INQUEST report of the Family Listening Days held to support the independent review into deaths and serious incidents in police custody.
Introduction

INQUEST were invited to hold two family listening days to gather evidence to inform the review, a link to the terms of reference can be found below¹.

The events took place over two days (26th and 29th of Feb 2016) and involved family members whose relatives died in police custody. The event on the 26th was for those who had been through the investigation and inquest, and the second event for those still awaiting the inquest.

The structure of the days saw feedback from families split into two parts; the process and systems that frame the investigation and inquest process, and the emotional, physical and relationship impact during/following a death and subsequent investigation.

Methodology

The family listening day model is a tried and tested methodology for seeking participant feedback and uses the following framework consistently:

- planned – in conjunction with the review team, families and INQUEST staff
- facilitated – by experienced INQUEST staff, briefed and knowledgeable on the key issues, and with an understanding of the families’ particular cases
- thematic – to provide focus and to avoid the event becoming too wide reaching and broad based
- discursive – by encouraging participants to discuss the issues in a safe and understanding environment, allowing a free flow of ideas and thoughts surrounding the review’s themes
- inclusive – ensuring as wide a range of families affected by the issues under scrutiny felt able to attend and speak
- confidential – information shared during the FLD is honest and heartfelt, and families recognise what is shared within the group should not be used outside the FLD environment. Families are linked by common experiences and should not feel isolated by judgemental attitudes
- compassionate - as an INQUEST caseworker pointed out, "families find it difficult and painful to talk through these things". The importance of compassion and understanding is crucial to the success of the process

• reflective – offering a chance to re-balance power structures and give participants the chance to reflect on the impact of events

• archived – the families’ contributions are recorded and placed in the public domain

INQUEST has run five of these events in the past for organisations such as the Independent Advisory Panel on deaths in custody, the IPCC, the EHRC and for Lord Toby Harris as part of his Independent Review into Self Inflicted Deaths in Custody of 18-24 year olds.

This report draws out the thematic issues that arose in conversation and uses extensive family quotes to illustrate the evidence and ideas. There are a series of points for consideration, initially included at the end of sections as they arose, and consolidated in the final section of the report.

1. Process

Families discussed the key themes arising from their cases. There was a consensus on key issues and are outlined in this section. These broadly centre around expectations of the process and how initial contacts and communication began to raise doubts about whether these would be met. Families described delays, inconsistent relationships with the investigatory bodies, including Coroners and the variable quality of investigations and reports. Important contributions were made on the relationship between the IPCC and the police and how this has the potential to influence subsequent decision making. Importantly families wanted to discuss the need for information, the need to be equipped to engage with the process, and the vital role legal representation plays in securing successful outcomes.

1.1 Family expectations – what do they want from the process?

No family that experiences bereavement following contact with the police is the same, and every experience is personal and particular to them. If the reaction is unique, the Family Listening Days revealed common threads and families identified commonality within the investigative and inquest process. When asked what they expected of the process there were shared hopes that it would be ‘independent’, ‘quick’, ‘thorough’, ‘truthful’ and that lessons learned would prevent other families having to go through the same thing. It is evident that these expectations were rarely met, although some good practice was apparent. Unfortunately best practice rarely occurred consistently but instead cropped up in an ad hoc way across a range of cases, or worse, in none.
One family member summed up his hopes:

"Fundamentally all I wanted was an investigation that produced something resembling the truth about what happened. And then if there’s any wrongdoing for that to be dealt with promptly and to make sure lessons arrived at through the death are learnt and properly learnt. Six years on and none of those have been delivered yet”.

Another made the point that families have no prior knowledge of investigations following a death and sadly the process resulted in a gradual erosion of belief that it would provide answers:

"Never been through it and I didn’t know what to expect. At some stage you lose that belief you have to start off with”.

Others were quick to call into question the perception of an independent process, describing the emotions of what feels like a struggle for balanced investigations:

"We believed it would be ‘independent’, but it was never independent”.

"Independent for who? It was always them against us. It felt like a battle ground between all the parties”.

For others the concept of justice was brought into question. The current system provides little in the way of support for families following a police custody death:

"Prior to this I would have glossed over it, now I’m looking for justice but it’s not always out there”

"The system needs to protect us. It’s up to us to try and prove them wrong. There needs to be a balance”.

For many the biggest hurdle to having their expectations met was the lack of accountability in what felt like a one-sided process:

"What would make the process easier for me is if the police are held accountable, and they show a real desire to change”.

**Considerations**

- Clearer expectations and guidelines; an explanation of what the process involves, how long it might take, and what to do if you wish to complain about the process.

**1.2 Notification of a death**

For years families have been telling INQUEST about inconsistencies relating to the notification of deaths in police custody. It has been a recurring theme of previous
Family Listening Days and, as was evidenced at these events, remains a serious issue for families. On reflection many of those who spoke identified it as the point at which their faith or trust in the process began to break down and set the tone for much of what followed. At the heart of the problem appears to be a lack of consistency in the protocols for informing families of the death of a relative, with many explaining the distress at knowing something was wrong, but having no official notification. For some it was a case of delay: “He died on Saturday, we didn’t see anyone from the IPCC until Monday”. In other cases families’ first information came via the media. There was evidence of officials being in a state of denial, or seeming unsure how to break the news, which was then compounded by promising further support or liaison which did not arrive. There is also a belief amongst families that those tasked with informing them are not always sensitive or humane when breaking the news of a death as they need to be:

"There was 6 hours before the family members were informed, they said they didn’t have next of kin, his sister rang twice, so they had a point of contact. Two FLOs turned up at 2am, woke the rest of the family and told them, and said someone will be out to see you tomorrow. There has to be a better format for contact with families”.

"My sister had mental health problems and she was detained. Dad and Mum didn’t know. Phoned up at 5pm and kept fobbing my father off, wouldn’t tell him she was there. At 7 or 8 o’clock (they) phoned and the doctor told him she was dead. They said ‘we will get someone to phone you’ but they didn’t. No police came to the house. We were told ‘you need to go to the hospital’, our dad went but they wouldn’t let him see her, they told him to go home.

One family described a series of events around the notification that pointed towards a lack of sensitivity and empathy:

"I’ve got three children; they came to my house and told me in the doorway downstairs. Two police officers and two IPCC came together. They were not empathetic, they just walked off. My children were left upstairs thinking I’ve been arrested as they took me off to see mum. The Police were in uniform and my daughter phoned me, but they didn’t let me go back upstairs. They told me in the communal doorway, didn’t take me to a separate room. I had to break the news to my mum over the phone. They didn’t care that I had to do that.

One family member explained her feelings, suggesting it feels like the police are already assessing the family with an eye to the future investigation:

"They see how intelligent you are, trying to belittle you and undermine you. I’m a nurse I know how the system goes. If someone dies, you notify the relatives first thing".
1.2.1 Finding out about a death via the media

In some cases families found out about the death of their relative via the media:

"Our case was played out in the media. We heard my brother had shot a policeman, and we went from hospital to hospital thinking he was still alive. No police told us till the Thursday. It took three to four days for the IPCC to contact (his) mother”.

One family had unknowingly witnessed attempts to resuscitate their relative on television:

"Our experience was the same – we saw it all on the news. They came to my house 10 hours after he was shot and told us. We saw the resuscitation on the news but didn’t know it was him”.

Another had not been contacted by the police and found out via Facebook:

"On the first day they took me to (relative’s) ex-girlfriend, but she’d found out on Facebook before I got there”.

With hindsight, some families believe the delays gave those involved time to finalise a version of events that projected blame on to the victim, or time to confer prior to the start of the investigation process:

"We heard on the news, after the police had released a story about him being a burglar, and this was before they’d contacted the family. It took them nine hours to come up with their story”.

"He died at 4pm, we were told at 6pm when they came around. There was collusion between the police and IPCC regarding first contact, very intrusive and we felt cornered and interrogated on the same day he died”.

The absence of a national protocol was highlighted by one family:

"The IPCC told us, there’s no timescale by which they have to tell a family of the death. It’s not written anywhere”.

Considerations

- There needs to be a clear protocol for informing families of a death; including by whom, when and a guarantees that all those involved in informing families are skilled communicators trained in dealing with bereavement and grief.

- Every effort must be made to inform families of a death before it becomes public knowledge via the media.
1.3 Information - where to turn for help and advice?

In the immediate aftermath of a death, in a state of shock and confusion, families want advice and information. Some made the point that on first hearing of the death of their relatives, they felt numb and were “unable to take things in”. What became clear is that the earlier they received independent support and advice, the more worthwhile their engagement with the investigation and inquest process was. There was almost universal agreement that without information the whole process was distressing and riddled with confusion and prevarication:

"We were given nothing. It was like a black hole, you feel like you’ve been swallowed”.

However it is evident this is the norm; information is inconsistently administered, absent or late in being offered. Families, desperate to get answers both about their loved ones and the ‘practicalities’ of what happens next, were offered little by way of advice:

"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 (26) 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’”.

The information vacuum leaves families struggling to make sense of what’s going on and in the absence of state support it’s easy to become isolated and left to become their own investigators:

"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”
1.3.1 Post mortems and viewing the body

The lack of information available on the matter of post mortems causes heartache and anger but also establishes a pattern of mistrust and suspicion around neutrality. Families have the legal right to attend the post mortem, and if they are unhappy with the process or the results are inconclusive, request a second one. According to INQUEST in contentious deaths there can be multiple post-mortems. The initial findings from post mortems can have a significant impact on any subsequent investigation and getting it right from the outset is vital. As one family explained:

"The investigation is always informed by the initial post mortem report. Misconceptions about his position in the van were given to the pathologist as factual evidence and affected the conclusion. The state employs the police and the pathologist. I’m not suggesting that the pathologist was unethical, but (families) need a neutral pathologist”.

Others described being unaware the post mortem had even taken place:

"We were not told about the first post-mortem. They took his brain for investigation. Miscommunication led to a two week delay. We were not told about the second post-mortem and the Coroner’s officer didn’t know either”.

"You can be at a post-mortem, so why have a process where it’s done behind your back”?

In some cases this initial indignity was compounded by a refusal to allow families to see the body of their relative:

"(They) did the post-mortem before we identified the body. We had to wait 24 hours before they even let us see the body”.

"I was never told when the post-mortem took place. I know there was possibly more than one, but not confirmed. I was not allowed to see the body. If they had allowed, it would have been from behind a screen”.

And one family member described the cultural and religious insensitivity of delays:

"What kind of a post-mortem were they arranging between themselves? They knew my husband is Hindu and needs to respect the body; they said ‘you won’t get it back for another week’. It’s only because we found a Hindu funeral director who knew people and he got the body back in an hour. It’s not the right process”.

Further concern was raised about the way in which post mortem information was delivered to families when contents could be traumatic. It was felt that a letter in the post was inappropriate and where the basis of the report is complex medical
information, families were ill equipped to interpret the findings. As one said, “it’s full of jargon”.

“They should not send a post-mortem through the post as the contents are upsetting”.

“It’s difficult even understanding the letters they send you with the autopsy, what samples were taken, you don’t understand it”.

Considerations

- Families should be informed of their rights to attend the post mortem and request further post mortems if required.
- Could post mortems be filmed so the procedure is placed on record?
- Families should receive a copy of all instructions and material sent to a pathologist.
- Families should be given the option of viewing the body of their relative if that is their preference.
- Post mortem reports must include a ‘translation’ in lay person’s term outlining the process and findings.

1.3.2 INQUEST – a source of information

Families were rarely told about the work of INQUEST and were more likely to find about its services on the internet than to have been given details by the police, IPCC or the Coroner’s office. None of the families received the INQUEST leaflet explaining the process, legal requirements or the support on offer following a death. When asked if information on INQUEST would have helped them make sense of the process, there was unanimous positive agreement. One family member identified the crucial information that should be made available to all families at the outset:

“Information should be there – INQUEST, lawyer, pathologist, three things they should tell people, and then you have a fighting chance of getting to the truth”.

Considerations

- INQUEST information (leaflet and web details) needs to be made available by the police/IPCC/Coroner’s office at the earliest possible time.

1.4 Delays during the investigation

Families’ expectations of a prompt and thorough investigation are rarely met. One family described the delays, complications and the anxiety of the wait for resolution as “inhumane for the process to be 8 or 9 years. Why not do it in 18 months”? At a time of crisis families want answers and it was a common complaint that these are
very hard to come by. INQUEST has been campaigning on disclosure for years, but delays remain common place. These issues add another layer of uncertainty and suspicion for families, and the negative impact on trust in the justice system should not be underestimated. The emotional impact should also be noted with families framing their concerns in the context of being unable to grieve for their relatives while uncertainty as to what happened remains. The longer the delays, the greater the burden placed on families to "hold things together” as they seek answers to what happened:

"We had lots of questions; we emailed them, and were told we can’t give you that at the moment. We were told we can’t interview them (the officers involved), they can’t give statements. Every time we asked anything it was like a brick wall. After 6 weeks, have you got a response? No. We chased the toxicology for 10 weeks”.

"We had an interview with the arresting officer. We gave him questions. We rang him a few weeks later and asked for feedback and he couldn’t even remember what the questions were”.

"We would raise questions with the IPCC. When they come back we’d ask ‘have you got the answers’ they’d say ‘no’. We made a complaint to the IPCC, because they’re not taking our questions seriously. We waited a month and are still no further”.

"The police wanted to disclose to us quickly. The IPCC said, ‘you can’t have it’, the police said ‘we did everything we could’”.

One family found that even the intervention of their lawyer failed to produce results:

"The only response to my questions, for example about copies of videos and custody report, is they should be available as quickly as possible, not ten months down the line. I do have a lawyer now, he wrote to them in December asking them for disclosure, two and a half months after I still have not got it”.

1.4.2 Delays in conducting formal interviews and interviewing officers under caution

Chief amongst the concern is the delays in interviewing police officers and other witnesses. Families want officers and witnesses to be interviewed promptly and under caution, as would be the case in any other legal investigation following a death.

"There was five weeks before they made statements, then five weeks for interview and they walked out of interviews. We were told that the delay was because they worked shifts. It’s been too long from beginning to end”.
"(He) was arrested by 3 special constables who were not represented by the police federation, the IPCC left them 6 to 7 weeks before interviews, and they could concoct stories".

Families are concerned that deaths involving the police are not investigated in the same way as other crimes. Central to this was an apparent disregard for witnesses and witness statements, all the more galling when that applied to family evidence:

"We had a burning need for the truth, not to get the wrong people blamed. As families, we should be given a large benefit of the doubt, not to have our evidence questioned. I recorded what I absolutely remembered and to have it disregarded is absolutely frustrating. Like in the way that rape victims have a lower status, bereaved families are in the same category”.

A member of the same family continued this theme:

"There were 10 civilian witnesses who were dismissed as inconsistent as they were in different places in the street. Because the officers’ accounts were consistent it was accepted that what happened was their version of events”.

There was further frustration at the failure to disclose witness evidence which could have helped them piece together the events that led up to the death of their relative. The gap in information creates a sense of bias:

"It was all one sided, the officers could see what witnesses had said”.

Families wanted to know why officers involved in a death are not more often cautioned prior to interview and felt this could confer greater authority on those conducting the interviews, which in turn would help restore family faith in the independence of the process:

"No interviews were conducted under caution. We had to go to court to order them to restart the investigation”.

**Considerations**

- Families are entitled to a swift, thorough and independent investigation. Those conducting investigations should provide a schedule, or timeline, of the process.
- If families are unhappy with any part of the process they should be given the opportunity to complain, and to meet with the Commissioner responsible for their area.
1.4.3 Officers conferring

There is a perception that some police officers confer to establish a narrative which protects the action of fellow officers and provides a false picture of the person who has died. Families believe initial statements influence the tone and direction of the investigation and it is difficult to shift the police version of events after ‘false evidence’ is placed in the public domain (see section 1.8 False narratives and victim blaming). This was a common thread from both events.

"We saw on the BBC news police officers with masked faces all standing around. I’ve got pictures on my phone, they’re talking amongst themselves. The IPCC said they could have been talking about anything but they just shot my brother, are they expecting me to believe that they were chatting about the weather? Of course they’re conferring, and you can’t stop them. No body cameras were worn so there is no record of what happened”.

For others it was officer statements that aroused suspicion that the events leading up to the deaths were ‘managed’ or agreed prior to the investigation starting:

"I’ve read 23 police statements, all with the same sentence. Just by reading it you can see its conferring. They thought that they were going to be criticised so they made a plan and everyone was part of the plan”.

Confirming this suspicion one person noted:

My friend who joined the police told me 'if anything happens, we all stick together, we all write the same thing”.

Another simply stated:

"Their statements were very similar”.

One person believes the Police Federation (the officers’ trade union) help orchestrate the process and exerts undue influence over the whole investigation and their role should be examined more closely:

"The Police Federation were there within hours in a room where they (the police officers involved) were conferring. They are very anonymous and always there at the inquest. No-one is questioning their role. One leaned on a police expert, this was subject of a complaint by the family and they had to change the expert”.

Families pointed out that if it’s yet to be established whether it’s a criminal investigation or not there is a risk that evidence could be adjusted.
Considerations

- Officers to be interviewed more consistently under caution.
- Officers must be prevented from conferring where evidence may be adjusted prior to the conclusion of the investigation, or the decision is taken to bring criminal charges.
- Witness statements to be gathered promptly as would be the case in other investigations involving a death.
- Families welcomed the idea of statutory time limits for collecting evidence.
- Families welcomed the suggestion of immediate access to legal advice, but stressed the need for it to be independent.

1.4.4 Denial or delays in accessing CCTV footage

CCTV footage can often play a key part in the investigation process and families resent the way in which access to footage is either denied or delayed. There is an argument, often forwarded by police and IPCC investigators that viewing the immediate circumstances of a death can be upsetting and have used this argument when families request access to the pictures. Families at both events reject this and fundamentally believe they have a right to view any CCTV evidence. It is consistent with families’ desire to understand what happened, to see how their relatives died, however traumatic.

In keeping with other failures to disclose information, families view it as a tactic to cover up or hide vital facts and it does nothing to engender trust.

Initial difficulties include a denial on the basis of on-going criminal proceedings:

"We asked when we can see the CCTV, when we can see what the officers have said, we were told you can’t, there’s a criminal process”.

For others it was the length of time before they were able to view the footage:

"We had to fight to see the CCTV, they were keeping a bit of it back, and they didn’t want us to see. They kept back the filth that came out of the officers’ mouth, which they didn’t want us to see. The IPCC person said ‘we don’t like inquests’”.

"Six months after we got the CCTV, it should have been a week. They’d (IPCC investigators) viewed a bit but were not going to let us know”.

"We saw footage which we were lucky to have; the coroner gave it to us. It contradicted everything they said. The IPCC didn’t want us to watch it. They didn’t know we had it. They wanted to edit it and advised the family to watch edited version”.
Transcripts were also denied families on the basis of it being evidence in an on-going investigation:

"We had been told throughout by the IPCC who said ‘it’s inaudible’. CPS said they had a transcript but they can’t give it to us as its part of the investigation”.

Families are angry that potential evidence of wrong doing, and therefore a potential answer to questions of ‘what happened’ are denied them. Families felt they had to become their own investigators in an effort to guarantee evidence they regarded as vital being included for the purposes of the investigation and report. Aside from wanting legal answers, families want to know what happened as part of the grieving process:

"Initially we wanted CCTV at the police station. He only had 17 minutes of contact with the police from their arrival at the house, and in that time he was dead. As a family you have a million questions running through your mind: its 17 minutes to go from fighting fit and healthy to being dead”.

"We got a specialist to look at the CCTV and evidence of whether her life could have been saved. In that time frame she could have still been alive. We paid for the expert, not the coroner. The coroner focused on another time-frame and totally ignored how the police treated her”.

**Consideration**

- Develop national, consistent protocols for accessing CCTV footage and ensuring proper working CCTV and audio equipment, to avoid future problems of evidence being held back, unavailable or designated not relevant.
- Families who wish to see the footage from CCTV should be given full disclosure of video evidence (that is without delay when requested).
- Transcripts should be routinely required as part of an investigation and made available to families.

**1.5 A lack of empathy**

A common thread from the events was the lack of empathy families experienced. Where there were empathetic relationships, these stood out as exceptions rather than the norm. The negative experiences were across the board; from initial contact with the police, Family Liaison Officers (for those that had them), IPCC investigators, and in much rarer cases, Coroners themselves. Families suggest they want to develop good relationships with their points of contact during the process but feel a basic lack of empathy, humanity and defensiveness is a barrier to useful engagement and successful outcomes for investigations and inquests. Of the police families observed:
"Need more empathy towards families. I know it’s a job they’ve got to do, but they chose to do it, families are shell shocked and reeling from what happened. Not sympathetic at all”.

"There was no empathy for how we were feeling”.

Similarly the IPCC were criticised for failing to act in a way that suggested empathy or humanity towards people who are grieving:

"They don’t come across as being there for you”.

"The IPCC were defensive from the moment they stepped into the room with us. It was a battle with the IPCC from start to finish”.

One family had to engage with their initial interview using the telephone, rather than in person, and in an environment that felt supportive:

"I asked to meet the IPCC. She said ‘can we do it over the phone, we live a long way from you’. So after two days I’d lost faith. On the Sunday I asked them to come as there was a list of questions the family wanted me to ask, she wouldn’t come to meet me face to face. We had to sit there with a conference call”.

**Considerations**

- IPCC investigators are trained in dealing with bereavement.
- IPCC investigators are able to develop relationships with families without judgement, and using skills of empathy, understanding and compassion.

**1.6 The IPCC – reflections on independence and relationship with the police**

Families recognise the difficulties of conducting investigation but want the process to be independent. Many feel this desire is compromised by the close relationship shared by IPCC investigators and those they are investigating. There is a perception that the IPCC operate with the police to protect officers, that investigators tend to be made up of ex-officers who are working with ex-colleagues and this leaves process feeling one sided or lacking true independence. A perception that investigations lack independence angers families and they provided evidence of ways in which the police and IPCC seem to work together.

The IPCC acknowledged these concerns in it review from 2014[^2] in which it committed to increasing the diversity of investigators, encouraging the recruitment of investigators from non-police backgrounds and placing restrictions on

investigators leading investigations into forces they had previously worked for. However families reported continuing concerns of partiality which has a negative impact on their satisfaction with the process:

"When they first came in, the way they talked, we thought someone’s here to help us, but very quickly you realise, actually no, they’re on the side of the police. "We had to get into the police station and get the photographs to show to the inquest. The IPCC should have done that”.

"I didn’t feel the IPCC were biased, but after reading the report there was confirmation of bias, they want to find the police not guilty”.

Some families observed the closeness of the relationship during the investigation and felt this is a betrayal of trust:

"At the pre-inquest hearing, they walk in chatting together, makes you feel they’re hand in hand”.

"Police have been there with the IPCC every time, even the autopsy”.

"At the funeral they wanted a police presence and the IPCC gave them information. The IPCC is independent so why are they giving police private information? They judge you on what you know, and this effects how they work with you. This is wrong as there are vulnerable people out there, and treating them differently”.

Many families viewed the work of the IPCC as an attempt to cover for police mistakes, and as such had an undue negative impact on the investigation:

"The IPCC is a half-way house to monitor the police investigation”.

"The IPCC were on a mission to show the police were not in the wrong”.

Others felt they were attempting to manipulate statements from families:

"I’d been on my own, they wanted to force me to say things about (relative), tried to put words into my mouth as they saw how vulnerable I was”.

"The number of times I pointed things out, that what we were saying was right, was totally ignored. In the report they said it was inconsistent, but it wasn’t, I know it wasn’t. He was telling me what I experienced, it’s outrageous”.

"The IPCC investigator was a brick wall. Witnesses said that the IPCC sat in the living room for hours, tried to tell them what they saw and what they hadn’t seen”.

There was also disquiet at investigators being former police officers and families believe investigators should not have a previous relationship with the police:

"Which ones are ex-police? There’s an element of luck”.
"The IPCC investigator wasn’t real; he was an ex-policeman who was a wall. We couldn’t talk to him, he was there to defend. It felt like he was protecting his job, protecting the Metropolitan Police”.

"An ex-police officer was being both FLO and investigator. He was obnoxious and had no feelings whatsoever, so rude and arrogant. He was talking to dad like he was an idiot. He asked him to leave. He was taken off the investigation”.

"Needs to be someone above the police, it can’t be ex-police officers. I’m not anti-police, one day I might need them, but it has to be someone who has no connection to the police”.

For some the over representation of families whose cases related to a particular force highlights the need for neutral investigatory powers:

"I want to point out that there are three families here from West Yorkshire. What needs to happen is that all these deaths should be taken out of the local police, and there needs to be a specialist national police branch to deal with these cases”.

Considerations

- Less reliance on ex-police officers when recruiting IPCC investigators

1.7 Quality of investigators and final reports

The quality of investigators and final reports was also criticised by families. Whether families had a competent investigator seemed to be a lottery, and information sharing or good communication was inconsistent:

"The first investigator was well meaning, it was one of his first investigation jobs. He was unconsciously incompetent, not experienced enough. It took lawyers to get involved for us to realise how bad it was”.

"The IPCC are such a mixed bag, some were good, but the second half was really bad because of the lead investigator. It’s totally wrong that the lead investigator "owns” the report, so no-one can advise him. It leads it open to mistakes or corruption if they side with the police officers. Ours was so bad it was either incompetence or corrupt. They compiled it to let the officers off”.

The ability of the IPCC to fully staff investigations with experienced investigators is often a question of resources and was highlighted as a failing by families. In one case a family were told there was simply not enough staff:

"IPCC said they’ve not got resources to do the forensics so they bring in the police”.

Another heard from their investigator that the police are also outsourcing:
"Police forensics are outsourced to private companies so can’t they get them to collect (evidence)?"

1.7.1 Final reports

Families were, in the main, scathing in their response to the final investigation reports. There were accusations of bias, inconsistent findings and a perception that investigators simply massaged facts to find officers involved not responsible or guilty of wrong doing. In addition the problem of delays and inaccuracies were consistent with much of what preceded them:

"The report was a big disappointment, a complete whitewash”.

"It was a lightweight report, dates crossed out three times and he hadn’t noticed”.

The evidence of delays upset families and adds insult to injury and nurturing a sense of justice denied:

"We’ve not got the final report after five years. They promised to do things; we’ve still not got the answers. People are still employed; there are no consequences, no misconduct action. They said ‘don’t pursue it, as it will cost too much money’”.

"Most of them (officers involved) retired after the event, we’re still waiting for justice”.

"The report never came until last year. It was the longest bit of rubbish. It was all in defence of why (relative) was shot. There was no misconduct action. It was self-defence, they feared for officers lives, despite what forensics showed, all the evidence and what witnesses said”.

Even when families felt sections of the report had provided an accurate assessment of what happened, the overall tone and findings failed to provide the lessons that might prevent future deaths:

"There were two sections of the report which were quite robust. But the key issues that led (relative) to die, they got the evidence wrong. They looked at little sections of time, small enough to justify actions, but they’d not looked at the cumulative set of circumstances. Two police officers passed away in the intervening years. We want something that aids, but this feels like an insult and a total waste of time. I’ve had counselling, but the report floored me. It’s such a huge let down”.

Their comment to the commissioner made it clear how they felt:

"This guy is either incompetent or corrupt”.

Where reports are seen as positive by families, it remains a ‘hollow victory’:
“I’ve been reading the report at 2 or 3 am, starting work at 6 am, I can tell you the report inside out. I get satisfaction reading it over and over, but there isn’t a day where I don’t cry”.

1.7.2 Positive experiences of IPCC investigations

Some families had a positive experience with investigators, but were keen to establish the ‘random’ nature of who might be in charge of their cases. They did identify the attributes of a positive investigation; good communication, hard work, commitment, independence (i.e. not an ex-police officer) and empathy:

"The great investigator we had was not ex-police…. Tenacity and follow through, ability to work bloody hard, and disclosure. We also had meetings every month”.

"In the second investigation there was lots of momentum, frequent meetings and feedback. Then we had a new investigator, the meetings stopped, and the report was a big disappointment, a complete whitewash”.

"We had a number of investigators, one of them did beautifully but left for maternity leave. She was so on board and the way she communicated was so clear, really analytical thinking and questioning, and her mind was really open, and she transmitted incredible empathy”.

Considerations

- Fully resourced investigations teams with specialist skills to do the job properly.
- IPCC should identify best practice and share across the agency
- Families should have a role in developing the reports, an understanding of their function and a chance to review or question report contents before its finalised.

1.8 False narratives and victim blaming

Families outlined two key ways the media had impacted on their experiences of the process; for some (see above, section 1.2) the first they knew of their relatives’ death was via media outlets (including on Twitter), and others had complaints about the way the media was used by both the police and the IPCC immediately following a death. Families were unhappy that stories, often un-checked by them prior to release, ended up misinforming or “muddying the waters”. This took the form of creating false narratives thus helping erode any confidence in the veracity of the investigation and inquest process. Some families felt this was an intentional tactic (often starting at the point at which officers conferred see section 1.4.3) employed with the express purpose of deflecting blame or responsibility away from those
involved with the death and shifting it onto the victims. Evidently this ‘tactic’ is not rare as a number of families provided examples where information about the families or their relatives was used to create a false narrative, and according to families, often in collusion with the media:

"They said information was given that (relative) was a drug addict, but that’s not true, she had mental health problems. There was an article in the press saying she was a drug addict and the reporter said the information was from the IPCC”.

"Within hours the police wrote a statement and read it out in the Mosque that (relative) died in a drugs raid”.

"In the media my brother’s name was being linked to riots”.

"We were presented like a criminal family. How did we become this? A police car was parked outside our house, we felt we were being watched. Our whole lives changed, we had to be careful what we texted on the phone. During the actual case there was a van outside continuously”

"Police came to the hospital at 3am to take a statement but we refused. They wanted details, we said ‘why are you asking for this information, it’s irrelevant’, they were trying to paint a bad picture”.

One family explained that they knew they were being portrayed in a negative light and it damaged their hopes for the investigation; simply an apology for wrongdoing:

"They are trying to criminalise your loved one, trying to paint you as being a bad character. They’re trying to discourage you by painting a case that is never against the police, but is against you. No-one wants to say ‘we are wrong’. If that happened then families would be satisfied as accidents do happen”.

The negative portrayal of relatives and their families appears to be a common occurrence and does nothing to facilitate trust from families or indeed the wider community. Whilst this continues mistrust in state institutions and agencies will continue. Families want to be seen as victims of a crime.

1.9 Mental health

Another area of particular concern for those present at the events was the treatment of people who were experiencing poor mental health at the point at which they were in contact with the police. Families shared concerns at the way officers treated people who were ill; the absence of training in dealing with their relatives, the immediate recourse to police custody rather than A and E, a reliance on restraint rather than de-escalation when dealing with people in mental health crisis and failures in assessment and monitoring whilst in custody. Ultimately families were describing a lack of care in repeated cases.
Experiences of poor training and a lack of experienced responders were outlined:

"All those who dealt with my son were not trained police; they were PCSOs, or "specials". Her excuse was that she only had six weeks training. If you are put out on the street you have to be able to do the job".

"People don't understand mental health and become scared. You have to improve the police force so they can understand, like they do for social workers. You can’t learn some things as you can face to face, it’s scary if people are acting erratically”.

Current de-escalation techniques were questioned:

"The lead investigator decided that the officer had de-escalated as it was 56 secs from his arrival to (relative) being on the ground. Is that de-escalation”?

It was pointed out that other professions had managed to adapt their working practice to avoid the need for restraint and de-escalated the situation instead:

"They need to learn how to work with people with mental health. In the NHS and in schools, other professional’s work, the last thing you do is put your hands on. With the police the first thing is to put hands on”.

Another person highlighted the problem of using out-dated techniques and the need to share best and emerging practice:

"Most forces are still using a restraint video that’s been withdrawn, Marcia Rigg (whose brother Sean died in police custody) knew and they didn’t. Each police force is different, there is no standardised training, and they all do their own little thing”.

Families felt that without specialist, trained responders the default position is to take people into custody rather than to a place of safety with medical expertise. One, who works in the field of mental health, explained:

"There was a mental health problem. If I had a toothache, I wouldn’t go to a shopkeeper, they’re not trained. A person with mental health can act very bizarrely, even for me, but they’re expected to treat them. They shouldn’t be taken to a Police Station”.

The benefits of using A and E and the impact of learning from a notable death in the West Midlands was referenced:

"A person with mental health crisis is a medical emergency and should go to A&E. This would have saved countless people, why can’t they learn it. Section 136 in West Midlands is quite good, which is down to the response after the Micky Powell case and shows follow up can be valuable”.

Another family with personal experience agreed:
"Five years before (the relative) had a psychiatric episode and they did it right, took him to hospital and he came back alive".

However, where people were taken to police stations there was evidence of poor monitoring and assessment

"There was a lack of any assessment (the relative) was vulnerable and they knew he was a self-harm risk and they knew he was going through bankruptcy. They had a duty of care, but just let him go. The mental health assessment at the end was just a tick list".

Another family outlined their case in which their relative was taken to a police station but was not monitored whilst in his cell. The officer involved was found to have been watching pornography instead of checking the video feed from the detention cell resulting in the death. In this case recommendations were made at the inquest:

"When someone comes into custody they need to be monitored on camera, but if they’re not near to the custody suite that doesn’t happen. The coroner made a recommendation for a monitor to be away from the custody desk and report to the custody officer if any changes”.

1.9.1 The use of restraint

Where restraint had been used families provided harrowing accounts of the events leading up to the death of their relatives. There was unanimous agreement that the recourse to restraint in medical emergencies was inappropriate and wrong. By using de-escalation techniques these deaths are avoidable:

"We heard how 7 police officers held her down in a cell and stripped her. She was 5’2. There were 4 male officers and 3 women officers. She was restrained in leg restraints like an animal. It was never mentioned to the jury how she was treated. They struggled 15 minutes to get the clothes off her and just left her there”.

The use of force was also described by another family, who also believe that inherent racism plays a part in the police’s decision making processes:

"Our son was restrained by 13 police men and women in a psychiatric hospital and police told the doctor to get out of the room. The doctor heard him say “I can’t breathe”. They didn’t tell us this. Another police force in the morning had been fantastic with him at the Maudsley Hospital. Police and staff worked together, laughing and talking with him. Why couldn’t the evening crew do the same”?

They went on to explain:
"Sometimes the police are bully boys. They see young black men as “superman”. My son was a big boy, tall and a boxer. They cannot cope as their mentality is “big black superman”.

Families offered alternative strategies for addressing issues of race and mental health. At the core of these is diversity:

"In Toronto they have different policing – specialist mental health workers alongside police crews. They reduce police deaths and add specialist expertise. It gives police on the job training, they see and understand the issues, so even if they arrest someone for a criminal offense they deal with the mental health first. Also Toronto police force is hugely diverse”.

"Twenty to twenty five years ago there were a lot of black mental health deaths. Animation was interpreted as aggression. Employing black people to look after black people has worked”.

Another suggested medical support to work alongside officers called to incidents:

"Having a nurse specially trained on the scene is a possibility“.

Ultimately there is a need for the police to implement actions that could improve the care of those in custody:

"It’s important to have police forces take on board the recommendations and let families know this is happening, not just forgotten about”.

**Considerations**

- Police officers to receive specific mental health training
- Police officers are trained in de-escalation techniques.
- Officers responding to incidents involving mental health are accompanied by trained medical staff.
- Those experiencing a mental health crisis are taken to a hospital rather than into custody.

**1.10 The role of the Coroners**

Of all the state agencies encountered by families it was Coroners and their officers who received the most positive feedback. Families were keen to recognise the role they played in explaining what the investigation and inquest was about, offering legal support and crucially, acting in ways that exhibited empathy, humanity and remorse for what had happened. (It should be noted that families will rarely have direct telephone contact with Coroners and reference to Coroners in the quotes below are more likely to relate to Coroner’s Officers)
"The Coroner was great and his associate told me more than the IPCC, I would speak to her daily, but it’s not her job, should be someone else. After the first post-mortem or the second post-mortem, the Coroner’s assistant rang to tell us that the initial findings were inconclusive; she came to our house and explained”.

"The Coroner was very helpful. The day after we were helpless, how can we get help, where do we start? The Coroner told us the questions we needed to ask”.

"She was fantastic. First person who said I’m so sorry’. She was the first person who made a link with us”.

However the praise for Coroners was not universal, with questions over partiality and experience raised by families:

"The Coroner was okay. He did stop when things were getting bad (during what the family described as very aggressive questioning by the police barrister), but he seemed to be on the side of the police”.

"A friend said to me you need to get a second post-mortem, it has to go through the Coroner. The Coroner brought us in for a second meeting, not a very pleasant experience, fortunately he’s retired. He said ‘why do you want another post-mortem’ I said, ‘I want to know the truth’, he said, ‘it’s very costly, you won’t understand it’. This to a mother who has just lost a son”

"You need Coroners who are specialists. He had to go to another Coroner for advice”.

Considerations

- Coroners hearing cases involving deaths in police custody need to be experienced.

1.11 Legal representation – ‘equality of arms’

Legal representation is something families felt strongly about and the ‘inequality of arms’ is a strong symbol of how the current investigation and inquest system fails to serve family needs. Families reported that they are rarely told about their rights, or are misinformed about the need for legal representation. Cases involving deaths following contact with state agents are complex and are impossible to manage without specialist legal input. However this knowledge is not shared with families unless they access advice at the very start of the process. In the worst cases some families were told they didn’t need legal representation at all:

"We were told by the police we didn’t need anything. We’ve still not got one”.

"They say you don’t really need a solicitor, you believe what they tell you”.


"I asked the police ‘do I need to get a solicitor’ and they said ‘it’s up to you, most families don’t’”.

"She (the IPCC investigator) said she had never had a case where there was a solicitor, but this was high profile, shouldn’t she have dealt with such a case before”?

Others made the point that solicitors need specialist inquest knowledge and INQUEST have its INQUEST Lawyers Group to refer to:

"You’ve got to have an expert. INQUEST said you can’t just go to someone in the high street, it’s got to be a specialist, we were advised by INQUEST about where to go”.

"I really struggled, rang lots of solicitors up and down the country and couldn’t get a solicitor. If it wasn’t for INQUEST getting me a direct access barrister, I wouldn’t have anyone”.

"That’s why you need an independent solicitor who believes in justice and understands you and knows how it works. So you feel you’re not alone”.

The importance of legal representation is made all the more relevant when families got to the inquest. They described the ranks of multi-party lawyers representing all the state bodies involved:

"The custody officer had a barrister, there was a police barrister and a doctor had his own solicitor. The police barristers worked together to block any questions”.

"The Force and the officers each had a barrister”.

"There were six or eight barristers in our case”.

The difficulties of attending the inquest un-represented were outlined by one person:

"We had to do everything ourselves. We had no lawyer at the inquest. Those three weeks were the most terrifying thing I’ve ever done in my life. I had to cross examine witnesses, it was absolutely terrifying, and they had lawyers. There needs to be a level playing field; a family member should never be put through that”.

However, families face a further obstacle to obtaining legal representation and that’s cost. There is no legal aid for inquests other than in exceptional circumstances and families face an intrusive and complex and mechanism for securing funding. For some this proved to be a step too far, and in the midst of grief and heartache opted not to engage with the applications. Families explained the difficulties they encountered and the inherent inequality in a system that has the tax-payer cover
legal costs for state agencies but places a punitive income threshold on families seeking justice:

"Costs were discussed and we were asked to pay £8000 for legal aid. We had to fill in forms to declare savings. R didn’t declare a bank account, it was very invasive but R said "I’m not telling them about money we worked hard for. We got the MP involved, he was brilliant. He talked about it in parliament. Why should I pay to hear what’s been done to our son"?

"They delved into our private lives. We felt we were being investigated, but we are the victims here".

Another person agreed:

"We didn’t qualify for legal aid. Exceptional funding was refused three times. The MP got involved. We finally got it and we had to pay £5000. The costs would have been £50k-£60k even at legal aid rates. I feel incredibly strongly that legal aid must be given automatically as a right, not means tested”.

For many it is a matter of justice and equality, and families feel this is denied:

"Funding should be available across the board and no issue about income streams. State bodies have the best legal representatives money can buy. I can sell my house, but I’d rather not be in this position after everything else I’ve been through”.

"It doesn’t matter who you are, you deserve justice. Money should not be involved because it’s not your own choice to have the process”.

It was agreed by the group that if the state provided funding it would demonstrate a commitment to reducing police deaths and put an end to the current ‘abusive’ approach to supporting families through the investigation and inquest:

"If the state seriously wants the police to stop killing people, it’s crucial we are organised and given funded expert legal advice from the word go. INQUEST has the right sort of lawyers. Nothing can prepare you for it, you need someone to advise you on the process from the start. What we’re having is inadvertent abuse”.

**Considerations**

- Non means tested legal aid for families from the outset.
- A requirement to inform families of their legal rights from the outset.
2. Emotional, physical and relationship toll on families

The emotional toll on families is huge and the fact the process can take months and in exceptional cases years prolongs the impact of grief. Families described the dreadful burden of grief, of having to support other family members and the current shortage of professional services. This was felt most acutely for those supporting children and grandchildren.

It was common for families to describe putting grief on hold until they had been through the investigation, inquest or felt questions had been answered; one person put it simply:

"The ability to grieve is postponed”.

Another agreed, highlighting the anguish of surviving a protracted process:

"Losing a child is very difficult as parents. He had mental health issues which took up a lot of emotional time and energy. For the last five to six years it feels like we are looking after him while he is dead. I feel numb and sad. I won’t really grieve properly until this process is finished. It is inhumane for the process to be 8 or 9 years. Why not do it in 18 months’?

Another described the all-consuming nature of the process

"It (the investigation process) completely interfered with the ability to grieve. It consumed me, it’s my life”.

Another person described the sense of hopelessness felt during the emotional fall out following a death:

"It is like you are punching a great wall and you can’t see what’s behind it”.

One person described what it’s like to live with grief and trauma, whilst trying to negotiate the legal system:

"Over five or six years, all the meetings we’ve had, three investigations, met the Home Secretary three times, can’t imagine how many days I’ve had to take off work. A day or two before hand I can’t sleep and I can’t eat. I have to psych myself up and afterwards I’m completely exhausted the next day. It takes me three days to get over it. Then the trauma of remembering everything”.

If delays and uncertainties place barriers to grieving there are further hurdles for families to overcome and these too seem to be embedded into a systemic culture of neglecting families’ needs. They were left to question the absence of support, the waiting time for NHS services such as counselling, the difficulties of supporting children and grandchildren. There is a ripple effect drawing in parents,
grandparents, aunts, uncles and children; whole families are left devastated and this can lead to relationship difficulties. In the meantime families are seeking answers to what happened to their relative whilst mourning a loss of life. One person summed it up:

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

2.1 Lack of support

Families compared their experiences, as victims of ‘state crime’, with other victims of crime and how their support network is different. They felt there was a clear deficit of support on offer and that the nature of the deaths meant employers, schools, counsellors, even friends found it difficult to respond. In order to access services families are confronted by perceptions of stigma and judgement, and there remain serious questions about the inconsistent provision of support services. One of the services afforded other victims of crime is provided by Victim Support and families were unanimous in their belief that:

"Victim Support should be extended to families”.

Others made the point that:

"Murder victims are provided with counselling”.

Once a referral has been made to Victim Support there are chances that state funded support is made available, which is not the case for families affected by police deaths. Accessing services can be both costly and reliant on the ability to find them in the first place. In other situations referrals may be made by employers or, in the case of children, schools. However where there is misunderstanding or uncertainty about the circumstances of a death this may not happen:

"The school didn’t understand what was going on. His wife didn’t speak much English, which affects accessing services and benefits”.

The importance of family support is obvious, but it places a strain on relationships. Families described the difficulties of processing grief and bereavement in the context of a police death and it appears stigma plays a huge part in accessing informal support from outside the family unit. Explaining things at work is difficult:

"I can’t fall apart as people are relying on me. It’s very difficult for me as I have nobody to talk to. At work they all thought I was on holiday”.
Another agreed:

"It’s harder when it’s in public. I work in the NHS and it was splashed all over the paper, they all knew at work”.

There was evidence of the strains placed on families as they tried to provide mutual family support:

"We were married 32 years, the number of times we could have walked out, the strain, there was no-one to talk to. There were different questions within the family, Dad was like a skeleton. In the inquest he wanted to vomit due to presence of police in the room. Five years later I still see the impact. We had to shoulder all of it. I felt let down by everybody – the police, CPS, IPCC, the misconduct hearing. They should have been able to come with some comfort. We still have the same questions”.

"I read something and my husband punched the door. I can’t talk about it for five months every night. He said 'it’s got to stop, they have got to be made accountable’”.

2.2 Counselling

A few families had used counselling services, and for some this has helped a great deal. There are problems with provision of these services and waiting times and there are acute shortages within the NHS. For those who’d used it the results were positive:

*I got counselling through the doctor, bits of it helped me, the death was only last June. Some days I’m in a state of shock”.

*"Without the counselling I’d be a bit of mess. I’m always 5 minutes away from ranting”.

Coping strategies were discussed:

"Afterwards in counselling, she said speak to someone impartial, not one person said this prior to this. Murder victims are provided with counselling”.

"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”.

"I said to the counsellor, 'I can’t ever work again’ and she said, 'you’re doing it for (her son)’. She made me feel better that I can do stuff”.

For others it still felt too soon, or they’d been put off by the potential cost and waiting times in their area:
"I’m already exhausted by the IPCC, I don’t have energy to talk to another person, maybe in future years”.

"I’ve never seen someone to talk to, it’s been recommended but now I would have to pay for it because of the cuts”.

One person was able to pay for the services, but this is not an option for everyone:

"I did have counselling and it worked for me, it was extremely valuable. I know psychotherapists and I paid for it myself and got discounts”.

2.3 Supporting children

If the gaps in provision make it difficult for adults seeking support, the situation is even bleaker for children. Those who have children and grandchildren already face challenges in helping them understand what the death of a relative means, and when there is ‘gossip’ and information on social media surrounding such cases, the need for child centred services is even more pressing. Those who had experience were keen to highlight some of the challenges they face. One person explained that although she is a social worker and is used to working with children, she finds it really hard to support her 3 year old daughter who is struggling.

"It is difficult when it is your own child. It is difficult to access help. CAMS is not helpful in our area, as she does not meet the criteria”.

One mother tried to access support for her 5 year old child but she had to wait 24 weeks for it. She was eventually offered 7 sessions but that came to an end and further support required another referral.

Another described the difficulty of protecting children from the cause of death:

"What do you say to people when it’s in the press? I told his daughter he had and accident and then she saw it on the internet”.

The impact on children is often overlooked by professionals linked to the investigation and inquest process, and families observe the ramifications, both in the short and long term:

"It broke my heart when my grandchild said that he wanted to join his uncle. There is very little support out there”.

"The children is the hardest part. (His)three year old daughter said ‘daddy’s on his own, I have to go with him’. I have to stay strong for the children, put up a front. I support my 11 year old daughter, I can’t cry with her.

"The children are on a downward spiral, they can’t understand the system”.
"The children 5, 8 and 11, they’ve now grown up 8 years on, and they’re well aware of what happened and need support”.

"As they are growing up, it’s an issue, problems with behaviour at school and at home. They were included at meetings and attended the inquest; the impact on the children is that they’re beginning to grieve now, they need specialist counselling”.

One person highlighted the need professional support, recognising its importance for the wider family unit

"My daughter is two and a half, how can I be a mother to her if I’m depressed all the time. I don’t want her to grow up with that. I got counselling through the doctor, bits of it helped me, the death was only last June. Some days I’m in a state of shock”.

Considerations

- Families should be given information on and funding for counselling and professional support at the earliest opportunity. These interventions are often only considered at the conclusion of the process when evidence suggests early interventions can be beneficial
- Families need to contact INQUEST for support on contacting employers and schools

3. Justice – what does it mean to families?

During the course of both events families had the opportunity to discuss changes that might encourage a culture shift and a reduction in deaths in police custody. Families re-iterated their wish that others never had to go through what they had, but it was also evident that notions of justice were rooted in the negative experiences of the inquests and what happens subsequently; misconduct hearings, failure to take action on recommendations made by Coroners, the failure to prosecute and the slow pace of change.

The experiences of inquest were described in terms of ‘bullying’, a ‘missed opportunity’ and as ‘terrifying’. One person described her experience:

"I was treated very badly. I was a witness and the police barrister had me on the stand for there and a half hours. He battered me literally with questions. He accused me of not caring about my son, he was shouting at me, slamming books, was so aggressive. The coroner did nothing for a long time, he was asking very offensive questions and only after three and a half hours the coroner said "okay that’s enough now". 
It was pointed out:

"An inquest is supposed to be inquisitorial, which is meant to be about the truth, no adversarial, I was incredulous at the time that the police could adopt such tactics in the inquest situation”.

Families were confused and angered by misconduct hearings and the lack of meaningful action taken by police forces after officers had been found guilty of misconduct:

-Misconduct – Families do not know what happens when misconduct proceedings start in relation to officers.

"Police have admitted wrong doing, and have decided the fate of the officer. I struggle with the IPCC allowing the police to manage the case themselves. They allow the police to decide what happens to the officer. They said as it’s the first time it’s happened, he will get a slap on the wrist. If it happened again he would get a disciplinary. If it happened at any other organisations there would be criminal proceedings”.

"Officers are still keeping their jobs. They are not being suspended or their duties limited whilst the investigations are taking place. Families are not informed but most believe that it will be nothing more than a ‘slap on the wrist’. They also try to retire to avoid action. They know that they can get away with it”.

"There will be no change until the Police are convicted of crimes, brought to account for gross misconduct, lose their jobs. In any other job that would happen. They need to know ‘if we don’t do our jobs properly, this is what’s going to happen’. Until they are brought to trial, I don’t think they will do”.

"You hope they will give you the justice you are searching for. The officer found guilty of gross misconduct got a written warning because he was an exemplary officer with 22 years’ service”.

Families felt the police were hypocritical on the subject of taking responsibility for wrongdoing:

"It was in the news a few weeks ago, when a civilian was convicted of murder or manslaughter, and the inspector said ‘one stupid punch can kill someone, people have to take responsibility for their actions’. But if police do it, it’s okay”.

There is also dissatisfaction at the failure to change the culture of policing and families believe there is little or no accountability:

"The police need to be accountable, there needs to be a desire to change in the police and there is none. They’re not punished when they’ve done something wrong.
You can’t prove they’ve done something wrong, the whole machine is geared to crunching out a ‘no-fault widget’. There is never a level playing field. How can you get justice in a system geared toward finding no one at fault”?

Families welcome examples of where Coroner’s recommendations have been taken on board, and it chimes with a shared desire to prevent future tragedies. Examples given included:

"They changed the size of vans, the cages are a different size and have cameras in, we saw the new vans, they were two feet square before”.

"They should now have defibrillators at police stations”.

"Learning about not doing spy hole checks, they now need to open the hatch. Bootham Hospital has reopened a place of safety, they had closed it and in January 2016 it was reopened”.

"Recommendations for drug searches and mouth searches came out, also that the scene of death is a scene of crime and should be kept sterile”.

However much families welcome changes there is still concern that compliance remains sporadic:

"The coroner can write a letter saying you need to change. They will write a letter and five years later it’s no different”.

"Unless the police become accountable, nothing will change, whether they follow recommendations or not. There has to be some means of enforcing change, they’ve got to follow the recommendations”.

For all the discussion around systemic changes there is a clear evidence for a more personal response to grieving families and saying sorry is central to this. Families are struck by how rarely anyone said sorry or apologised for their actions. When it does happen it’s welcomed:

"We appreciate them saying sorry, it’s about admitting, some person high up saying ‘we’re very sorry”’.

"After the misconduct proceedings we had a one to one with the Chief Constable, the Police and Crime Commissioner and the family. He did apologise to all of us ‘we’re really, really sorry and we got it wrong”’.

The cultural implications were compared to another high pressure profession:

"With airline pilots they’re told ‘you won’t face prosecution if you admit a mistake early on’. They don’t try to cover it up, it is an incentive in the system to own up”.
The rationale for wanting someone to apologise is simple:

"You want to feel that they actually care what’s happened”.

The need for change is vital because “at the moment no-one is getting justice” and what’s needed was summed up thus:

"If there is not one successful prosecution it’s a deeply dysfunctional system. I’m really glad Theresa May is doing this review, cultural change is needed. I’ve seen that the IPCC is trying to reform, its leaders are well intentioned, but they’re not there yet. Please can we actually see some action to reduce deaths, follow through is incredibly important. I would have to say to the Chief Constable ‘what are you doing about policing of mental health’. Higher up the food chain you need the will to create a culture change. The Chief Constable should be in the firing line for reckless stupidity of the people he employs”.

Considerations

- Clearer expectations and guidelines; an explanation of what the process involves, how long it might take, and what to do if you wish to complain about the process.
- There needs to be a clear protocol for informing families of a death; including by whom, when and a guarantees that all those involved in informing families are skilled communicators trained in dealing with bereavement and grief.
- Every effort must be made to inform families of a death before it becomes public knowledge via the media.
- Families should be informed of their rights to attend the post mortem and request further post mortems if required.
- Could post mortems be filmed so the procedure is placed on record?
- Families should receive a copy of all instructions and material sent to a pathologist.
- Families should be given the option of viewing the body of their relative if that is their preference.
- Post mortem reports must include a ‘translation’ in lay person’s term outlining the process and findings.
- INQUEST information (leaflet and web details) needs to be made available by the police/IPCC/Coroner’s office at the earliest possible time.
- Families are entitled to a swift, thorough and independent investigation. Those conducting investigations should provide a schedule, or timeline, of the process.
• If families are unhappy with any part of the process they should be given the opportunity to complain, and to meet with the Commissioner responsible for their area.

• Officers to be interviewed under caution.

• Officers must be prevented from conferring where evidence may be adjusted prior to the conclusion of the investigation, or the decision is taken to bring criminal charges.

• Witness statements to be gathered promptly as would be the case in other investigations involving a death.

• Families welcomed the idea of statutory time limits for collecting evidence

• Families welcomed the suggestion of immediate access to legal advice, but stressed the need for it to be independent.

• Develop national, consistent protocols for accessing CCTV footage and ensuring proper working CCTV and audio equipment, to avoid future problems of evidence being held back, unavailable or designated not relevant.

• Families who wish to see the footage from CCTV should be given full disclosure of video evidence (that is without delay when requested).

• Transcripts should be routinely required as part of an investigation and made available to families.

• IPCC investigators are trained in dealing with bereavement.

• IPCC investigators are able to develop relationships with families without judgement, and using skills of empathy, understanding and compassion.

• Less reliance on ex-police officers when recruiting IPCC investigators

• Fully resourced investigations teams with specialist skills to do the job properly.

• IPCC should identify best practice and share across the agency

• Families should have a role in developing the reports, an understanding of their function and a chance to review or question report contents before its finalised.

• Police officers to receive specific mental health training

• Police officers are trained in de-escalation techniques.

• Officers responding to incidents involving mental health are accompanied by trained medical staff.

• Those experiencing a mental health crisis are taken to a hospital rather than into custody.

• Coroners hearing cases involving deaths in police custody need to be experienced.

• Non means tested legal aid for families from the outset.

• A requirement to inform families of their legal rights from the outset.

• Families should be given information on and funding for counselling and professional support at the earliest opportunity. These interventions are often
only considered at the conclusion of the process when evidence suggests early interventions can be beneficial

The report was written for INQUEST by independent consultant Chris Tully. He assisted in designing the Family Listening Day model. He has helped deliver Listening Day events and written reports arising from the day for the Independent Advisory Panel on Deaths in Custody, the Independent Police Complaints Commission, the Equalities and Human Rights Commission and the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. He designed the INQUEST Skills Toolkit for families and has delivered training for the organisation. He has 27 years of working with voluntary sector organisations and has also conducted monitoring and evaluation projects for Clinks, Women in Prison and INQUEST.

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