INQUEST
TRUTH, JUSTICE & ACCOUNTABILITY

Angiolini Review into Deaths and Serious Incidents in Police Custody: Policy briefing.

October 2017

POLICY • ADVICE • CAMPAIGNS

Introduction

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In July 2015, in her former role as Home Secretary, Theresa May announced the Independent Review into Deaths and Serious Incidents in Police Custody. She did so after meeting the families of Sean Rigg and Seni Lewis, saying that she was struck by the pain and suffering of families still looking for answers. She said at the heart of the review would be the experience of the families of those who have died in custody and the voices of victims of other serious incidents. As such, she invited INQUEST to undertake a formal role in the review and provide liaison with affected families. The Review was chaired by Dame Elish Angiolini QC, previously Solicitor General and Lord Advocate of Scotland.

It is the first and only review of policing practises and related processes following police related deaths ever to take place. The Terms of Reference for the Review were broad and ambitious. They include the experiences and needs of bereaved families. They cover the causes of deaths and serious incidents along with directly and indirectly related policing issues: restraint, intoxication, mental health, self-harm, ethnicity, medical care, issues affecting children and young people, women, those with communication and perception disorders, the homeless. They cover the various investigation and accountability mechanisms: IPCC, NHS, Crown Prosecution Service, Health and Safety Executive, coroners' inquests and police misconduct systems. Finally, and importantly, they address the broader questions around sustained learning, a crucial element of accountability.

INQUEST's Director Deborah Coles was appointed Special Advisor to the Chair. INQUEST organised two family listening days for Dame Elish to hear directly from a large number of families with varying experiences, as well as separate meetings with individual families. INQUEST also organised three meetings with groups of lawyers who regularly represent families.

INQUEST considers that overall the Review and its report presents many bold and positive findings. Many of the issues identified and changes recommended echo those argued for by INQUEST and the families we work with.

The report represents an opportunity to save lives and transform the experience for the vast numbers of vulnerable people who come into contact with the police. Its value must ultimately be judged by the changes it brings about and we call upon the Government to respond now with an urgent programme of action in response to the report's findings and recommendations. Many of the recommendations of the review also point to the need for the implementation of the proposed "Hillsborough Law" imposing a duty of candour upon public bodies in their dealings with inquests and public inquiries.

Spanning such a broad swathe of issues and running to over 250 pages, the report cannot be summarised here. This briefing maps the chapters, pulling out the central issues under discussion in each and highlighting those recommendations that INQUEST considers to be most significant and far-reaching. The Review, including the Family Listening Day reports included in the annex, and INQUEST's written submission should be read for more detailed insight into each particular issue (to be published on the website).

About INQUEST

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. Our specialist casework includes death in contact with the police, in prison, 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 and wider issues around Hillsborough and Grenfell Tower.

Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people. This integrated approach is crucial to families, not only in making sure their voices are heard and holding the state to account for individual deaths, but also in changing policy and practice to prevent future deaths.

SPECIALIST CASEWORK: We work directly with bereaved people, empowering them through the post-death processes of investigation and inquest to establish the truth about a death in the care of the state.

CAMPAIGNING: We use the direct evidence from our casework, alongside statistics and rigorous research, to exert pressure on public bodies and government and drive systemic change.

SHARING KNOWLEDGE: We are the only organisation with a comprehensive overview of deaths in custody and detention. We use our expertise and statistics to track patterns and trends and situate deaths in their broader social and political context.

SOCIAL JUSTICE: We work to improve the investigation and inquest process for all. We campaign for non means-tested public funding for families in state-related inquests and stronger post-death investigations. We lobby to ensure that government, state and corporate bodies are held to account and that action is taken in response to systemic failings.

We are entirely independent of government. Founded in 1981, we campaign alongside families and others to access the truth, hold those responsible to account and effect meaningful change to prevent future deaths.

Key recommendations

Restraint

This chapter looks at the use of restraint particularly against those who are vulnerable or at high risk. It notes that when the citizen dies during or following such an encounter the State and its officers must be held to account.

The extent to which restraint techniques contribute to deaths and the adequacy of current training is identified as a crucial aspect of the Report. INQUEST welcomes the broad position adopted that police practice must recognise that **all** restraint has the potential to cause death. It reiterates that the use of any physical force should only be contemplated where absolutely necessary, rather than as a default position to achieve compliance.

It notes that use of restraint was found to be more prevalent in cases of Black, Asian and Minority Ethnic (BAME) individuals who had died in police custody and amongst those with mental health problems. It points to the fact that more than fifteen years after the death of Roger Sylvester, deaths continue to occur in circumstances involving the use of restraint, particularly in those suffering a mental health crisis. There have been many highly publicised deaths over the years where restraint has been a significant factor in the cause of death, including those of Sean Rigg, Kingsley Burrell, Olaseni Lewis and Thomas Orchard.

It notes that such deaths have led to critical findings at inquests and occasionally reviews but the emergence of the same themes in many of these deaths is indicative of the failure to learn lessons.

It looks at the need for improved safety where restraint does take place. It highlights the need for wider understanding and recognition of the mechanisms of death in restraint cases and in particular the inappropriate use of the term 'excited delirium'. It addresses the links with mental health and the dangers of restraining a person who is in a heightened physical and mental state. It looks at the use of other restraint equipment linked to deaths. It also considers the dangers arising during transportation in police vehicles and the need for effective recording of police use of force.

INQUEST strongly supports the following recommendations, which should be taken forward urgently by national policing bodies:

- Police practice must recognise that all restraint can cause death. National policing policy, practice and training must reflect the now widely evident position that 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.

- Police must be held to account both at an individual and corporate level where restraint has been found to be used in an unnecessary, disproportionate or excessive way.

- There should be mandatory and accredited national training for police officers in restraint techniques, including supervision of vital signs during restraint, with appropriate refresher training for officers. There should be national consistency in approaches to the use of force.

- The ability to de-escalate should be paramount skill of all officers.

- ‘Excited Delirium’ should never be used as a term that, by itself, can be identified as the cause of death. Collaboration between pathologists, psychiatrists and emergency medicine practitioners is required to clarify and standardise the medical understanding around restraint-related deaths involving mental health crises. This should underpin future police training.

- A mandatory safety officer approach should be implemented by all police forces similar to that used in the prison setting.

- Restraint equipment should be strictly limited and subject to robust monitoring and review.

- CCTV should be introduced in police vans nationally to allow monitoring of restrained detainees, in conjunction with vigilant supervision of welfare and safety during transport.

- The national ‘use of force’ data collection must be continually reviewed. Monitoring of ethnicity and mental health should be part of that system.

- There should be robust data collection on near misses and non-fatal serious incidents by the police and IPCC.

Intoxication

This chapter addresses the implementation of observation regimes for intoxicated detainees and the long history of compliance failures resulting in a litany of very similar deaths. It points to figures that highlight that drugs and alcohol remain a significant factor in deaths in police custody and that this is as much a public health as a policing issue. It considers the viability of ‘drying out centres’ as an alternative to police custody or Accident and Emergency (A&E) departments. It also explores the refusal of access to A&E or to health based places of safety to intoxicated individuals, the life threatening nature of alcohol withdrawal and the need for mandatory training across police forces, private sector providers of detention services and doctors working in custody settings.

INQUEST encourages the implementation of the following recommendations as a significant step forward in addressing the number of drug and alcohol related deaths:

- HMIC should include a focus on inspection of observation regimes for intoxicated detainees within its Expectations of Police Custody (updated April 2016). HMIC should monitor police forces’ internal inspection procedures for observation regimes.

- The Government should give consideration to the viability and cost-effectiveness of drying out centres, and consider piloting a centre or centres in large urban areas where it is most likely to be cost-effective and linking such centres to A & E departments.

- AN NHS initiative at the national level should examine whether to prohibit the refusal of access to A&E or to health-based places of safety under Section 136 of the Mental Health Act on the basis of intoxication.

- Comprehensive and standardised mandatory training is required across forces for custody sergeants, officers, civilian detention staff on the dangers associated with intoxication.

- Training for privatised detention and medical services must be to the same standard as for police staff and include joint training with police. Joint training is also required for Forensic Medical Examiners and custody sergeants.

Mental Health

This chapter reports the link between mental health and deaths in police custody. It highlights the increasing role of policing in dealing with those with mental health issues. It discusses the associated problems arising from the use of section 136 Mental Health Act. It addresses the inappropriateness of police custody for those in mental health crisis and the need to divert away from the policing context through use of 'street triage' and 'liaison and diversion' schemes. It considers the legal framework whereby mentally ill people are arrested for criminal offences and police stations are used as a 'place of safety' under section 136. It also addresses the critical need for mental health training for police officers and the use of police officers to conduct restraint in mental health detention settings.

INQUEST strongly encourages the adoption of the following measures, which could make a real impact on ensuring the safety and protection of mentally ill people who come into contact with the police:

- Commitment and responsibility at leadership level is needed across police forces to ensure prioritisation of the issue of mental health and to bring about sustained cultural organisational and practical changes.

- Police recruitment and training should incorporate the different personal skills and experience needed to fulfil duties relating to the needs of highly vulnerable groups including empathy, communication and the ability to employ de-escalation techniques.

- There should be consistent national police policy and guidance encompassing current learning and best operational practice, reflecting the need for a drastically improved policing approach to those in mental health need.

- National, comprehensive, quality assured mental health training consistent with the above is needed for all officers in front-line and custody roles. Training should be interactive and should involve from mental health users to help break down fears and assumptions.

- There should be clear procedures around the operation of Section 136 from initial point of contact, including joint protocols between police, local health services and voluntary organisations. Health-based 'places of safety' should not be permitted to exclude those who are intoxicated or showing signs of agitated/aggressive/disturbed behaviour.

- There should be proper resourcing of national healthcare facilities to accommodate and respond to vulnerable people in urgent physical/and or mental health need coming into contact with the police.

- The use of police stations as section 136 'places of safety' should be completely phased out. Guidance should not advocate the use of police custody on the grounds that a detainee's behaviour would be 'difficult to manage' in a healthcare setting.

- Successful local mental health policing pilots and initiatives, particularly street triage and liaison and diversion schemes should be funded on a sustainable basis

for national roll out so that, as far as possible, those in mental health need are dealt with through medical and community based pathways not through police detention. Such schemes should be subject to regular review.

- An unambiguous and high threshold should be set for police involvement in any health care setting. Clear guidance should identify medical primacy of role in any health based setting involving the police.

Ethnicity

This chapter notes how a disproportionate number of people from BAME communities have died after the use of force. It notes that deaths of people from Black, Asian and Minority Ethnic communities, in particular young Black men, resonate with the Black community's experience of systemic racism and reflect wider concerns about discriminatory over-policing, stop and search and criminalisation. Further it notes that Institutional racism identified by the Macpherson report still appears to be an issue within the police service.

It looks at how the stereotyping of young Black men as 'dangerous, volatile and violent' is a long standing trope that is ingrained in the minds of many in our society and acknowledges what INQUEST describes as the 'double discrimination' experienced by Black people with mental health issues.

It notes the lack of IPPC data on restraint related deaths by ethnicity. It also notes that police forces in England and Wales do not include Gypsy, Roma and Traveller communities in their ethnic monitoring systems. In looking at accountability it says that where there is evidence of racist or discriminatory treatment or other criminality or misconduct, police officers must be held to account through the legal system.

INQUEST considers the following recommendations to be helpful, if pursued in conjunction with other demands for increased accountability:

- IPCC investigators should consider if discriminatory attitudes have played a part in restraint-related deaths in all cases where restraint, ethnicity and mental health play a part (in line with the IPCC discrimination guidelines). A systematic approach should be adopted across the organisation.

- The IPCC should address discrimination issues robustly within misconduct recommendations, including where discrimination is not overt but can be inferred from the evidence in that specific case or from similar cases involving the same officer.

- National policing bodies and police forces should implement mandatory training and refresher training on the nature of discrimination, including on race issues, which aims to confront discriminatory assumptions and stereotypes. Policing bodies should consult with bereaved families on how such training can break down barriers and promote change.

- Police training should include an understanding of the Macpherson report, the social context of Black deaths in custody and the impact they have on public confidence.

- The IPCC should monitor the correlation between ethnicity and restraint-related deaths, including in healthcare settings where the police were involved. Statistics should be published breaking down restraint related deaths by ethnicity.

- National data collection on the use of force should be analysed by the Home Office to draw out patterns and devise national strategies to address discrimination issues.

- There should be mandatory ethnic monitoring of Gypsy, Roma and Traveller communities in England and wales by police forces in their ethnic monitoring systems.

Self-inflicted deaths within 48 hours of release from police custody

This chapter notes that self-inflicted deaths within police custody have dramatically reduced since the 1990s through such measures as removing ligature points and constant observation. It addresses the need for a similar raising of awareness of vulnerability particularly at the point of release. It notes that the number of deaths shortly after release are extremely high and that certain groups are at especially high risk. It addresses the need for improved pre-release risk assessment, medical advice at point of release and the availability of services from other agencies such as mental health services, social services and housing organisations.

INQUEST considers that the following recommendations would help in reducing the number of self-inflicted deaths:

- Police forces should include medical input in the risk assessment process at the point of release.

- The College of Policing APP on detention and custody and force training should include guidelines for pre-release risk assessment setting out specific practical steps that should be taken to provide support and protection for those at risk of self-harm on release (for example contacting family/carers before release with the detainee's consent, or referrals to community support groups).

- Custody inspections should continue to focus on the use of liaison and diversion schemes, pre-release risk assessment, and actions taken on release, as part of the inspection regimes of police forces.

Children and Young People

This chapter considers self-inflicted deaths shortly following release by several 17 year olds and the potentially devastating impact of custody on children and young people. It explores the excessive overnight detention of children and the reasons for this. It looks at the inspection criteria in respect of detained children and at the difficulties surrounding the provision of sufficient numbers of appropriate adults required by children who do not have family members to take on this role.

INQUEST considers the following recommendations to be important to eliminating the overnight detention of children in police cells and notes that the obstacles are mainly on the part of local authority provision of alternative accommodation and funding of non-police bodies:

- Local Authorities should ensure that they have reasonable systems in place to guarantee that all police requests for accommodation, whether secure or non-secure, are accepted. Adequate funding must be made available for local authority overnight secure accommodation of children in police custody.

- Police training and inspection should focus on utilising non-secure accommodation for children other than in exceptional circumstances, where children pose a risk of harm to the public.

- The use of police custody for children detained under Section 136 should be brought to an end with all NHS Trusts required to make sufficient provision of health-based places of safety to meet this requirement.

- Increased funding is required for appropriate adult schemes within a national framework for commissioning. This should include improved training and consistency of Appropriate Adult services.

Other vulnerable groups

This chapter considers the dealings of the police with those who have social communication and perception disorders such as Autism and learning disabilities, including use of 'support card' schemes. It also addresses the impact of epilepsy and police responses.

It explores the particular vulnerabilities of women detained in police stations, especially around contact with children, and the re-traumatising effects of strip searches and removal of clothing upon survivors of abuse. The vulnerability of transgender individuals also needs to be addressed with great care and sensitivity. Finally, it considers the links between homelessness and custodial death.

INQUEST calls for the implementation of the following recommendations:

- Mandatory police training on vulnerability must include understanding of, and appropriate policing responses to those with learning disabilities and difficulties, mental ill health, epilepsy or who are on the autistic spectrum as well as other conditions which may compromise the ability to communicate and understand police actions or processes.

- The use of support card schemes should be developed by all forces and included in police training.

- Police training should address the particular stressors that affect women detainees and young women in particular.

- Custody procedures should be developed to lessen the impact of separation of mothers from young children. For example, supervised telephone contact around childcare issues should be prioritised and visits with children and their carers facilitated for longer detentions unless the nature of the alleged crime or the ongoing investigation prevents this. There should be monitoring of the extent to which police bail decisions take account of caring roles and the effects on the likelihood of absconding.

IPCC investigations

This chapter provides an overview of the history of the IPCC's creation and its 'Article 2 review' process since 2012. It considers the issue of IPCC independence and its use of former police officers as staff. The review noted that there is still a view among many families of those who have died in custody and of campaigners, lawyers and police

officers who spoke to that the IPCC does not always feel truly independent of the police or of police culture. It notes that if an independent investigative body is to succeed, it must have the trust of families, and the full cooperation of police forces It proposes a Deaths and Serious Injuries Unit, and addresses family liaison and bereavement training, disclosure to families, pre-interview disclosure to officers, length of IPCC investigations and IPCC involvement in the immediate aftermath.

INQUEST considers that the following recommendations contained in this Review are helpful:

- The creation of an expert Deaths and Serious Injuries Unit within the IPCC staffed by senior and expert officers from a non-police background to help address delay and problems with the quality of investigations.

- Ex-police officers should be phased out as lead investigators within the IPCC.

- Written information about sources of specialist support, including information about INQUEST, should be given to every family at the very first contact with an IPCC representative.

- IPCC staff should tell families immediately following the death of their loved one of the right to independent specialist legal advice, the benefit of securing advice from the earliest possible stage, and the right to seek a second post-mortem.

- IPCC staff should be vigilant about language and communication with families and of how their conduct and communication with police officers may be perceived by next of kin.

- The IPPC should urgently consider whether to adopt a formal time limit for the completion of Article 2 investigations, with the lead investigator obliged to set out in writing why an extension to this limit was required. Complexity and seriousness should not in itself be an excuse for unnecessarily long and protracted investigations.

- The IPCC should be resourced to provide a 24 hour national on call 'post incident' team with sufficient national coverage to ensure immediate response and attendance at a death or life threatening injury in custody within the shortest possible timeframe.

- Police forces should be held accountable at the most senior level for protecting the scene where there is a death or serious incident in custody and preserving evidence until the arrival of the IPCC. Any failure to fulfil this role should be treated as a misconduct issue. Failure to maintain CCTV cameras and audio equipment in good working order should carry a disciplinary sanction.

- Investigations should maintain a strong focus on obtaining independent evidence, including prioritising CCTV coverage, mobile phone video recordings and the existence of independent witnesses during the immediate aftermath of an incident as well as appropriate instruction of experts.

- Families should be involved on an ongoing basis in the provision of staff training in the IPCC, including training on the impact of a traumatic bereavement.

Police Conferral

This chapter examines the contentious issue of conferral between officers immediately following a death and before they produce their first accounts, whether deliberate collusion or mere contamination of evidence. The chapter examines police guidance, the most recent decision of the Court of Appeal and the IPCC draft guidance which proposes that officers should be separated as soon as possible until after their detailed individual factual account is obtained. INQUEST strongly supports the Review opinion that this is "entirely sensible and reasonable guidance" and that any officer involved in a death or serious incident should not confer or speak to each other prior to producing initial accounts.

- The IPCC draft guidance on post-incident procedures relating to separation of officers should be accepted by the Government

- Other than for pressing operational reason police officers involved in a death in custody or serious incident whether as principal officers or as witnesses to the incident should not confer or speak to each other following that incident and prior to making their initial account and statements on any matter concerning their individual recollections of the incident, even about seemingly minor details. As with civilian witnesses all statements should be the honestly held recollection of the individual officer.

- Body-worn cameras should be rolled out nationally to all police officers who may have contact with the public.

NHS Investigations

This chapter considers NHS investigations which take place alongside IPCC investigations, for example where police officers have restrained the deceased in a hospital or failings in healthcare services preceded police contact. The chapter considers the NHS framework for investigations and that there is no formal independent investigatory body for deaths in healthcare facilities including NHS hospitals and mental health detention settings. It notes that NHS investigations are often internal with the NHS Trust or healthcare facility effectively investigating itself and evidence that families were often frozen out of the investigatory process due to a defensive mindset inherent in NHS investigations.

INQUEST strongly endorses the following far reaching recommendations:

- Independent investigations should always be held for all Article 2 related cases on NHS premises where there has been police involvement, or where someone died after contact with the police.

- The Government should consider whether there is a need for a formal independent investigatory body for NHS Trusts in England and Wales.

- NHS Trusts should engage with families throughout their own investigations. There should be formal guidelines setting out the nature and expectations of family engagement.

- Where the NHS is only one of a number of agencies investigating the death involving both police contact and NHS contact with the deceased there should be early and regular communication and coordination to minimise confusion, loss of evidence and delays.

Medical care, inspections and external agencies

This chapter considers the quality of medical care in police stations, noting the critical role doctors must play within police stations and concerns expressed about poor quality medical care and a lack of consistency across forces. Inadequacies on the part of private healthcare providers and companies providing civilian detention staff are also addressed, along with the need for proper regulation of privatised services and the need to integrate them properly into police processes and training.

Most importantly the need for NHS commissioning of healthcare services in police stations is endorsed, the Review reporting that every stakeholder spoken to supported this commissioning, which was unexpectedly halted during 2016.

The establishment and implementation of joint protocols between police forces and external medical services such as hospitals and mental health services is also highlighted, along with the current limitations affecting the Independent Custody Visitors scheme.

INQUEST strongly endorses the following recommendations:

- Forensic Medical Examiners and other medical services within police stations should be brought within NHS commissioning, in order to introduce minimum standards of medical care in police custody and so that medical records are quickly available to the doctor.

- Privatisation of detention services should be avoided. Where private service providers are used the training of their staff should be to the same standards, preferably carried out jointly with police staff.

- Local joint protocols should be in place between all forces and their local ambulance service, mental health services and hospitals around 'crisis planning', particularly in respect of detainees suffering a mental health crisis and/or disturbed behaviour.

- The Government should consider whether Independent Custody visitor should have governance within HM Inspectorate.

Police misconduct

This chapter examines the complex topic of the police disciplinary system and importance of accountability. The chapter opens by acknowledging family perceptions that police sit above the law, and that a different set of rules apply to them. It notes that suspensions are rare and identifies the need for transparency if the police disciplinary system is to have any chance of commanding the confidence of either families or the public.

Importantly the Review identifies that the first step is to establish whether an IPCC investigation will be carried out as a 'conduct investigation' or not and that the threshold for this is low. It points out that campaigners believe that there is a reluctance on the part of the IPCC to consider criminal or disciplinary offences in contrast to the way civilians are treated if they meet the same threshold.

The Review addresses the opinion expressed by the Home Affairs Select Committee (HASC) on the IPCC that more officers should be interviewed under caution and the threshold applied consistently with civilians.

The Review correctly identifies long delays in the investigation and legal processes following deaths in custody as being highly damaging to cases and extremely harmful for families, for officers and for public confidence.

INQUEST fully supports the Review's recommendations:

- There should be a duty for police officers to provide full and candid statements at the earliest opportunity.
- Article 2 related cases should be dealt with in the same time scales as a civilian homicide case and the appropriate resources deployed by all agencies to achieve the completion of the investigation and decision making process within the robust timescale achieved in those other cases.
- In Article 2 cases the IPCC should, consider making a formal written request for the restriction of duties (in misconduct investigations) and the suspension of officers pending the outcome of gross misconduct and/or criminal investigations.
- The IPCC should publish criteria for deciding on whether police action amounts to misconduct or gross misconduct.
- The Government to consider whether a family's role at a misconduct hearing should be clarified and standardised.
- Once clear criteria have been made open and transparent, dismissal should always follow findings of gross misconduct unless there are wholly exceptional circumstances which justify a different sanction.

Prosecutions

This chapter notes the strong perception that families of those who die in police custody are not treated as 'victims' in the same way that relatives of murder or manslaughter would be and that the criminal justice system is resistant to and uncomfortable in treating deaths or serious incidents as a potential crime from the outset. It notes the lack of any successful manslaughter or murder prosecution following a police-related death. While the occurrence of a death in custody may cause great concern and shock within the police force, families feel that very rapidly that is replaced with defensiveness.

It looks at referrals to the CPS and communication between the IPCC and CPS and notes that concerns about delays and consistency remain. It notes concerns about bias on the part of prosecutors against prosecuting police officers and that CPS decision makers should be trained to identify 'unconscious bias' and that they must fully heed the 'merits based approach' to decision making

Delays, communication with families and the use of expert evidence by the CPS are also considered. Difficulties in obtaining evidence from forces are noted where there may be criminal responsibility by the police.

The chapter also examines the offence of Corporate Manslaughter, which has not been used since it came into force, and the protocol between the CPS, HSE and National Police Chiefs' Council.

INQUEST considers the following recommendations to be important:

- There should be an explicit duty of candour on the police to cooperate fully with all investigations into allegations against its officers.
- The CPS specialist unit handling prosecution decisions about deaths in police custody should be reviewed to ensure it is properly resourced with experienced prosecutors for consideration of such serious cases.

- There should be a formal meeting between the CPS, HSE, and IPCC within 14 days of a death or serious incident. The liaison should be formalised through a Memorandum of Understanding.

- In cases where the IPCC and HSE are actively involved, Coroners should hold prompt and regular pre-Inquest hearings requiring the agencies to liaise closely and account for the progress of their work and coordination.

Family Support

This chapter pays homage to the dignity and tenacity of families who have engaged with the inquest processes and struggled to bring about change. Aspects of the family experience are explored including: access to information and advice, police release of information to the public, attending inquests, counselling and support services, the role of INQUEST and families as a source of learning. The review notes that the involvement of families should not be seen as a matter of being sympathetic or benevolent to bereaved families. It is the duty of the state to ensure that their participation is meaningful and this extends to free legal advice assistance and representation.

INQUEST considers the following recommendations to be fundamental for families to participate effectively in the investigation, inquest and other legal processes:

- There should be access for the immediate family to free, non-means tested legal advice, assistance and representation from the earliest point following the death and throughout the pre inquest hearings and Inquest hearing.

- Before the IPCC has formally taken over an investigation the police should make no public comment on the matter. Unless there are exceptional circumstances which require the urgent release of information the police should not issue any information to the media, but should leave this to the IPCC.

- The Government should consider the feasibility of a scheme to pay reasonable travel and subsistence and compensation for loss of earnings for immediate family to attend the inquest in those inquests relating to deaths in police custody.

- The Government should ensure that families have funded access to appropriate bereavement services offering specialist counselling to families of the deceased and these services should understand the impact of a traumatic bereavement.

- Police forces, the IPCC, CPS, Coroners offices and the College of Policing should give consideration to how family experiences can be brought into training and awareness packages.

- All state agencies who are engaged with the family, including police, IPCC, CPS and Coroners and their staff should provide both oral and written information about support services, including INQUEST, to families as early as possible when contact is established following the death. Agencies should not assume that this has already been done by others.

The Coronial system

This important chapter examines numerous aspects of the inquest process including: inadequate resourcing, issues around the post-mortem, disclosure both to the coroner and to the family, coroner's investigations, pre-inquest reviews, the family experience, inequality of arms and prevention of future death reports. The chapter considers in some detail the establishment of a National Coroner Service and the calls for such a service by a variety of public bodies over many years.

A broad range of positive recommendations include the following:

- The Coroner and IPCC staff should tell families immediately following the death of their right to independent free specialist legal advice and specialist support and right to request a second post mortem.

- There should be access for immediate family to free, non-means tested legal advice, assistance and representation from the earliest point following the death and throughout the Inquest hearing.

- Consideration should be given to the creation of statutory time limits for the investigation by the agencies unless there are to be criminal charges made and the Coroner suspends the Coroner's investigation.

- Urgent consideration should be given to the mandatory video and audio recording of post-mortem examinations in contentious Article 2 deaths.

- The Coroner should provide information to families about the post-mortem examination before it takes place and the 2013 Coroners (Investigations) Regulations should be amended to allow for a second post-mortem examination as of right.

- There should be a presumption that families should have access to the body of the deceased as soon as possible even if this has to be through a screen or CCTV. Where this is not possible it must be explained with all the empathy, discretion and awareness of cultural and religious sensitivities. Steps should be to allow access once the forensic examination is complete.

- The Chief Coroner should consider issuing guidance on what constitutes disclosure of relevant information and, subject to the superintendence of the High Court, how Coroners should approach the issue.

- Families should be provided with a private space for the duration of an inquest and treated with respect and dignity. There should also be designated family space within the courtroom itself.

- The Chief Coroner should issue formal guidance to Coroners to prevent inappropriate or aggressive questioning of next of kin by counsel for interested persons at Inquest hearings. Coroners should be trained to be able to identify and prevent such styles of questioning where necessary.

- A nationally funded National Coroner Service should be urgently considered as a means to address persistent inconsistencies of service and the inability of Coroners to pursue investigations without complete reliance on the IPCC and other agencies.

- A specialist cadre of ticketed and experienced Coroners should be created to preside over Article 2 inquests, under the auspices of a National Coroner Service.

Sustained Learning

In the view of INQUEST this is one of the most critical chapter of the Review, examining long-term solutions to the many difficulties identified throughout the other chapters. It engages with the bigger picture on learning and accountability, noting a multitude of reports and reviews over recent years and how damning it is that the same issues are still being discussed. It notes that good local initiatives are not embedded nationally, lack of follow-up of coroners' reports to prevent future deaths, no co-ordinated way for coroners to share best practice and the painful frustration for families who are trying to ensure that no-one should have to go through the same experience again.

The report notes that Article 2 of the European Convention of Human Rights obliges the state to have independent investigations of deaths where there has been state involvement and it provides the opportunity to uncover institutional failings and potential wrong doing against individual citizens on the part of individuals who are agents of the State.

It notes that in looking at the conduct of many inquests over several years it is clear that the default position whenever there is a death or serious incident involving the police tends to be defensiveness on the part of state bodies. It points to the tendency of individual state agencies to attend inquests represented by their own barristers and legal teams who go on to adopt an adversarial style of advocacy, does nothing to reassure the public that the inquest truly is an inquisitorial process concerned. It emphasises that learning is important but accountability must also be addressed through the disciplinary and criminal system where there are failings amounting to offences.

For a great many years INQUEST has been calling for an effective national oversight mechanism that is able to embed learning from investigations and inquests.

The chapter identifies that only a proper implementation of actions in a nationally co-ordinated way can achieve assured learning and proposes an 'Office for Article 2 Compliance'. It questions whether the Ministerial Council on Deaths in Custody is fit for purpose, quoting INQUEST's view that it lacks the necessary resources, capacity and independence to fulfil its role. A new body would require an independent secretariat and would need to be appropriately resourced. The Review proposes that such a body would cover not just deaths in police custody but all deaths in state custody.

The following recommendations, if implemented, have the potential to introduce long-term sustained learning into the current fragmented system, to save lives now and into the future:

- The Government should consider the need for an independent Office for Article 2 Compliance, accountable to Parliament, and tasked with the collation and dissemination of learning, the implementation and monitoring of that learning, and the consistency of its application at a national level. It should report publicly on the accumulated learning and compliance arising from Inquest outcomes and recommendations. It should provide a role for bereaved families and community groups to voice their concerns and help provide a mandate for its work.

- An Office for Article 2 Compliance should oversee a coordinated, methodical and routine process around the dissemination of Coroners' PFD reports and jury findings to all stakeholders, including (but not limited to) police forces, the College of Policing, the IPCC, and healthcare professionals.

- The Home Secretary should provide an annual update to Parliament on the progress of the recommendations from this review.

- Police and Crime Commissioners should report annually on deaths and serious incidents in police custody in their jurisdictions.