THE PUBLIC INQUIRY

CONCERNING THE DEATH OF SHEKU BAYOH

QUESTIONS FOR DEBORAH COLES (INQUEST)

NOTES:

In answering the questions below, you are asked:

1. To draw as fully as you consider appropriate on your professional experience.
2. Where the position in respect of any of the matters below has changed over time, please distinguish clearly between –
    a. The position as at 3 May 2015.
    b. The current position and the developments which have led to it.
3. To comment on where, if at all, in your experience, the race, religion or ethnicity of the deceased person or their family is a factor.

To draw on any conclusions, recommendations or lessons learned from previous cases which you consider to be relevant.

Introductory questions

1. My name is Deborah Coles (DOB [redacted] 1962). I am the Executive Director of INQUEST[1], a post I have held since February 2017. I previously acted as Co-Director from 1994 and have worked for the charity since 1989. I sit on the cross-government Ministerial Board on Deaths in Custody, and I have a public appointment to the cross-government department sponsored Independent Advisory Panel on Deaths in Custody. I was awarded an honorary

[1] www.inquest.org.uk

doctorate for my work on human rights, social justice, and equality issues from the University of Essex in July 2023.

2. I was an advisor to the Corston Review (2007) which examined women in the criminal justice system women, the Harris Review (2015) which examined self-inflicted deaths of 18–24-year-olds in custody. I was appointed as the special advisor to the Chair of the Independent Review of Deaths and Serious Incidents in Police Custody, set up by the Home Secretary in October 2015. This review was published in October 2017 making 100 evidence-based recommendations to prevent future deaths. I have also been on the advisory group to the establishment of the Health Service Investigation Branch (HSIB) and to the Care Quality Commission's work on how the NHS investigates deaths in health settings. I am the author and co-author of several reports on the improvements needed to the oversight and implementation of lesson learning and accountability after deaths in custody and detention.[2] I have worked alongside families and their lawyers on such cases for over 30 years and have advised policymakers, parliamentarians, and human rights organisations at both a national and international level. I lead on INQUEST's strategic policy, legal and parliamentary work.

3. I have given evidence to numerous parliamentary committees and inquiries, most recently oral evidence to the Home Affairs Select Committee Inquiry into Police Complaints (January 2021) and the Justice Committee Inquiry on the Coronial System (May 2021).

4. As well as working in England and Wales I have conducted work in Scotland looking at the way in which deaths in custody and detention are investigated and the treatment of bereaved people. This has included meetings with the National Preventative Mechanism (NPM), HMIC and the Mental Welfare Commission and I have given written and oral evidence to the Scottish

[2] https://www.inquest.org.uk/learning-from-deaths-in-custody; https://www.inquest.org.uk/deaths-in-mental-health-detention

government Section 37 review of the way in which deaths in mental health settings are investigated.

5. I have advised NGOs working internationally. For example: I was part of a delegation looking at the investigation of police shootings in Brazil; spoke about police related deaths and women in prison at the Women Of the World Festival in Rio; delivered a paper to the United Nations on deaths of Black people in custody; contributed to an expert seminar on deaths of people on the migrant journey with the Last Rights Project; and helped inform the establishment of the Daphne Caruana Galizia Foundation and addressed a meeting of their lawyers group on our work and to assist their pro bono work on state related deaths. I am regularly consulted by the United Nations, most recently as part of their work looking at law enforcement, human rights, and racism.

Role of INQUEST

6. INQUEST is a charity and non-governmental organisation ("NGO") founded in 1981 to provide expertise on contentious deaths. We are the only charitable organisation in the UK that provides an independent, specialist, comprehensive advice service to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public on contentious deaths, their investigations, and the inquest and inquiry process, with a particular focus on deaths in custody and detention and other deaths raising questions about state and corporate accountability such as Hillsborough football disaster, and Grenfell Tower fire.

7. We work with bereaved families from the outset, supporting them through post death investigation processes. We co-ordinate a national network of over 400 lawyers, the Inquest Lawyers Group[3] ("ILG") who provide specialist legal

[3] https://www.inquest.org.uk/inquest-lawyers-group

representation for bereaved families. We hold regular roundtable meetings between ILG members and investigative bodies to inform discussions around best practice and raise issues of concern. This includes regular meetings with investigation bodies, the Prisons and Probation Ombudsman ("PPO"), Independent Office of Police Conduct ("IOPC"), and other relevant stakeholders including the HM Inspectorate of Prisons ("HMIP"), the Chief Coroner and the Crown Prosecution Service ("CPS").

8. Our specialist casework service gives INQUEST a unique perspective on the operation of the post death investigative system. This overview enables us to identify systemic issues arising from deaths and the way they are investigated; and understand how recommendations arising from individual deaths are followed up and changes made, both at a local and national level.

9. In addition, our focus on deaths in custody and detention means INQUEST holds knowledge on the operation of detention systems. Our knowledge and experience is extensive, detailed, and evidence based going back four decades. INQUEST's policy work and casework situates deaths in their broader social and political context. For example, we have carried out thematic areas of work on: deaths in women's prisons; deaths of children and young people, deaths of Black and racialised people in prison and following police contact; deaths in immigration detention; and, deaths in mental health settings. Our research shows that state-related deaths are not just isolated individual tragedies but, in part, related to historic and systemic issues such as structural racism, discrimination and other concerns such as inequality and poverty.

10. NGOs serve a vital function in monitoring deaths of detained people, and ensuring they are properly scrutinised, particularly where there are no family members present to demand openness and accountability. The incorporation of the European Convention on Human Rights ("ECHR") by the Human Rights Act (particularly Article 2 on the right to life) has had a considerable impact on the

rights of bereaved people and the way in which deaths in custody are investigated. There is an obligation on the state to conduct full, open, and transparent investigations into deaths, particularly where the person was detained. Such investigations should be public, independent and involve members of the family of the deceased so that they can participate effectively in the investigation. In practice this means more than merely informing them of the progress of investigations - it involves ensuring and enabling families' active involvement. INQUEST works to help families navigate these legal processes and supports them through their duration which can be many years.

11. A properly conducted investigation - in which the bereaved utilise their legal rights and can play an active part in the process - can expose the truth about what led to someone's death, and the identification of changes that need to be made. This can play a key role in families' grieving process.

12. I was contacted by Aamer Anwar solicitor a few days after the death of Sheku Bayoh who was aware of my work at INQUEST on other restraint related deaths following police contact. We have over 400 lawyers in our INQUEST Lawyers group who benefit from our extensive resources and information. Aamer joined this network in 2015. In the absence of any similar organisation in Scotland with expertise in this area, and with no funding available for legal representation I supplied as much information and resources on restraint related deaths and Article 2 investigations to assist the legal team. In the first instance I advised on the importance of a second postmortem and the expertise in this area of pathologist Nat Carey and Dr Maurice Lipsedge.

13. I attended several meetings with family members to share my experience and offer ongoing support through what I knew would be a protracted and complex legal process. I attended meetings with the family's Counsel and shared a variety of resources to assist them in their background research.

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14. I attended a meeting with the PIRC, the Lord Advocate Frank Mulholland, the Crown Office, and James Woolf the second Lord Advocate involved, all of whom welcomed meeting me because of my knowledge in this area. It became clear to me that there were real concerns with the rigour and independence of the PIRC investigation and the very limited scope of any subsequent Fatal Accident Inquiry. I worked with the family and their legal team to develop arguments for why the seriousness and complexity of Sheku Bayoh's death warranted a statutory public inquiry, with a broad term of reference. This involved meetings with the then Justice Secretary Humza Yousaf and First Minister Nicola Sturgeon. I have also shared my experience on restraint related deaths and their broader context to public meetings and the media.

15. INQUEST has identified how the search for the truth after a police related death in Scotland is protracted and complex, wherein families often face significant obstacles. I have been conducting some scoping work on the investigation of deaths in custody and detention in Scotland, as well as supporting some bereaved families and their legal teams after such deaths. As a result of this work I have concerns regarding: the absence of any similar organisation to INQUEST to support bereaved families; the lack of independent, specialist advice on families' Article 2 rights, lack of support to bereaved people and non means tested funding for their legal representation; delays in the Fatal Accident Inquiry process and their limited scope; and the lack of public reporting and scrutiny of police related deaths and of the policing of Black and racialised communities.

16. In this regard, this statement and its findings and recommendations for best practice should be considered by all those with a role in investigating and scrutinising state-related deaths such as the Police Investigations and Review Commissioner (PIRC), the Crown Office, and the Fatal Accident processes as well as more broadly Police Scotland, the Scottish prison service, and the National Preventative Mechanism (NPM) Scotland, involving inspection and oversight bodies concerned with places of custody and detention.

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What are INQUEST's principal ways of meeting their aims and objectives?

17. INQUEST meets its aims and objectives through our unique integrated model of working which covers:
    a) **Family casework:** We advise and support bereaved families to navigate the complex investigations and legal processes and work with them to establish the truth concerning the circumstances of the death.
    b) **Family Engagement:** We work in partnership with families to shape services, foster peer support and solidarity, set the agenda and create a movement for change.
    c) **Policy change**: We use the evidence gathered from our casework, alongside research and statistical data, to expose failures and achieve systemic and legislative change.
    d) **Influencing**: We exert pressure on public bodies to ensure accountability and reduce the numbers of deaths. We work with the media to shine a light on failings. We provide expert evidence in strategic litigation leading to significant legal developments.
18. A fundamental principle underpinning all our work is the empowerment of families to effectively participate in the legal process and influence policy and practice change.

How is INQUEST funded? How does the output of your organisation compare to its level of resources?

19. INQUEST does not take state funding to protect our independence. We are funded through a mix of income streams, the largest of which (between 78-85% year on year) being Trusts and Foundations. We also receive a significant number of donations every year and manage to secure a substantial amount of earned income, through the membership fees from the INQUEST Lawyers Group, fundraising events and training we provide to external stakeholders. From time to time, we are commissioned by statutory bodies and other

organisations to deliver discrete projects, such as family listening days and research projects. The funding landscape having become increasingly challenging, we tend to only secure income to sufficiently cover our expenditure budget, which means that our level of reserves remains low (between 2 and 3.5 months).

What experience does INQUEST have in relation to legal proceedings, including public inquiries, concerning deaths in following contact with the police?

20. INQUEST has intervened in many significant cases involving the police and deaths in custody. I have provided witness statements on behalf of INQUEST following state related deaths and involving concerns about the investigation and inquest processes and I have given witness statement regarding several public inquiries including the ongoing Brook House Inquiry and the Grenfell Inquiry. In respect of legal proceedings involving the police and deaths in custody there are two cases:

    a) Supreme Court case of W80[4]– joint intervention of INQUEST/Stopwatch.

    b) A Witness statement in the case of Chief Constable of West Yorkshire Police and Others v Dyer and Others: CA 27 Oct 2020 R v Dyer[5] concerning open justice and the screening of police witnesses from the family in the case of Andrew Hall, a Black man who died after being in police custody in September 2016. This was judicial recognition of the powerful importance of open justice, the significant public interest in the investigation into the death of a black man in police custody, the need for catharsis for the family, and other factors. [see paras 115 to 127]

[4] R (on the application of Officer W80) (Appellant) v Director General of the Independent Office for Police Conduct and others (Respondents) (supremecourt.uk)
[5] https://www.bailii.org/ew/cases/EWCA/Civ/2020/1375.html

What is your professional experience of legal proceedings, including reviews and public inquiries concerning deaths following contact with the police?

21. I was appointed as the special advisor to Dame Elish Angiolini, Chair of the Independent Review of Deaths and Serious Incidents in Police Custody, set up by the Home Secretary in October 2015. This review was the first inquiry to look specifically at deaths and serious incidents in police custody and was published in October 2017 making 100 evidence-based recommendations to prevent future deaths. I was engaged in this work for 18 months and helped inform its terms of reference, the membership of its reference group and those we consulted with. This also ensured that the voices of bereaved families were heard through a family Listening Day in which Dame Elish Angiolini was able to hear firsthand about families experience post death through to the conclusion of legal processes. The Review heard extensive evidence from a variety of other stakeholders about the broad issues impacting on deaths and their investigation including family and state lawyers, policing organisations, coroners, as well as oversight and monitoring bodies. The Review made a series of recommendations pertinent to this Inquiry, some of which I draw on in this statement.

22. I was also on the expert panel to the Independent Police Complaints Commission (IPCC) in its review of cases involving a death following police contact set up by Dame Anne Owers in 2012.

23. I am currently a member of the reference group to the cabinet office review of the Independent Office of Police Conduct (IOPC), established by the Home Secretary in June 2023.

24. I meet regularly with the IOPC senior leadership team and INQUEST convenes meetings with our lawyers and the IOPC to feedback concerns and issues relating to the investigation of police related deaths.

Informing bereaved families of a death

- *In your experience, what are the main issues that arise in relation to how family members are first informed about the death of a relative following contact with the police?*
- *What issues, if any, arise about the delivery of "death messages" to family members:*
  - a) *The timing of death messages.*
  - b) *The accuracy of information provided to family.*
  - c) *Failures to inform family members about a death.*
  - d) *The way messages are delivered.*
  - e) *By whom the messages are delivered.*
  - f) *The delivery of death messages with appropriate religious and/or cultural sensitivity.*
- *Focusing on the immediate aftermath of an incident, how would you describe the most common concerns of bereaved families in relation to ("the initial account"), particularly with regard to:*
  - g) *The amount of information bereaved families receive about the circumstances of a loved one's death.*
  - h) *The accuracy of information given to bereaved families about the circumstances of a loved one's death.*

Overview

25. Whilst many of us will experience the death of a close relative, few will experience the death of a loved one in the care and control of police and with a subsequent investigation, inquest, or other legal processes. This compounds the state of shock and confusion.

26. Many bereaved families have reported negative experiences of post-death procedures at a time of great trauma and vulnerability and in circumstances

that are outside their previous experiences. The most frequently cited complaints that continue to the time of writing include lack of early or indeed any information, misinformation, the inappropriate manner of notification and delays. This also includes lack of information about the location of the body, the identification of the deceased, the postmortem, and processes to follow.

27. The difficulties families face begin within moments of being informed that their loved one has died in police custody with what families have described as the '*information deficit*'. Often the deliverer of the death message has no information about the circumstances of the death nor whom the family should contact to get more information. In some instances, families are given incorrect or inconsistent accounts. There is a paucity of information available to families about their legal rights. The body of their loved one is under the legal control of the coroner, all the information about what happened is with those involved including police forces and families typically describe a wall of silence.

28. Information is inconsistently administered, ad hoc, absent or late in being offered. Families, desperate to get answers both about their loved ones and what happens next, are offered little by way of practical advice and are not always signposted to places where they can get access to specialist advice and support.

29. Many families report how they felt abandoned and left feeling bewildered once they had been told about the death, an absence of human contact and compassion which contributed to the distress that the family experienced both at the time the news was given and afterwards.

30. Some bereaved families have made the point that on first hearing of the death of their relatives, they felt numb and were *"unable to take things in".*

Signature of witness..... [redacted] .....

Family Voice [6]

"We were given nothing. It was like a black hole; you feel like you've been swallowed".

"The following day the IPCC came, they had no information, nothing about what happened to her, why she was even detained".

"The IPCC didn't give us any information whatsoever about what had happened. They didn't give us any information about what would happen. There was no support, no transport".

"A counsellor told us about INQUEST but it was too late for us. Twenty-six months down the line we'd had no advice and support. Crucially, few families received advice on legal matters, specifically whether a solicitor was required: *"I asked the police 'do I need to get a solicitor' and they said 'it's up to you, most families don't."*

31. The information vacuum leaves families struggling to make sense of what is going on and in the absence of state support it's easy to become isolated and left to become their own investigators, such as in the following example:

"Every night, seven nights a week after coming home from work and I had nobody to bounce it off. I was looking on Google because I didn't understand what things meant. I was very ill equipped for the process, so out of my depth".

32. Underlying families' testimony is the common theme that the families of those who have died in custody, of *"state crime",* are not provided the same support services as other victims of crime. Therefore, the degree of assistance they

[6] Angiolini Family Listening day 2016
https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=aa0df9a7-5fc6-410f-9650-f39248b51de6

receive is ad hoc, with many left isolated and alone whilst others can secure good quality advice and support through working with INQUEST and specialist lawyers.

33. There is no requirement on the police who often deliver the death message, coroner's officers or IOPC staff to refer families to INQUEST, suggest that they seek legal representation, provide them with contact details, or make families aware of their rights in relation to for example, the post-mortem (other than the fact that a post-mortem will take place and when and where this will occur.) The combined effect of these issues means that as well as dealing with their grief, families may be anxious about their lack of understanding of the legal process.

34. A death following state contact with its associated complex and protracted post death processes disrupts the natural process of grieving. The provision of early independent advice on these processes gives families the opportunity to grieve and carry out post death rituals knowing that their interests are being represented.

35. On several occasions families found out about the death from social media, local TV, and radio news before being notified officially. Delay in being informed of the death creates suspicion for many families that the police are spending time creating a 'story' before information about the death emerges. Some families report that before the involvement of the IOPC has begun the local force has contacted close family members to seek information about the deceased. This is seen as an attempt to investigate or discredit the deceased.

36. Whilst many negative experiences of families prevail there is some good practice, which can make a considerable difference to the confidence in the processes moving forward and set the tone for future engagement.

Signature of witness..... [redacted] ...

Family voice

'We were met at home by IOPC officials the day after our loss. We were given a booklet which was very helpful and informative it has to be said.'

37. Sadly, this is not the norm despite the availability of various guidance documents including the Guide to Coroners Services for Bereaved People[7], the 2019 Home Office leaflet[8] produced with family input and sets out the right to representation. These guides are often not provided to families with coroners and coroner's officers deciding it is too soon to signpost families, contrary to what families have told INQUEST over four decades. It is interesting to note that the PIRC[9] leaflet for bereaved families makes no mention whatsoever of their legal rights to play an effective role in the investigation, nor that they may wish to appoint a solicitor.

Best practice

38. In order to facilitate their effective participation in legal processes following a police related death, including the post mortem, investigation, inquest/fatal accident inquiry:

a) All forces and the independent investigation body should agree protocols to prioritise notifying the family as soon as possible when someone is hospitalised following police contact or where a death occurs. Where possible this should be done face to face.

b) All families should be provided with written information about support services and their legal rights.

c) Families should have access to free, non means tested public funding for advice and representation from the earliest point following a death and throughout the inquest to the conclusion of the legal processes.

[7] A Guide to Coroner Services for Bereaved People (publishing.service.gov.uk)
[8] Deaths in police custody: leaflet for families (accessible version) - GOV.UK (www.gov.uk)
[9] https://pirc.scot/media/4904/pirc_a_guide_for_families_web.pdf

Signature of witness..... [redacted] .....

Family Liaison Officers (FLOs)

- *What do you understand to be the role of a Family Liaison Officer ("FLO")?*
- *How would you assess the importance of that role, from the perspective of a bereaved family? In your experience, what skills and personal qualities does the FLO role require?*
- *What factors undermine the effective performance of a FLO?*
- *To the extent that it is not addressed below, how does the possibility that a death has occurred following contact with the police affect the relationship between a FLO and a bereaved family?*
- *In your experience, what challenges are presented to the relationship between FLOs and families? What do you see as the typical reasons for such breakdowns?*
- *How could this liaison between the police and the family be improved, bearing in mind your knowledge and experience of concerns families have when a family member has died after contact with the police?*
- *In your experience, where it occurs, what are the effects of friends or family members becoming the subject of police interest and/or investigation in the aftermath of a death in custody on (i) the investigation of the death and/or a family's experience or perception of it?*

39. The well-established role of a police FLO is to support victims of crime, primarily homicide, road fatality, mass disaster or other critical incident and other deaths that do not involve the conduct or actions of police officers contact and where they may well be evidence of wrongdoing or criminality. This role has not translated well for those families who have been bereaved following police contact. Alongside their support role, the FLO is also an investigator and an evidence gatherer. Families are not always aware of this and so tensions can arise when families perceive a lack of transparency. The FLO role is often confusing and at worst intrusive.

Signature of witness..... [redacted] .....

40. Where families are legally represented the role of a FLO often becomes redundant with lawyers communicating directly with the investigator, coroner, and family members.

41. The most common observation from families about the FLO role is underpinned by a wariness and suspicion that FLO's are police officers from the same police force involved in their loved one's death. A FLO from the very police force under investigation has a clear conflict of interest and their investigative role sits uncomfortably when it is their colleagues who may well be the subject of the investigation. Many families believe the closeness of these relationships blurred impartiality and their primary function was to try and find out as much information as possible.

42. Families have described how they felt they were being investigated, or how the FLO tried to secure information from them and about their loved one to report back to the police and investigation team to shape the narrative and to try and discredit them or justify their treatment. FLO's have been defensive and failed to understand or appreciate the trauma and grief of a bereaved family particularly so soon after a death. Families have reported a sense that they were *"spying on them"* rather than providing a neutral and supportive role to the family. This has undermined trust and confidence, the result of which is that the relationship has broken down. As well as this it was very often the investigators themselves, rather than the FLO, who was the individual with the relevant information on progress of the investigation being undertaken which often made their role redundant.

43. For anyone carrying out the FLO role, independence is crucial. It is inevitable that the family will be desperate to find out as much as they possibly can as soon as they possibly can and highly likely that the family will have serious concerns about the circumstances of the death.

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44. In respect of IOPC family liaison some families do report positive experiences of how they are treated by the IOPC through investigations, in particular being kept updated on progress and provided with timely information. However, many families report negative experiences and tell us of the additional emotional burden placed on them because of the way the IOPC performs its role. Bereaved families are unlikely to have experienced IOPC processes prior to the loss of their loved ones, and so enter these processes unprepared. The way family liaison officers and investigators prepare them for what will be difficult and traumatic experiences – such as seeing their loved one in a mortuary or receiving detailed descriptions of what happened – is crucial.

45. Where families have been provided with an FLO, it is necessary for the FLO to be equipped with information in relation to all aspects of the post death investigation – from viewing the body, postmortem, release of body the role of the investigation, and as a priority to ensure that families are signposted to relevant emotional, legal, and practical support. Families want the right amount of information delivered at a pace that suits their needs and not the police or other investigation bodies. FLO's need to be contactable and available at times that suit the family – not simply at the end of a phone but able to respond in person as required and to ensure that they have listened to families' questions and answered them where possible and if not provide an explanation as to why not.

46. This information should also be provided in writing so that families can review at a later stage and a facility of an interpreter or materials to be translated for those whose first language is not English. Likewise, consideration must be given to neurodiversity and accessible formats. They also need to understand and recognise family dynamics and that often the responsibility for informing other family members on progress falls to an individual. The FLO can also help ensure that a clear timeline is provided and within which answers will be

provided and if it emerges that that timetable is not going to be met, sensible reasons provided.

47. One of the challenges in police related deaths is the proliferation of people the family encounter and the complexity of the legal processes. As one family commented *"Knowing who to trust is one of the biggest things.*

48. Trust and independence are key. A lawyer can act as an effective conduit between these but in their absence, families must navigate this alone. In the absence of independent advice and following often negative experiences of being told of a death, families often find it hard to establish trust. Families are often inevitably suspicious of information which often comes from employees of the very state agents/ institutions being investigated.

49. Accordingly, the response of the FLO must be to avoid defensiveness and attempts to justify the conduct of the institution or the officers concerned. The FLO can never be an apologist for the police. The starting point for the FLO should be that something has gone terribly wrong and that it is likely that some errors have been made until proven otherwise.

50. FLOs should ensure that families are provided with clear and accurate information about the circumstances of a death from the very beginning regardless of the brevity of information. Families report incorrect information being provided to them before it was verified. Where there is little detail, the FLO must ensure that it is clearly communicated to families.

51. The FLO should provide and talk families through the IOPC guide. Far too often families are handed another booklet at a time when they are in a state of shock. It is important that the FLO walks a family through the next stages in an empathetic calm manner.

Family voice[10]

"We were assigned a Family Liaison Officer, but her role wasn't clear to us as she didn't liaise with us at all. She didn't explain the process of going to see Jake at the mortuary and when we were there, she didn't help at all, for example she didn't answer our questions about the bruises we saw all over Jake's body." Alison Anderson

"They also need to have more empathy with victims, it often felt like individuals and the organisation forgot they were talking about investigations of loved ones. There are exceptions but in general that was my feeling". David Ridley.

Best practice

52. The following is a summary of the key points of best practice in respect of FLOs:

    a) Clarity from the outset of the role of the police FLO.

    b) Signposting to independent advice and support - the provision of advice and support both orally and in writing about the processes that will follow a death – from the identification of the body, their rights regarding the postmortem and release of the body. The leaflet[11] co-produced with INQUEST, the Chief Coroner's office, Ministry of Justice, National Police Chiefs Council is a blueprint for the type of information that should be provided in an accessible format to bereaved people and made available in different languages and easy read versions.

    c) All families should be advised of their rights to legal advice and representation. All agencies in touch with bereaved people, including police, independent investigators, coroners, and their staff and the Crown Office should provide written and oral information about support

[10] Written evidence submitted to Home Affairs Select Committee Inquiry by INQUEST, Police Action Lawyers group, and INQUEST Lawyers Group October 2020

[11] Deaths in police custody: leaflet for families (accessible version) - GOV.UK (www.gov.uk)

services, including INQUEST, to families at the earliest opportunity and not assume others have already done this.

d) IOPC or investigation Family Liaison Officers should proactively refer families to INQUEST at the earliest opportunity.

e) Training on the specific needs of those bereaved after a death in police custody adopting a trauma informed approach and involving bereaved people themselves and those working with them.

f) Clear protocols for the structure of the relationship of the police FLO with the independent investigation body and all others involved in a death, to include families' legal rights, the role they can play and their right to legal representation, proposed timescales for disclosure of information and completion of the investigation. Furthermore, a clear explanation on the different roles and responsibilities of those with whom bereaved people will meet and to ensure they are clear about the purpose and function of meetings. Continuity of support is also important.

g) Bereaved people should be treated with dignity and respect, empathy and compassion and the consideration that any bereaved person should expect. This is a skilled role and requires proper training, clear protocols, and input from bereaved people themselves.

Signature of witness... [redacted] .....

The post-mortem

- *How would you describe the common experiences of bereaved families in relation to communication regarding post-mortem examinations?*
- *To the extent that you have not addressed it above:*
  a. *How would you describe the experience of bereaved families in the identification process and what are common concerns?*
  b. *How would describe the experience of bereaved families for whom a death engages particular religious or cultural rites?*
  c. *How would you describe the experience of, and common concerns of, bereaved families who wish to view their loved one's body after death?*
- *What, if anything, would you consider to be best practice in relation to issues that you consider to have arisen in relation to post-mortems?*
- *What support, assistance and information could be given to families prior to and after viewing the body that would help them?*

Overview

53. The experience of knowing that their loved one is being subjected to a post-mortem is particularly sensitive, painful, and traumatic for families. It is essential that families are told immediately about the post mortem process and their legal rights within that process prior to the post mortem being carried out.

54. By failing to give families information on the legal process that follows deaths and their rights in that process families are already at a distinct disadvantage. Many families have reported that by the time they were told about the post-mortem it had already taken place. The family have a right to have a medical practitioner present at the post-mortem. However, there is no opportunity to do this if they are not made aware that the post-mortem is being conducted. Families will also be distressed by the invasive nature of a forensic postmortem particularly if there are significant delays before the body is released.

Signature of witness [redacted] .....

55. Furthermore, many families have been told that they cannot view the body or can only view it from behind a screen. Others described the pain of having their loved one's body described as belonging to the coroner/the state. Whilst this is legally correct it can be explained with sensitivity and the coroner must also explain the reasons for any delay in releasing the body for burial and cremation.

56. Initial steps should be taken immediately after a death has taken place to give the family the opportunity to attend the mortuary to see the body and say goodbye to their loved one. Arrangements can be made to ensure no forensic evidence is compromised and families will understand the need for caution to ensure this.

57. Families do not always have the post-mortem procedure explained to them so that they remain unaware that organs such as the brain and the heart have been removed for examination. Major concerns about the standard of postmortems and the removal of body organs and samples were raised in the Alder Hay and Shipman Inquiries which led to detailed legislation being passed to govern the process and the establishment of the Human Tissue Authority. Some families may wish to have these returned to the body prior to burial, sometimes for religious and cultural reasons. Other religious and cultural post death rituals such as the washing of the body should also be enabled where possible to do so. Any delay in releasing the body must ensure that it is properly looked after and preserved in the mortuary. In my experience families will understand postmortem processes if they are explained with sensitivity and compassion.

58. Families often face significant delays of many months before they receive an initial cause of death or postmortem report, particularly where the cause of death is contentious and additional testing of tissue samples is required.

Current delays are compounded by a shortage of pathologists and toxicologists adding to the existing backlog. Such delays cause additional distress and trauma to families wishing to lay their loved one to rest.

59. It is crucial that families are informed of their right to request a second postmortem at the earliest opportunity. This is particularly important when considering deaths following the use of force and restraint/positional asphyxia, but also in other deaths where there may be a high level of mistrust about the cause of death. The mechanism of death under or after restraint is complex and has long been the subject of conflicting expert opinions and issues of restraint, pathology and psychiatry are debated after every death, including the highly controversial and contested cause of death 'excited delirium'. The pathologist appointed by the coroner/Crown may only have been provided with the police version of events which may be partial and one sided. A second postmortem by a pathologist with expertise in this area of restraint related death can both assist the understanding of the death and help allay a family's fears. Too many of these have been wrongly attributed to heart disease or excited delirium and the role of the family's pathologist has often been crucial in the identification of positional/restraint asphyxia.

Best practice

a. Families should be informed well in advance of the date, time and place the postmortem is to take place, its purpose and what it will entail, particularly if toxicological and histological samples and body organs are to be retained.

Signature of witness..... [redacted] ....

b. They should be advised of their rights to have someone attend on their behalf and given the time and funding to arrange a second pathologist to attend.

c. All briefings to pathologists should be in writing only and should be disclosed to the family and their lawyer.

d. All post-mortems in death in custody cases should be video and audio recorded.

e. Families, through their lawyer or GP, should be provided with a copy of the postmortem report and any other expert reports.

Signature of witness... [redacted] .....

Media engagement

- *What are the common concerns that families have in relation to media reporting of deaths following contact with the police?*
- *What is your experience of media engagement by the police and/or Police Federations, where a death has followed contact with the police – in particular, are there any common themes arising out of such media engagement?*
- *How would you describe the common experiences of bereaved families in relation to the media, particularly including the following:*
  - *The representation of their loved one.*
  - *Friends and family members of the deceased.*
  - *The representation of the police and/or other state bodies.*
- *The release of information to the press, in particular before that information has been shared with the family of the deceased.*
- *What steps, if any, are you aware of that can be taken to alleviate these concerns?*

Overview

60. The most common concerns that families report are the use of misinformation and 'spin' which has been a long-standing feature of many contentious deaths in custody.

61. Families have regularly reported that before the involvement of the independent investigation has started, the police force has very quickly sought to defend its position by releasing their narrative about events to the public before the basic facts have been established.

62. There are numerous examples of this, some of which INQUEST included in a submission to the Leveson inquiry in where we described*: "a recurring issue of concern to bereaved families and the people who work with them:*

misinformation following deaths involving the use of lethal force by the police". They highlighted that "misinformation about such contentious deaths not only damages bereaved people; but it also undermines public confidence in authorities. Misinformation following contentious deaths makes it hard to allay any suspicions of wrongdoing and failures in the minds of bereaved families and the public at large. As well as obscuring the picture of what happened, misinformation fuels fears that the state is attempting to deliberately prevent information about its own culpability in deaths becoming publicly known"[12].

63. Many families have described how they felt that instead of the death of their loved one being investigated it was their private life and that of their relative that was subjected to the most scrutiny. Families regularly find that as well as promoting their own version of events, police sources have briefed the media with prejudicial, irrelevant and in some cases inaccurate information about the deceased, intended to besmirch their reputation and blame them for their deaths to deflect attention away from the acts or omissions of police officers or public bodies, instead focusing on "problem" or "dysfunctional" families and the deceased's "criminal" or "anti-social" behaviour.

64. Families reported having to defend not only their loved one but themselves against racialised stereotypes from the outset and how they faced negative media reporting and inaccurate police statements that started in the immediate hours after a death had occurred.

65. These attempts to demonise the person who has died and build up a negative reputation creates the idea of an "undeserving" victim. Once this false narrative seeps into the public consciousness through the media it is difficult to challenge. We have no doubt that police statements to the media, in the

[12] INQUEST Statement to Leveson Inquiry (Module 2), dated 28 March 2012, paras. 7 and 10.

immediate aftermath of a death in police custody, and during inquest processes, play a key role in undermining families' confidence in the process. Worse, they can hamper the system's search for truth, and in the most serious cases, lead to the promotion of an accepted public narrative of events that is simply untrue, but which families find it hard to dislodge. The focus of a police force typically becomes how to defend its actions, rather than to assess whether in fact its actions fell short of expected standards and what learning and improvements can be made.

Family voice[13]

"They said that my son was some maniac, that story was put out in the paper before I knew he was dead."

"The police and media would like to paint a picture and provide justification and families have to keep their mouths shut."

"They said he was a gang member. We asked them to tell the paper to withdraw this information as everyone was saying he deserved to die. Everyone had an opinion".

"In the meantime, police and press were very active in the press releases, they were trying to deflect any criticism of him".

66. Families also reported that information given to the press is not always accurate with incorrect name spelling, their age, etc, factual inaccuracies that at first might seem trivial but undermines faith in the police's ability to get facts right.

[13] IPCC Family Listening Day report 2014

Best practice.

a. Consideration should be given to preventing a police force whose officers' actions are being considered in an independent investigation from commenting on the matters in issue to the media at all.
b. There should be no contact between the local force and bereaved family where an independent investigation is to take place and they should be the main source of contact after a death. Where this is felt to be necessary it should be agreed with the IOPC and family/lawyer.
c. Any press release to be issued by the IOPC/PIRC should be agreed in advance with the family of the deceased.
d. Inappropriate media briefings by the police should be commented on in the independent investigation and should be considered as a misconduct issue.

Post incident management

- *Are there, common experiences or concerns of bereaved families in relation to the aftermath of a death following contact with the police? If so, how would you describe them?*
- *To what extent, if any, have the following issues arisen in your experience of cases concerning deaths following contact with the police; and if they have arisen, what is your assessment of their impact on their relationship and engagement with the families?*
    a. *The status of officers in the aftermath of an incident – whether as witnesses or suspects.*
    b. *Issues arising in relation to or arising from legal advice and taking accounts from officers.*
    c. *Issues of candour.*

Signature of witness..... [redacted]

d. The taking of initial accounts (the completion of notebooks; obtaining operational statements; or taking witness statements) from police officers.

- *What would you consider to be the main issues that impact family involvement in post-death investigations?*
- *What, if anything, would you consider to be best practice in relation to post-incident management and any issues that you have referred to above?*

Overview

67. The confidence of families, local communities and the wider public continue to be undermined because of the significant concerns about the post incident management that continues. The overriding need identified by bereaved families is to establish the truth about how they died, to hold those responsible to account for any wrongdoing, criminality, or systemic failure, and to bring about changes to prevent others going through a similar experience. Those objectives are ones we should expect from the processes for holding the police to account at an individual and corporate level. However, all too often we see families that have been failed by the very systems that should deliver police accountability, particularly when contact with the police has resulted in a death. This is not just about the independent investigation body but the role of other agencies including the Crown Prosecution Service, the Coroners Court and the Health and Safety Executive, and police forces and the Police Federation themselves.

68. INQUEST has documented how there has been an institutionalised unwillingness to approach deaths in custody as potential crimes from the outset, resulting in loss of forensic evidence identification of witnesses, and ability to probe police officers' accounts of events. Families want cases to be dealt with as a disciplinary or criminal investigation from the outset where it appears on the face of it to have been potential disciplinary or criminal

offences. They should be entitled to expect that the correct procedural steps are taken to ensure the integrity of those proceedings in the event that prosecutions or disciplinary proceedings are ultimately brought.

69. When it comes to evaluating the actions of police officers, many bereaved families and clients experience a sense of IOPC bias towards the police, particularly where decisions are made from the outset that investigations are not criminal or disciplinary investigations. This perception is in part because some of the IOPC's staff are ex police officers,[14] an issue which is constantly raised by families as being at the heart of their perception of bias and lack of independence. The IOPC's structural independence from the police is undermined by this lack of cultural independence. This can be manifested in the IOPC taking an overly cautious and conservative approach, and a lack of robustness and rigour in decision making when investigating the actions of police officers who are unable to provide a reasonable explanation for their actions. This has been a long-standing issue and one reflected in the Casale review, Home Affairs Select committee inquiry into the IPCC (2013) and the Angiolini Review.

70. As the Home Affairs Select Committee[15] said in its report in 2013 on the IPCC: *"The issue of interviewing officers in cases involving death and serious injury is indicative of a culture of treating officers differently from members of the public. Where officers are not interviewed promptly under caution, this can lead to weaker evidence and loss of confidence in the process of investigating serious matters such as deaths in custody. The application of the threshold test for special requirements should be reviewed, so that officers are routinely interviewed under caution in the most serious cases, exactly as a member of the public would be."*

[14] IOPC: Nearly 200 ex-police work at 'independent' police watchdog | openDemocracy
[15] https://publications.parliament.uk/pa/cm201213/cmselect/cmhaff/494/49409.htm

Signature of witness..... [redacted]

71. Obtaining and preserving early evidence is crucial to the integrity of the investigation and there is a risk that immediate evidence gathering will be compromised for want of family involvement and a lawyer to ensure that basic protocols and best practice is being followed. Delays can lead to loss of this evidence, body-worn video (BWV), clothing, Tasers, irritant spray, batons, handcuffs, and spit and bite guards, and the identification of key witnesses, for example footage being deleted, or witness memories becoming impaired because of delay in their identification. The failure to promptly preserve a potential crime scene is an example of how these deaths are typically not treated as potential crimes from the outset. The starting point of any investigation involving death, particularly after the use of force by police officers, should be to treat the incident as if a potential wrongdoing or criminality has arisen until the evidence proves otherwise. Families we support will not have had an opportunity to obtain this evidence themselves and are more often than not reliant on the IOPC's disclosure. Failure to gather evidence promptly and risking its loss is a complete denial of justice for people who look to the investigation to establish how their loved one died.

72. If the IOPC do not assess the case as subject to 'special procedures' from the outset and serve disciplinary notices upon the officers, the investigation will be an independent investigation but not a disciplinary one. Accordingly, the IOPC will then be prevented from interviewing the officers under caution and ultimately making a referral to the CPS even if the evidence does meet the relevant threshold. This failure from the outset - which has occurred in a number of cases including the investigation into the police restraint death of Olaseni Lewis[16] has meant that it is then incumbent on the family to apply to the High Court to quash the investigation which ultimately leads to further delay.

[16] https://www.inquest.org.uk/olaseni-lewis-ipcc-investigation-quashed-by-high-court

Signature of witness... [redacted] .....

73. The lack of cooperation and candour of police officers is one of the most contentious issues concerning deaths in police custody. The perceived reluctance to be interviewed or for the IOPC to interview under caution arises in most cases. For most families, this goes to the heart of the issue of independence and why it is that police officers are treated differently to other citizens. We are also concerned that the efficacy of IOPC investigation is frequently undermined by the absence of candour shown by police officers under investigation. It is common for IOPC investigations to face significant delays while officers under investigation are interviewed, only for the officers to give 'no comment' interviews, occasionally accompanied by short-written statements.

74. As the Home Affairs Select Committee noted in February 2022: "*There is a clear absence of urgency and a culture of non-cooperation from some police forces involved in investigations.*"

75. Very significantly for families, the IOPC often miss the opportunity of ensuring that officers write their early first accounts without collusion or ensuring that any debriefing meetings are not merely an opportunity for officers to rehearse their evidence in front of each other (getting their story straight) before recording their accounts. Police officers are usually the only witnesses to key events preceding the death and the integrity of their accounts is therefore critical to the integrity of the investigation overall. So long as officers remain together following a death many families will have suspicions which undermine their faith and confidence in the investigation. Concerns about officers need for support and welfare considerations can be fully addressed by any relevant person to meet those needs so long as that person or persons were not witnesses to the relevant events.

76. The Casale review 2013[17] into the death of Sean Rigg said: *"The Review considers that, in the interests of an effective investigation, the arresting police officers should have been separated and instructed not to speak or otherwise communicate with each other about the events until the IPCC was able to take detailed initial statements from each. This should be standard practice in cases of deaths in police custody. Such a safeguard would not preclude any necessary support being provided to each officer individually by appropriate other people."*

77. It is often the case that the Body Worn Video is turned off following an incident and therefore objective evidence capturing post-incident procedures is lost. In many cases the police officers involved in an incident leading to a death (including where use of force has caused or contributed to the death) have remained together following an incident, under the supervision of the local force and with officers receiving early joint and shared input from Police Federation representatives and lawyers.

78. This has also been the subject of critical comment by coroners following police related deaths. For example, following the shooting by police of Mark Duggan in 2011, the coroner HHJ Cutler who preside over this inquest in 2014 prepared a report to prevent future deaths in which he raised concerns that comprehensive accounts were not taken from police witnesses at the first possible opportunity and there was considerable scope for conferring before any account was given and that the officers gathering in a room together for many hours to compile statements created a perception of collusion. *"My concern is that not all witnesses to a fatal shooting are asked to give full statements as soon as possible after the event, giving a detailed account of what they saw"*. He also noted that *"a civilian who uses lethal force in defence of himself or another would not be given 48 hours to compose himself prior to*

[17] https://www.seanriggjusticeandchange.com/Review%20Report%20FINAL.pdf

being questioned by police, and it is not immediately obvious why a trained firearms officer should require what a civilian is not given." 18

79. The danger of this is that the IOPC receives a bundle of evidence obtained from the key officers without IOPC control over the process by which that evidence has come into existence. In effect, a key part of the Article 2 investigation has been under the control of and conducted by the local police force and the Police Federation alone. This can fatally undermine confidence in the investigation as these early mistakes can rarely be undone, including by questioning at an inquest some years later.

80. In the context of deaths of Black people there has been well documented evidence about the disproportionate number of deaths of Black people following the use of restraint and how these deaths have caused considerable public and parliamentary disquiet and censure from the United Nations. (Casale, Angiolini, HASC 2013, 2021, UNOHRC, INQUEST 2023)

81. Black men and those with mental ill health continue to die after police use of dangerous restraint and there remains a culture of impunity and a failure to enact meaningful systemic change. And we know that bereaved families, campaign groups and lawyers have been subjected to surveillance over the decades and this issue forms part of the scope of the ongoing Undercover Policing Inquiry.[19]

82. Through analysis of our casework INQUEST has identified that the racial stereotype of *'big black and dangerous'*, *'violent'* and *'volatile'*, when woven into the culture and practice of the police, has been a recurring feature of

[18] https://www.judiciary.uk/wp-content/uploads/2014/06/Duggan-2014-0182.pdf

[19] www.ucpi.org.uk

deaths following use of force and restraint. AS INQUEST reported to the Angiolini review,[20] it is not uncommon to hear comments from police officers about a young Black man having '*superhuman strength'* or being *'impervious to pain'* and often wholly inaccurately described as the '*biggest man I have ever encountered*'. Such perceptions increase the likelihood of force and restraint being used against an individual who is unwell.

83. "*The detainee is effectively dehumanised. In such circumstances the police officers may also use force and restraint in order to gain compliance to the exclusion of any focus on the wellbeing of the detainee which can ultimately lead to a medical crisis or death."*[21]

84. In cases where people have experienced a mental health crisis, either because of mental ill health or drug intoxication, additional negative imagery, and stereotyping – *'mad, bad, and dangerous'* – has informed their treatment.

85. However, in our experience it is extremely rare for investigation bodies to properly scrutinise the potential role that race, racism and discrimination has played in the death. As the Nachova[22] case found, Articles 2 and 14 of the Convention impose a duty on the authorities to *"to take reasonable steps to unmask any racist motive and to establish whether or not ethnic hatred or prejudice may have played a part in the death".*

86. A key recommendation of the Angiolini Review was that the IPCC should ensure that race and discrimination issues are considered as an integral part of its work and that they *should "consider if discriminatory attitudes have played a part in restrain related deaths in all cases where restraint, ethnicity*

[20] Angiolini Review
[21] Angiolini review page 88, 5.19
[22] *Nachova and others v Bulgaria* (App nos 43577/98 and 43579/98) - [2005] ECHR 4F3577/98)

Signature of witness..... [redacted]..

and mental health play a part".[23] This remains an outstanding issue of concern.

87. As Silvia Casale said in her review: "*The lack of reference to race throughout is not a sign of non-discrimination, but rather an indication of malaise and/or a lack of confidence about how to address racial issues appropriately."*

88. Delays in investigations and charging considerations by the Crown Prosecution Service also have a significant impact on those awaiting their conclusion: they damage confidence in the system but can also compound feelings of stress, foster concerns about investigatory collusion with the police and, in cases involving deaths, prolong periods of bereavement or grief for the deceased's family.

89. Although families want to be treated with empathy and humanity, in INQUEST's experience what families primarily want is an investigation that will uncover the truth. Families usually begin with faith in the investigation process. Many report that as times goes on that faith wains as the investigation progresses. The importance of the IOPC setting out clearly and publicly its expectation of police cooperation and calling out the risk to public trust where this does not occur, should not be underestimated.

Best practice

90. To secure a meaningful investigation, families seek:

a) Involvement in setting the Terms of Reference and being given the opportunity early on to put forward their key concerns;

[23] Angiolini Review page 93

b) A chance to spend time with the investigator early on receiving answers to all initial questions, or where the answers are not yet known a commitment to explore those matters during the investigation. Families often feel that they are simply met by a brick wall when they request information;

c) Reassurance that officers are required to give accounts promptly, give initial accounts without conferring and have been interviewed swiftly;

d) To be trusted to receive information on a confidential basis so that matters can be shared with them as the investigation progresses and key documents such as body worn footage, CCTV can be disclosed. Many families are told that disclosure of key materials cannot be provided although no family members is witness to the events covered by the investigation, simply because there is the potential for a criminal process. Many families have to battle to receive disclosure throughout the process;

e) The investigator to address the key issues within the findings of the report. Many find that there is a mass of detail, but key questions are fudged or sidelined;

f) Cases to be dealt with as a disciplinary or criminal investigation from the outset where there appear on the face of it to have been potential disciplinary or criminal offences, and that the relevant procedural safeguards are put in place to ensure the integrity of the investigation overall. Families feel strongly that a level playing field requires police officers to be treated as a civilian would if there are grounds to suspect that they have been responsible for a crime, or as they would be treated

in a place of work if there were potential serious misconduct. They naturally compare the process with how a civilian would be treated;

g) Independent Investigations and Coroners should ensure they meaningfully consider the role and impact of race/ethnicity of any Black and or racialised person who dies following police contact examining the potential role of racism or discrimination from the outset including in the terms of reference and through to the scope of the inquest and inquiry;

h) Non conferring cannot be established on trust alone but must be seen to be done and there must be clear protocols adhered to by senior management. The only practical method of doing this is to separate officers as soon as possible following the death and until they have provided their first account prior to going off duty;

i) Services which are sensitive to their needs including for example, faith and cultural traditions, literacy levels or second language considerations;

j) Timely access to funded specialist counselling services that recognise the impact of traumatic bereavement.

91. The families with whom INQUEST works report high levels of emotional trauma during a lengthy bereavement process. A death in custody is an event that is remote in the expectations of the bereaved in contrast to a death that is expected and where there is the opportunity to prepare psychologically. It is also a death that may be experienced not just as unexpected but as deeply

shocking because other people had jurisdiction over and a duty of care towards the deceased. It is subject to protracted and intrusive post death processes.

92. Many families report severe difficulty with day-to-day functioning, including suicidal thoughts and difficulty experienced by bereaved children. Families describe the toll this plays[24]:

Family Voice

"The ability to grieve is postponed."

"It (the investigation process) completely interfered with the ability to grieve. It consumed me. It's my life".

"It's coming up to five and a half years. The toll, the strain, the arguments, if I don't have a reason, I don't get out of bed".

"I was lucky enough to get counselling. I was sceptical at first. The inquest is so exhausting, the only way to move forward is to find a balance and counselling is a way to get a plan, a method of dealing with it."

93. The investigation and inquest process is so lengthy that several years is not unusual and in some cases legal proceedings continue for significantly longer periods of time. This is particularly the case where procedural flaws in the independent investigation result in investigations being re-started. Many people find that the grieving process is slow or cannot really begin until after the inquest or other legal process is over. Their need for professional support may vary over time. In our experience the issues relating to the aftermath of deaths in custody, including legitimate anger, are not widely understood by

[24] Angiolini Family Listening Day op cit

professionals. All those who have contact with bereaved people after a state related death, including those conducting inquiries, inquests, fatal accident inquires, and other legal processes must have training in the understanding of traumatic bereavement with the participation of bereaved people themselves who can best articulate their experiences and best practice.

Date September 14, 2023 | 10:59 AM BST .....Signature of witness..... [redacted] .....