons and NHS trusts.

Families acknowledged the importance of INQUEST's expert caseworkers and their role in ensuring representation,

“If it wasn’t for INQUEST and legal representation, we would be nothing.”

Another participant agreed,

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I JUST WANT TO SAY THE IMPORTANCE OF A GOOD LEGAL TEAM. FANTASTIC CASEWORKERS FROM INQUEST. THEY WERE SPOT ON.

Families spoke of how their lawyers supported them with complex legal documents and jargon, secured disclosure of documents in advance of the inquest and supported families with the investigations. However, even with this support, the process still proved incredibly difficult and traumatic,

“We were lucky to have a good legal team, but the coroner’s office was not really helpful. Having to navigate all these investigations whilst coming to terms with your grief was very overwhelming.”

Another person agreed; her lawyers found dealing with the Coroner’s Service problematic and her *“solicitor had to fight for disclosure”* and then *“worked night and day”* on the case.

One participant, legally unrepresented, described how she was informed of her relative’s post mortem after it had happened. By contrast, another participant was made aware of the importance of representation

before the autopsy. She was contacted by the coroner’s officer and informed that the autopsy was happening that day. On legal advice, she was able to postpone it until the family were represented.

One person felt that the legal delays and complexities could be avoided, but in fact the legal arguments proved useful for state authorities as they prepared to defend the actions of the police and prisons, a view shared by many in the group,

“You never understand the full legal thing, legal jargon. They use the law to get away with things.”

The same person believed that she was only kept informed of developments because of her lawyer and up until that point,

“We felt like shadows throughout the whole process.”

Families who secured legal representation felt more able to decipher the information they were given and felt supported in questioning decisions made by the Coroner’s Service and investigation bodies which otherwise would have gone unchallenged. This was in the families’ interests and helped re-balance what felt to many like unequal interactions.

The group’s evidence confirms that the lack of automatic access to legal representation is disingenuous at best and malign at worst. The investigation and inquest system is too complex, too demanding and families’ rights are too often glossed over without specialist legal scrutiny and support.

2.2 Legal Aid

Families outlined the difficulties they encountered in funding their legal

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**IT'S INTRUSIVE, I FIND IT MEAN,
YOU FEEL DOUBLY VICTIMISED. WE
HAD NO AUTOMATIC FUNDING AND
YET THE POLICE AND HOSPITAL GET
AUTOMATIC FUNDING, OUR MONEY!**

representation. The cases that were discussed all took place at a time when applying for means tested Legal Aid was complicated, intrusive and had no guarantee of success.⁵

Families described their surprise and shock on finding out the inquest system does not automatically trigger Legal Aid where a death has occurred in the care of the state,

“I was flabbergasted there wasn't automatic legal funding.”

The experience felt to many like a further example of families being treated with little compassion or understanding when facing a process that already felt imbalanced and obstructive,

“It's intrusive, I find it mean, you feel doubly victimised. We had no automatic funding and yet the police and hospital get automatic funding, our money! I don't get it; it was just beyond comprehension.”

At a time when families were fighting for justice and accountability, securing legal aid was another strain on their emotional wellbeing,

“It's just another fight, you don't need it! Why do they do this to the families?”

The application process was described as both intrusive and humiliating,

“We gave all our bank statements in, all our savings. I must have given my son £20 and they wanted to know how I got that money. I had to send my tax returns. They make you feel like you've done something wrong, why am I having to dig so deep?”

In this example the family got £6,000 but had to contribute a further £3,000 themselves. Her other son came out of prison and that helped them to get Legal Aid but he was unable to work as that would have negatively impacted on their application. This meant the family had to support him financially in order to pursue justice. This chimed with another participant who was also bewildered and frustrated by the application process, deeming it punitive,

“I got Legal Aid. I did not know how it all worked. I was given all these forms to fill in. I'd worked really hard to get to where I am in my career, but now this was being used against me. We put the Legal Aid in my parent's name, mum is disabled, and dad is a pensioner, and had to go through all their financial statements. In the meantime, you're going through all the other stuff, 'his sudden death.' All I know is

⁵ In December 2021, the Government announced the removal of the means test for Article 2 inquests (Exceptional Case Funding). This means for many families, where their case meets the criteria for an Article 2 inquest, they can now access Legal Aid. However, for families where it is less clear or the case does not meet the criteria for an Article 2 inquest, access to Legal Aid remains an issue. All the families who took part in this research had inquests prior to this change.

that I became very, very unwell, it was all too much.”

She went on to highlight the inequality of legal representation at inquests. Families are placed in the unenviable position of having to fight for representation, whereas the state is granted support and aid uncontested,

“I had to push on to get things in motion. Everyone who contributed to his death, his disability, multiple failures, they all had such great support. It was hard reading that in the disclosure about all the support they received, but who supported me, who supported my parents?”

Two of the participants present had unique insight into the impact of legal representation. They were twice refused Legal Aid in two separate cases (the inquest of a brother, and for the inquest of the father of a friend). Representing themselves meant they took on the investigations and the inquests without lawyers; interpreting legal documents, witness statements, evidence including CCTV footage, dealing with the Coroner’s Service and the process of questioning state lawyers at the inquest. The family were reliant on the expertise and support of INQUEST caseworkers and their own dogged determination to try and achieve positive outcomes for their loved ones. As one of them noted, *“it ripped my insides out”* with the responsibility and worry of it all.

They experienced first-hand the inconsistent nature of the process; in one case, a good coroner and coroner’s officer helped with information, disclosed information promptly and could be contacted anytime. The second case involved a coroner’s officer who *“wasn’t helpful at all, she was a nightmare.”* Without a lawyer,

“Google becomes your best friend.”

The experience was frightening, draining and one can only wonder how families, denied Legal Aid and without the necessary resilience and support and commitment to justice, could engage without legal representation. As one person said of their experience,

“How you could do it without Legal Aid, I just don’t know.”

CHAPTER THREE

PRE-INQUEST

The pre-inquest experience, between notification of death and the inquest, was very difficult for the group. For many, there were long delays which in some cases lasted years. This was described as incredibly frustrating and exhausting and meant that their lives were put on hold. Some made reference to the inability to start the grieving process, and others described their distress at having no set time scale which would have allowed them to focus on the inquest rather than operating in a constant state of flux.

Various reasons for delays were discussed; the failings in securing advance disclosure, cancelled Pre-Inquest Reviews (PIRs), or even failures to be notified of PIRs, changes of coroner, unexplained adjournments and lengthy investigations all holding the process up. What was evident was that the length of time for families to get to the inquest was unacceptable. The delays made it appear that the process was less to do with justice, accountability and preventing future deaths than with protecting the institutions supposedly under scrutiny. What also became clear was that the longer the delay, the harder

it was for families to grieve or to process their bereavement. Ongoing delays meant there was no opportunity to stop or take stock as families had to wait for answers to questions around how their loved one died and whether anything could have been done to prevent it.

3.1 Problems with delays and disclosure

Families talked about the length of time before the inquests could start, the “*sensitivity*” around information sharing and the vital role of specialist advice and legal representation in dealing with delays and disclosure. Many families had experienced long delays: for example with accessing independent advice, obtaining disclosure, accessing evidence such as body worn video or CCTV footage, adjourned PIRs, overlapping investigations, coroners retiring, or legal challenges. Families endured these delays right up to the evening of the inquest. The delays proved doubly frustrating because there was no specific explanation from official sources as to why they were happening. It must be stated again that families that contacted INQUEST, or had the good fortune to be forewarned by other families that had been through the process before, were better prepared. However, this

did not detract from the fact that delays were intolerable, that delays could be avoided, and that families deserved realistic timescales for the process,

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**YOU DO IT THINKING
THE INQUEST WILL BE
AROUND THE CORNER.
IT TOOK SEVEN YEARS
FOR US TO GET TO THE
INQUEST.**

Another added,

“No one tells you how long things will take.”

This was common and since families were preparing for the inquest without knowing when it would happen, they had to put their lives on hold,

“For the first 12 months I didn’t leave the house expecting [contact about] the inquest.

It wasn’t until we got in touch with INQUEST and UFFC⁶ that we had any idea of time. I didn’t even have a holiday, for a breather, the whole time.”

One participant described the lengths she went to in order to speed up the process,

“They were treating me like I was some crazy person. In the end my lawyer came on board and I decided to go public and

went to press. My MP mentioned [her brother’s] name in parliament. That’s when things started happening. I don’t understand why I was put in that position days after my brother’s death.”

What families found frustrating was the recognition that efficient coroners’ officers could reduce the waiting time. The family that was involved in two inquests and represented themselves provided examples.

“We first met the coroner’s officer five months after [the death]. The inquest was adjourned because we got [the information] late.

In the end the coroner’s officer hand delivered boxes of paperwork which they had been ‘holding onto for 18 months.’”

They went onto say that,

“Once I had all the paperwork no-one helps you prepare, no-one helps with the questions for court.”

They added that this was when you needed someone to,

“Put an arm around your shoulder.”

Those families with experience of a coroner changing mid-way through the process, e.g. due to retirement, commented on the toll of having to restart the process from the beginning. Having to tell their stories again proved upsetting and challenging.

Other participants wanted to emphasise how delays impacted their grief,

“The length of time between the death and the inquest affected the grieving process, [you’re] stuck, waiting on edge.”

⁶ United Families & Friends Campaign <https://uffcampaign.org/>

Others agreed,

“[You] just can’t grieve.”

Participants discussed the strain this placed on other members of the family. One person described how his sister became unwell with stress. Another described how the failure to get timely advanced disclosure, which resulted in delays to the final inquest hearing, placed a great strain on her and her elderly parents. She had been concerned that her father might not live to attend the inquest or hear the outcome,

“Disclosure is the biggest problem in terms of getting to the inquest. The coroner needs to be pushing. It causes delays and a lot of problems, I always thought will my dad be alive for the inquest?”

Delays were painful for families and placed a huge burden on siblings and other family members, and created a sense of powerlessness,

“You have no say or power of it. My son died in March, by September my other son had a heart attack through grief, the other left university, (he was studying medicine) through grief. You’re pushed out of it. It’s [the inquest system] not for the family.”

“It’s a totally inhumane process. You are containing your grief the whole time. It is such a long-drawn-out process.”

There was a clear message from the participants that the process does not consider the surviving family members - it fails to recognise the emotional and physical impact on a group of people who are already traumatised by grief, and it contributes to a lingering sense of scepticism and mistrust.

3.2 Pre-Inquest Reviews

Pre-Inquest Reviews (PIRs) are often portrayed as simple administrative processes held in advance of the inquest starting - to determine which witnesses will be called, what evidence can be admitted, whether a jury is required, when and where the final inquest will take place and whether other hearings or reports, e.g. investigation findings, need to be considered. However, families often experienced something different and provided examples of PIRs becoming complex legal hearings with legal arguments that they didn’t understand. Others described PIRs being delayed, being informed at the last minute that a hearing would be happening or not being informed or invited at all.

There appears to be no single approach for involving families in PIRs and, similar to other aspects of the process, they are often subject to delay. Where this was caused by retirement or a change of coroner, families were required to start their preparation for the inquest all over again. This, in turn, compounded families’ grief.

We heard examples where family participation in the PIR proved to be problematic. In one example the invitation to attend was sent to the wrong address so the family never received it. There were other examples where the families were entirely excluded,

“I did not feel involved with the Coroner’s Service at all, everything went through my solicitor. Her [daughter’s] partner was the next of kin, so all information went to her. The first coroner retired and I became next of kin after four years. For the PIRs etc I was never invited. I did not feel involved at all until the inquest started.”

Where families did attend, they were often given no information as to the purpose of the PIR and felt ill-prepared for what followed. One family had “two or three PIRs” and in one of them,

“The coroner almost told off our solicitor.”

They felt the coroner did not like their solicitor and they were worried about how that was going to impact their case. They became so concerned with the coroner’s behaviour that they considered a Judicial Review in order to force a change of coroner. They were assigned a different coroner in the end, but this added to the delay and they were angered by the sense that the allocation of the coroner was “the luck of the draw,” and that this could dictate the rest of the process.

Another participant was only asked to attend on the day the PIR was taking place. Again, she had no idea what to expect,

“I turned on the screen [it was a virtual hearing for the family] and there were lots of people and I didn’t know who they were. I thought only solicitors and coroner, but there were all these police.”

This felt intimidating and could have been avoided if there was clear information for families outlining their role and what to expect at a PIR. This was brought into sharp focus as one participant described how upsetting it was to be told, without forewarning, that they would be shown body worn footage of the death of their loved one as it was going to be shown at the inquest anyway. This was the first time they had seen the footage.

A consistent thread throughout the day was the lack of empathy afforded to families. The conduct in PIRs was no exception,

“When we had our Pre-Inquest Review my dad had died 10 days earlier, and it was the same day as he was being moved to

the chapel of rest. We went to the PIR and my emotions were all over the place. The coroner said, ‘somebody has lost someone else I heard’ and I had to put my hand up and say it was my dad. There was no compassion, there was nothing. They’ve got to understand this is a bereaved family.”

In many ways the PIRs were symbolic of the broader process - a lack of information, little or no time to prepare due to short notice, procedural rather than family centred and lacking a human touch. To engage families more effectively these issues must be addressed.

3.3 Impact of investigations on the inquest experience

The cases described in this FLD were subject to the added complexity of investigations into deaths which occurred in either police custody or prisons. Although the specific ways in which these non-coronial investigations were conducted was not discussed in any detail, we did hear how waiting for the conclusion of investigations and subsequent reports impacted on the amount of time it took to conclude the inquest process.

As noted earlier in this report, families were not given independent information about either the investigatory bodies or how investigations would interact with the inquest process. Those with legal representation were at a distinct advantage, but there remained frustration at the time these non-coronial investigations took to complete, especially as there was more than one such investigation in some cases. Families hoped this meant a more rigorous examination of the events leading up to their loved one’s death but there was also frustration at the time scales involved, the secrecy as to what was actually being looked

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YOU'RE WATCHING SOMETHING WHICH YOU KNOW FULL WELL IS WRONG, YOU HAVE NO POWER, NO SAY AS YOU ARE WATCHING THIS LEGAL COVER UP HAPPENING.

at and the scope of the investigations.

One participant felt the IOPC and the coroner were working together and withholding information,

“The IOPC and coroner, they know what’s going on, talking [to each other], they know things before you do.”

Others talked about their frustration at the delays caused by the investigation and felt that these were almost an inevitable part of the process. One participant felt the “*police are in control*” of the investigation, questioning the independence of the IOPC, and went on to say,

“If we do something wrong we have to write a statement straight away, it’s six months before they do.”

Others agreed,

“I thought it took so long so they could prepare themselves to answer questions.”

The delay prolongs the pain of loss,

“We were lucky to have a good legal team, but the coroner’s office was not really helpful. We need more empathy as having to navigate all these investigations whilst coming to terms with your grief was very overwhelming.”

Although frustrating, delays were seen by some as an indication of a thorough process,

“I was glad for the change of coroner. There were two IPCC [precursor to the IOPC] reports and the coroner, at the last minute, decided they wanted a health and safety report. Constant delays.”

For some, though, the investigations simply did not go far enough, or more frustratingly, coroners decided the findings could not be disclosed at the inquest. In one case a PPO report which was critical of the prison in which her son died left his mother feeling angry and let down,

“You’re watching something which you know full well is wrong, you have no power, no say as you are watching this legal cover up happening.”

CHAPTER FOUR

THE INQUEST

Accounts of attending the inquest highlighted the fundamental contradiction at the heart of the process. Families are told, and in some cases believe, that this is their opportunity to find out what happened to their loved ones, for justice to prevail and for those involved to be held accountable and ensure that systemic failings are addressed to prevent future deaths. What transpired was viewed differently by many participants. They discussed their belief that context shaped events, believing they encountered attitudes and behaviour that sought to shift the focus away from state bodies and on to them and their loved ones. Some encountered hostility from legal teams and witnesses and, in a few cases, believed the coroners involved did not do enough to challenge this.

There were also suggestions of inconsistencies; in how coroners supported families to engage with proceedings, in the facilities made available to them, and

to what extent they were able to actively shape the scope of what could and couldn't be discussed. The notion of the process as 'simply' inquisitorial was in fact a tiring, emotional, frustrating and profoundly adversarial experience. In the end very few participants felt the inquest was a good way of achieving justice, and some expressed their dissatisfaction at the coroners' findings and the lack of enforceability of Prevention of Future Death reports (PFDs).

4.1 Context shapes the experience of the inquest process

For many families, the context in which the death occurred had a profound impact and framed their experiences of the inquest process. Participants explained how deaths in prison and police custody shaped the response of state agents from initial contact with Family Liaison Officers and investigators from the IOPC, through to their experience of the inquest itself.

Families described attempts to negatively label their loved ones, to stigmatise and to place the focus of the process on individual and family failings rather than the systems,

resources and failings on the part of those tasked with carrying out a duty of care and keeping their loved ones safe,

“You go in and you feel like you are labelled, you are labelled. If he hadn’t been arrested, he would not have died. They have a duty of care for that person. There is no accountability.”

Other participants agreed. One person explained,

“Whatever you say about your loved one you are already labelled and they treat you with complete disrespect.”

He also believed that,

“

**MENTAL HEALTH
AND COLOUR IS A BIG
FACTOR. THEY RUN
YOU DOWN AND THEY
DIRTY YOUR NAME.**

Another participant agreed that stereotyping based on race underpinned the whole inquisitorial process right from the start,

“It is not long before you feel like the family of the criminal. You feel the stigma straight away even when you try to explain how they died. My son died of asthma, but they said it was a drug overdose. He had a totally clear system.”

Families felt this was a well rehearsed tactic to deflect away from institutional failings

and to avoid scrutiny and accountability. For many families, the inquest was a daunting experience; faced with hostile lawyers, aggressive questioning and inconsistent coronial procedures that did not reflect or properly consider families’ needs or how the place of death influenced proceedings.

4.2 Opportunities for family participation

It became evident as we heard from the group that coroners have inconsistent approaches to how families engage with inquest proceedings. We heard examples of great practice, but all too often families were left feeling unsupported or unheard. For them, the inquest is the culmination of years of preparation and families ascribed a huge importance to its capacity to deliver truth, justice and accountability. It was also seen as an opportunity to tell their story and that of their loved ones, to make real the lives of the those who had died. However, it was evident that families simply did not know what to expect from the inquest, did not feel prepared, or know what their role involved,

“I just followed the manual; it is not like you know what you are walking into.”

4.2.1 Pen portraits and family statements

One direct way families were able to participate was via pen portraits. These provided an opportunity for the family to tell the coroner, jury and court about the life of the person who died and to humanise a name. It became apparent that coroners granting pen portraits is not a uniform occurrence. One family was unaware that they could do one,

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THE CORONER KEPT ON GRINNING; I REMEMBER HER EXPENSIVE LIPSTICK. I TOLD HER, ‘I DID NOT RAISE MY CHILD TO BURY HIM’, I COULDN’T SAY ANYTHING MORE. I COULD SEE THE CORONER’S FACE CHANGE AFTER THAT, SHE WAS NO LONGER GRINNING.

nobody had mentioned it before the inquest,

“We never had a pen portrait. No opportunity to explain about my boy. No one asked us.”

One family said,

“My solicitor had never heard of pen-portraits.”

Others explained they were able to take in a photograph of their loved one, while one person said they were told the statement had to be short, her lawyer informing her it could be no more than 10 sentences long.

However, where the coroner was empathetic and acknowledged the importance of allowing the family to describe their relative in more detail it had a profound impact on their experience. As one person stated, she felt like the most important person in the room when telling the inquest about her brother,

“I read my 14-page witness statement. I told the coroner that I wanted to read the whole thing and coroner agreed. I wanted the jury to see my emotions and hear from me. I did feel very important, and I made sure I looked at them [jury and legal teams] one by one. As I went in they were all whispering about me being his sister. The coroner allowing me to give my evidence

in court was good. The fact that jury could ask questions was also great.”

She went on to say,

“When I was doing the pen portrait, there was an issue of getting [my brother’s] photo on the screen. I went up to the coroner and told him, ‘I need to see him when I am talking about him.’ The coroner was very respectful and said of course, we can wait for the picture to come up on the screen, then two big pictures came up on the screen.”

Families felt that good practice enabled them to speak about their loved ones, and to feel heard and valued. However, even more importantly it was about making their loved ones real, and humanising them. They believed they should have an opportunity to set the tone, to present the “*living side*,” in order to challenge the often negative narratives presented by lawyers,

“All I wanted was to have his voice heard.”

However, every coroner does things differently and there was evidence that some families were denied an opportunity to speak because coroners believe the experience would be “*too traumatic*.” Participants made it clear they believed that this should be the choice of

families rather than the coroner. Families who had been able to read out a pen portrait at the inquest spoke positively about the opportunity to represent their loved one in court. The responsibility weighed heavily upon them, but the need to humanise a life beyond the reductive place, time and cause of death was seen as vital.

4.2.2 Facilities for families

There was evidence of poor facilities in buildings that did not have the capacity to handle the number of people attending. This was difficult for families as it placed them in close proximity to witnesses and others responsible for the care of their loved ones.

Others spoke of inquests where there was no dedicated family room affording them privacy,

“We were not given a family room and ended up sitting next to the prison guards.”

This participant explained that they had to use the waiting room because the family room was flooded and she could overhear the conversation of witnesses,

“Others were whispering ‘that’s his sister.’”

Another person had a similar experience,

“The family room was next to the Police Federation room, and at the end of every day we bumped into the jury or the [Police Federation] lawyers and they were smiling at me and I thought ‘don’t smile at me.’”

Another example highlighted how insufficient room for the family members to sit together meant one had to take his place on a pew with the police officers involved in the death of his brother.

Families felt that inquests should be conducted in appropriate buildings, with sufficient space to allow families to sit together and for them and their lawyers to meet in privacy.

Families were also unhappy at the lack of support on offer; without their lawyer, family members or an INQUEST caseworker, they would have been alone. In other types of courts and tribunals it is common to have staff in place to support witnesses, but few participants had knowledge or experience of the Coroners Courts Support Service. One family were able to use the Coroners Courts Support Service and found it had a positive impact. Having left the courtroom, the family were approached by a woman who said,

“‘If you need me, I’m here.’ They’re volunteers. It was like having your granny there, she was very sweet.”

Another participant agreed saying families needed,

“Somebody in court coming and speaking to you in breaks.”

Families said independent support whilst attending the inquest, “someone to help you process the process” would be welcome.

4.3 Inquisitorial vs adversarial – families’ experiences

As has been established earlier, families went into the inquest unsure of what to expect. Those that initially believed the proceedings would be inquisitorial felt they participated in something quite different. Whilst not a universal experience, many were surprised by the conduct of key protagonists; of lawyers, the coroner, witnesses and how the adversarial complexion of the inquest impacted them.

There were positives as well - empathetic, rigorous coroners and the important role played by juries.

However, it was more often the case that families felt the inquest was not conducted on an equal footing and the scope was biased in favour of protecting state bodies, their reputations and the systems that had failed their loved ones. One participant believed blaming those that died and their families underpinned proceedings.

“The purpose is not to proportion blame we have never gone in to blame the police, but they went in with total intention to blame the deceased.”

This resulted in some family members deciding their participation was a waste of time. One participant said his older brother was so cynical about the likelihood of justice that he stopped attending the inquest, believing the police had a *“different agenda.”* In the end,

“He just couldn’t handle the process.”

He added,

“

THEIR [POLICE] WHOLE ATTITUDE IS TO COVER UP, TELL LIES AND GET OUT OF IT.

Others felt compelled to engage out of a sense of loyalty to their loved ones but suspected the inquest was not really there to serve their needs.

“It takes a while for you to realise it’s not about justice. It’s mostly about the lawyers and the coroner, they go home at 5 o’clock, it has nothing to do with you, but you are there.”

The same person suggested relationships between the legal teams and coroners meant the family were always outsiders,

“You’re lost. You see the eye contact between the coroner and lawyer for the prison. I was just sitting there thinking ‘this has nothing to do with you.’ I am better off taking flowers to my son’s grave.”

The difficulties in securing legal representation meant there was an imbalance regarding legal representation,

“We’re the victims and then the police/hospital, their numbers are overwhelming, so many counsels for the police.”

Others agreed,

“The police had the best legal representatives and it’s never going to be fair.”

“Same for us, the Police Federation and individual officers all had individual barristers. They were all in a room and able to watch each other give evidence.”

This felt both unfair and intimidating, and raised questions as to how this might influence coroners’ management of the inquest in relation to families’ interests. Some were straightforward in their assessments, describing the way lawyers acted towards the family as simply *“disgusting.”*

Families are not on trial, but many felt that is the way they were treated. They wanted answers to how their relatives had died and did not expect the inquest to become an

interrogation of their behaviour or indeed an exercise in denigrating the characters of those who died in state care.

4.3.1 Role of coroner

The conduct of coroners was presented as a power dynamic which did not always serve the interests of families; decisions made by coroners meant families were unable to adduce or admit admissible evidence or ask relevant questions to witnesses and experts. However, there was also praise for the way coroners created an environment that engaged with, and encouraged, families to take a meaningful role during the inquest.

Some families had a negative experience. The family with no legal representation questioned the coroner's decision on the order for questions and evidence,

“Officers spoke, pathologists spoke, lawyers and barristers spoke, and the family was the last. It should have been the other way round.”

She went on to add,

“99% of questions were to do with the CCTV and actions of the police officers and my questions were closed down. The order in which evidence was heard was not fair.”

Others agreed, saying coroners had refused to admit evidence which families saw as crucial,

“But even as a family, when you read the evidence, they then remove that. Camera footage they say they will not admit. You are a shadow and spectator in the whole process.”

Some families felt coroners failed to protect them from undue pressure, and aggressive

questioning and highlighted the impact of stigmatisation.

“[Coroners] need to stop treating you as a criminal.”

You go in you and feel like you are labelled, you are labelled. ‘If he hadn’t been arrested, he would not have died.’ They have a duty of care for that person. There is no accountability.”

There was a sense that families felt some coroners lacked empathy, understanding and therefore allowed proceedings to become adversarial at the cost of a “fair” inquest. Others thought the coroner was not tough enough on the state representatives,

“In the legal arguments bit he was being nice to everyone but we needed him to also make tough decisions without worrying about upsetting people.”

However, the role of some coroners was also praised by those families who experienced empathy and a commitment to ensuring the family voice was amplified throughout the proceedings. This was seen to be about attitude and behaviour by some participants,

“Only the coroner questioned me, she was very respectful and nice. She gave pictures [of my son] to all the jury. The coroner’s staff were exceptionally nice and kind.”

Respect and kindness as a minimum requirement of coroners' behaviour were noted by others,

“Our coroner’s background was medical, he was a great person and made me feel important, halfway I had a breakdown and he offered me a break.”

Others expressed gratitude that the coroner quickly established their authority during the

inquest. Families described the coroner as “excellent” for reminding the police lawyers that it was his court, Others described the coroner as “fair” and “right on point.”

There was agreement that the coroners’ background could make a difference to the way they treated and interacted with families,

“Our coroner was a surgeon, so she had some empathy.”

“Our coroner was a barrister; she had been doing cases 15-20 years. It is potluck and it shouldn’t be.”

If background was seen as advantageous, so were training and skills.

“As a coroner you are obviously dealing with families and you should surely get training on soft skills and compassion. So many families had such negative experiences.”

“Coroners should have training or acknowledgement of complex grief and an ongoing process. They should be aware of family dynamic Coroner’s Service or be able to see it. You need to have a level of compassion.”

Another family saw part of the issue related to resourcing the coroners’ courts properly.

“Coroners need help as well as they have so many inquests. They need more support.”

Some felt coroners needed to show more bravery when faced by lawyers representing state bodies, to allow greater scrutiny of those tasked with carrying out their duty of care.

“We had a good coroner, but she would not let you ask any question which were critical of the police.”

“The family wanted to address racism but coroner said no, and then later the coroner said racism was ‘the elephant in the room’ which was odd.”

When the coroner did question the narrative presented by witnesses it felt positive to the family,

“One thing that our coroner picked up on is the lies that they [police officers] told, and their coaching and they don’t even have the sense to come up with different lies. She said, ‘he is the strongest man you’ve ever met?’ Eleven of them were on one man [my son]. The coroner said, ‘and look at you, the eleven of you.’”

She added,

“I would say the coroner was our saving grace.”

4.3.2 Importance of juries

Although the role of juries was not discussed in any specific detail, when the subject did arise families were broadly welcoming of the role they played in their inquests. There was a sense that juries acted as an independent counterbalance in contrast to some of the other inquest proceedings. Families noted,

“The fact that [the] jury could ask questions was also great.”

Families also felt the make-up of juries was important. They found that the greater the diversity of the jury, the better equipped they were to set aside stereotypes or preconceptions,

“The jury was so engaged from day one. It was a diverse jury, many were Black.”

As a result, the family felt that the jury would understand the racialised issues in the case.

“We packed the inquest with families and church and friends. I noticed the jury was always watching. I would say the other counsel were nasty, tried to trick everybody, but there was one Asian, and one mixed heritage in the jury and they did good.”

For some the presence of a jury gave them faith that they were not alone in a desire to see truth and accountability prevail,

“Then the coroner said no one is getting out of it [responsibility] and at the end they were crying. The coroner’s conclusion said, ‘no known cause of death,’ and the jury did not agree. Jury got frustrated that nothing came of it.”

However, the jury is subject to the authority of the coroner, and where some will accept a jury’s verdict, others will not,

“In [this] case the solicitor didn’t agree with the jury’s verdict and tried to challenge it. The coroner said, ‘no that’s their decision’ but they [the solicitor] went on and on and in the end the coroner agreed to change the wording.”

Families felt juries added a greater level of scrutiny and, although not always able to influence the outcome of the inquest in these cases, they regarded the role of the jury as welcome and vital.

4.4 Inquest Outcomes

There was a mixed response when families were asked what they felt about the outcome of the inquest. Some had gone into the process with little or no faith the

inquest would get to the truth, others were more optimistic. Commonly, though families did want to hear an apology or an acknowledgement of their loss and suffering, they were also wholly committed to ensuring that an inquest’s outcome should result in the prevention of future deaths,

“You do this because you don’t want anybody else to go through it. You don’t go through the whole process for something which means nothing. I am sure my son is not the first person who died in prison due to bad health care.”

One participant pointed out that they were unaware of what types of conclusions or findings an inquest could reach. This highlights how, even at the very end of the process, information was not made available to them. She suggested.

“When there is a death if there could be a video explaining different verdicts and outcomes. I would have been grateful for a YouTube video explaining different processes and in fact there is nothing.”

Inevitably some families were angry at the findings of the inquest, feeling they did not go far enough or failed to take sufficient account of institutional poor practice and systems.

Receiving an apology from the authorities was important to all participants. One participant witnessed the contradictory problem implicit in inquests involving state bodies becoming defensive, where the acknowledgement of mistakes is tantamount to an admission of guilt. She recalled a conversation between prison officers, one of whom wished to apologise. The officer told her,

“I’m so sorry, I should have opened the door [to the cell in which her son was in medical distress],”

and that he “*couldn’t forget*” her son’s face. Another officer came up to him and said,

“You’ve thrown us all under the bus.”

That comment upset her sons but,

“I had to take something away and that apology was important for me.”

This was a common complaint from families, many of whom sought an apology that was all too often unforthcoming.

“[They] won’t apologise, not publicly. We just wanted the truth.”

However, when this participant reflected on her experience overall, she felt,

“

CATTLE HERDED THROUGH THE LEGAL SYSTEM.

If admitting mistakes is deemed to be an acknowledgement of fault, the objective of preventing future deaths is harder to achieve.

We heard to what extent families were updated about any changes to practice and systems following coroners’ recommendations as part of Prevention of Future Death reports (PFDs).

Families expressed disappointment and anger when the inquest concluded that a death was suicide, or there was no cause of death given. However, there were examples where the coroner was willing to provide additional context with recommendations,

“Suicide was a word which was difficult for my elder brother but when he attended

the inquest, he started to be more involved. He was there for the verdict and they said suicide but then listed all the contributory failures. For him to hear that, was important to understand how much he [their brother] suffered. It made us closer us a family.”

Another family wanted a conclusion of manslaughter, but the coroner refused. However, he provided a critical narrative conclusion which went some way to comforting the family.

PFDs were a particular concern for participants. Families saw these as a way of protecting others who were placed in police custody or imprisoned. Where they were issued families were grateful, not least when they felt the authorities were not acting quickly enough or with conviction to make changes to practices and systems,

“They called a witness from prison and one from the Trust. I thought that the coroner will be making a PFD. The coroner will only issue a PFD that’s based on the evidence that things have not changed, all the disability discrimination. They [the prison] said they had made changes, but he still issued a PFD.”

This was important because,

“I always wanted the verdict to be [my brother’s] voice, his suffering, and that’s what it was at the end.”

But many pointed out that PFDs are not enforceable in law. They are a recommendation with no recourse to ensuring compliance,

“They should be binding and be made national.”

“It seems pointless if there are no changes.”

The group were horrified by the number of subsequent deaths that had occurred in the institutions in which their loved ones died,

“It did not even take a year for another young person to die.”

“Within the year of my son dying six people died but they still did not do a PFD.”

It was agreed that until recommendations were enforced, they become devalued,

“You can make all the recommendations in the world, but it is such an institution with culture and systemic issues it is difficult for changes to take place.”

Some participants were encouraged by subsequent changes,

“In six years, they have put a lot of things in place. The coroner was asking the Home Office about systems not talking to each other and he also complained about the IOPC not being fit for purpose.”

But the overriding emotion was one of distrust and scepticism, as evidenced by the number of people who had subsequently died in custody in similar circumstances.

Where changes to practice and systems did follow the conclusion of the inquest it was often down to families to seek information as to what was happening or indeed to force through their implementation,

“The coroner made so many recommendations it took so long for them to respond to them, but we said even after that time expired we will make sure that changes will take place. We contacted [the] police federation about first aid course[s]. We said first aid surely

had to be compulsory, carrying PPE was not compulsory and that was made compulsory, the whole design of the police van changed so we made sure that all the changes they said they put in place [were] done.”

Another person pointed out the importance of involving families in solving problems with care,

“In an ideal world I want families to be involved in training them and have an input in the training. It is central to everything we said.”

However, another family member expressed her concerns that it is too big a job for families to ensure the state complies with recommendations,

“It is so lovely that you have done that. I feel bad that I have not done that, but life takes over and you trust the authorities.”

Ultimately families engage with a system that fails to consistently support their participation. It takes resilience, determination and a great deal of emotional energy from families to campaign for truth, justice and accountability. When asked why families wanted to participate in the coronial processes, they explained that they want to honour the memory of those that died and ensure that future deaths can be prevented.

“We are the voice [of our loved ones].”

“We are [the] best advocates [for our loved ones].”

CHAPTER FIVE

WHAT NEEDS TO CHANGE?

At the beginning of the FLD, families were asked to provide one word, or short description, of how they would describe their experience. The responses are below.

“Unsupportive”

“Challenging”

“Exhausting”

“Disgraceful”

“Frightening”

“Lacking uniformity”

“No support”

Families were also asked what would make things better and responded with the following,

“Empathy”

“Compassion”

“Independence”

“Information”

“Family-centred”

“Support to navigate the process”

“Personal approach”

“Coroner training”

“Fewer delays”.

5.1 What families told us they want

- Independent advice and information on the role of the Coroner’s Service and coroners.
- Support with navigating the process, provided by an independent third party separate from the Coroner’s Service and the investigation bodies.
- Compassionate, skilled and well-trained Coroner’s Service staff.
- Signposting to INQUEST at the first point of contact with the Coroner’s Service.
- Independent Liaison Officers.
- Independent investigators.
- Access to non-means tested Legal Aid.
- Prompt disclosure of all evidence relating to the death and subsequent investigations and a reduction in delays to the process writ large.

- Equality of treatment when preparing for and attending inquests – facilities, opportunity to question witnesses, admission of relevant evidence.
- Consistently enforced opportunities to deliver pen portraits.
- Better resourced Coroner's Service, in part to mitigate against delays.
- Provision of independent, emotional support throughout the inquest as is common in other court settings.
- Respectful treatment by state lawyers.
- Coroners' training – especially around the impact of complex bereavement and grief on families.
- Enforceable PFDs, rolled out nationally where appropriate.
- Prompt feedback/updates where recommendations have resulted in changes to practice and systems.

INQUEST

Truth
Justice
Accountability

