Report of a Family Listening Day Organised by INQUEST on behalf of the Independent Advisory Panel on Deaths in Custody March 2010

Contents

1. Introduction

On Tuesday 30 March 2010, 16 family members with direct experience of the investigation and inquest system following the death of a relative whilst in the care of the state met members[1] of the Independent Advisory Panel (IAP) on Deaths in Custody and representatives of its secretariat. Ten of those that attended had experienced a death in prison and six a death in police custody/following contact with the police. The IAP recognises that the number of family members represented on the day was relatively small and as a result the feedback received does not necessarily reflect the views and experiences of all bereaved families. However, this work represents an important first step for the IAP in terms of engaging with bereaved families and the Panel are extremely grateful to all those family members that felt able to participate. The views and experiences shared on the day have highlighted where the IAP's focus could be effective in terms of meeting the needs of families and the Panel are keen to learn from these experiences to improve the system for others.

The event was organised on behalf of the IAP by INQUEST following an independent tendering exercise, which took place in February 2010. The aim of the event was to share experiences of the inquest system, the investigative process and the families' impressions of the ways in which the state managed their cases. Facilitated small group discussions elicited thoughts and opinions and members of the IAP had the opportunity to listen first hand to the families' concerns, experiences and ideas for improving the system. This report aims to bring together the key themes from the day, to outline specific family examples of both good and bad practice and to suggest possible improvements to the current system, which take the form of suggestions for change in section 4. For the purpose of the report the evidence from the day has been organised into two distinct strands: firstly Process and Systems (defined in section 2), and secondly Institutional Attitudes and Behaviour (found in section 3).

[1] Lord Toby Harris, Chair of the IAP and panel members Philip Leach and Stephen Shute.

2. Process and Systems

Process and systems, for the purposes of this report, is a term that describes the practical measures that need to be undertaken following a death in state care. This includes:

- Notification of the death;
- Access to the body;
- Post-mortem examinations;
- Role of the coroner's court;
- Role of the institutions of detention and the investigating agencies;
- Disclosure;
- Funding legal representation for families.

The small group discussions took these narrative prompts and each of the families were invited to outline their own experiences of them. The evidence given by families had a greater breadth of information than these prompts alone, and the other issues discussed are interwoven into the fabric of the report.

2.1 Notification of the Death

The families' experiences of this issue suggest a significant degree of inconsistency and apparent "evasiveness". In some cases, families were informed of the death by local police officers, at times of the day and night that meant contact with the institution of detention was impossible. Often the police officers were so far removed from the area in which the death had taken place that they were unable to provide further details on what had happened. This lack of information and the inability to answer questions was a major cause of concern for families. In one case, the family were informed via text message by the police. There was also a sense of anger for some families who felt they were "interrogated" by the police prior to being able to identify the body.

Families reported a lack of sensitivity and a lack of preparation for the ensuing questions that for many set the tone for the whole process of identifying the body, the post-mortem examination and funeral arrangements. Families pointed out that they were at their most vulnerable on hearing the news of a relative's death and were unable to take on board the information and advice they were given. Crucially, the families had no idea of what action needed to be taken and felt those responsible for informing them needed to guide them through the process with care, sensitivity and information. A concrete example of the inability to pass on relevant information was the failure to explain the post-mortem examination. As one family member said *"The police did not mention at that point there would be an autopsy. We were told nothing but simply handed over a bunch of leaflets at 3am"*.

The problems with information can be compounded by the institutions of detention. One family was given the number of the prison by the police officer who had informed them of the death of their relative. The number remained unanswered for 24 hours. They commented that *"The following day someone answered the phone, but they too could not give us any further information"*. There were reported delays in the length of time it took for a Prison and Probation Ombudsman (PPO) Family Liaison Officer (FLO) to make contact. In one case, a family heard nothing for three days. Another family member reported that the FLO from the prison arrived with a prison Chaplain and pointed out *"We are an atheist family and felt this was inappropriate. What happens to those families who are Jewish or Muslim?"*. One family was informed of the death by letter and when the prison was challenged about this, it claimed it had been trying to contact the family. In fact, it had contacted the dead man's aunt by mistake.

Underpinning the families' concern and anger was the perception that their rights were being denied. The production of a systematic guide providing information on what to expect and guidelines on next steps was identified as a potential solution. As one family member pointed out *"I was a civil servant all my life and we always covered scenarios for every eventuality. We need a set of rules and regulations for the families of people who die in custody"*. There are protocols governing this matter, but the

failure to ensure best practice around the country can damage families' faith in the state's ability to proceed honourably and with respect for the families.

Some families had a better experience. Examples were given of the care and sensitivity shown by PPO FLOs and their willingness to explore and answer any questions. Another commented on the excellence of a booklet for bereaved families provided by Bedford Prison. However, these families appeared to be within a small minority. It was acknowledged by others on the day that their experiences were down to chance and a *"postcode lottery"*, as one person described the investigation and inquest system.

One area of consistency would appear to be the quality of the information provided by INQUEST to families, but it seems that chance plays a part in accessing its services. Some families found the organisation's leaflet amongst other information handed to them. Others found it by chance whilst undertaking desktop research for themselves. A number of families thought that the INQUEST leaflet looked like something the police themselves would design because of the colour and nearly dismissed it because at that point the family wanted an alternative source of information.

2.2 Access to the Body of the Deceased

Families reported a range of experiences regarding their opportunity to identify and gain access to the body. In one instance the family were denied the opportunity to identify the body for three days and another family were told they could not identify the body as it was "sealed up" (i.e. in a body bag). Similarly access was denied on the basis that the body constituted a "crime scene" and any attempt to access the body could result in a possible "contamination of the scene". This misinformation suggested to the family that they were unable to access the body at all. Other families talked of having to identify their loved one through a glass partition and identification using a passport.

In some cases, families were informed of a serious injury to their relative where the family had contact with the police prior to death. Descriptions of questioning and insensitive treatment by the police were not uncommon. As one person said, *"I was*

interrogated at the hospital before I was allowed to see him. It was questions, questions, questions, but no answers. He was still alive and died three days later. It was cruel".

In addition, families outlined the practice of being asked to sign medical records release forms. This would appear to be without any explanation as to what was being signed and whether informed consent could be sought from individuals at such a traumatic and vulnerable time. There are legal guidelines on the processes for gaining access to and identifying a body, but the consistency of application appeared to fall short in the eyes of the families represented on the day.

2.3 Post-mortem Examinations

There is always a post-mortem examination following a death in custody and this is to be carried out on behalf of the coroner. Indeed families have no choice as to whether it happens and they are not required to give their consent. The coroner is expected to notify any relative of the deceased of the time and date of the examination and pass that information onto any relative who has notified the coroner of his desire to attend, or be represented at the post-mortem examination. Some of the family members reported that they were given no information on their legal rights regarding the post-mortem, the fact that it was mandatory and what it would entail.

Initial concerns from families centred on a failure on the part of the police, prison or coroner to inform them of their rights regarding the post-mortem examination. In some cases, families were not told they had a right to attend or to have someone present on their behalf. In others, families received information from INQUEST or via leaflets that alerted them to their rights. Some families reported that they only found out about the post-mortem after it had taken place. One family found out that the autopsy had been scheduled for the afternoon of the day on which they were informed of the death. Another family, who had been informed that a post-mortem had taken place without their knowledge, spoke to the coroner about the matter and found that *"He was very unsympathetic about the whole situation, telling us we could have another one, but*

would have to pay for it. We then had four weeks of extreme stress; who could pay for it, how could we pay for it? It was an absolute additional nightmare".

Some family members reported that information was also limited regarding the option of having a second post-mortem. Families can ask the coroner for a second autopsy and this can sometimes be crucial where there is doubt around the cause of death, where a family needs reassurance that a third party had no part to play in the death or where there is suspicion or rumour as to the cause. In one example given by a family member on the day, it was reported that the first post-mortem was not conducted properly and failed to ascertain levels of methadone in the body of their relative.

All information relating to autopsies needs to be given out immediately after the death occurs. However, families made the point that due to the shock and grief experienced, information is not always absorbed. It may therefore be useful to reiterate the families' rights a number of days after first being informed of the post-mortem examination process.

2.4 Role of the Coroner's Court

What became clear from the evidence given by families was the more detail, advice and support offered by all those concerned, the better for the families involved. This was especially true when considering the coroner's court and the officers of the court. Families require clear information about inquest procedures and the experiences discussed on the day suggest that currently this is at best patchy and at worst unhelpful and misleading (e.g. the misinformation surrounding post-mortem examinations).

The evidence of those on the day suggested that no one took the time or opportunity to explain the purpose of the inquest or what to expect when entering the coroners court. In some cases, coroners were described as "insensitive" and one family suggested, *"The kind of coroner you get is a lottery. Some are very right wing, pro-authority and unsympathetic"*.

Families also detailed how traumatic the whole process of being in the coroner's court was for them. They spoke of the trauma of hearing evidence, being presented with photographs and evidence from the post-mortem examination and living with the anticipation of re-living the experiences of hearing how a relative had died. One woman explained how she found it "*very daunting, and went to pieces*". Many of these scenarios are unavoidable due to the nature of the coroner's role, but the families did suggest that a greater level of empathy and sensitivity would be of benefit to others going through the same thing. Family members also complained about the lack of respect and dignity shown by some prison and/or police officers. One family member described how she had entered the court first and heard a senior police officer laughing and joking in court. She subsequently made a complaint and requested that she should enter court last. She noted the atmosphere was completely different the next time she attended the court and felt there was an air of respect that had not been present before.

Of further concern was the lack of privacy afforded to the families whilst attending the coroner's court. One person noted that "*The inquest lasted seven weeks. It was in the Town Hall, but all the rooms had been bagged by the lawyers acting for the authorities. I had to get my MP to put pressure on for us to have our own private room to wait in. We didn't want to sit alongside the police during lunch breaks, etc"*. Further to this, one family member reported that *"Some of these buildings had gatekeepers who were responsible for all the various 'customers' entering, and we observed that some of these gatekeepers were ill-informed or dismissive in their response to families seeking directions to the inquest"*.

There were areas of positivity during this section of the discussion. Praise was given to individual coroner's officers and assistants who were helpful with questions and expectations. Some families had experienced very useful pre-inquest meetings with the officials that had helped familiarise them with the court. Some families had the opportunity to attend the inquest of others after making contact with the relatives' families. It was suggested that this was *"very helpful and a chance to see what the coroner was like", "Very useful to see one and gain a sense of what was coming up"* and *"It was comforting to have other families around"*. Finally, one person made a

statement that was echoed by others present that the coroner's court was an opportunity "*To look those responsible in the eyes for the first time"*.

2.5 Role of the Institutions of Detention and the Investigating Agencies

The role of prisons, the police, the Independent Police Complaints Commission (IPCC) and the Prisons and Probation Ombudsman (PPO) are vital in providing information and advice following a death in custody. Families concerns centred on a number of issues. Initially the time it took to be contacted by the prison, police, PPO and IPCC and then when they had been contacted, they complained of limited information and unrealistic assessments of what would happen next. Families reported "*They* (the PPO) *were not capable of giving the information we required"* and *"We met with the PPO once, they wrote to me once and then they left us to it"*. Other families complained of not being clear what the role of the PPO or IPCC was and the specific roles individuals played in their case and no one taking the time to explain. One family member commented that they were "U*nsure what the role of all the Family Liaison Officers (FLOs) were, from the police, PPO, etc"*.

The perceived rigour of the investigation and the potential for delay also caused families anguish and upset. Many were upset at the way in which they were given a timescale for the duration of the process and how this had been proved unrealistic. One family were told by the PPO that the investigation would take six months when in fact it took a year and a half and other families complained of investigations *"not being done properly"* and lacking a thorough approach. However, particular scepticism was directed towards the IPCC. Families complained of *"incompetence"* and a *"lack of transparency"*. In one example, the family were given a set of discs containing CCTV footage of their relative's arrest and subsequent death. The discs were labelled with terms such as *"Officer refuses to pick him up"* and *"Police officer bashes him on the door"*. This lack of sensitivity was further compounded by the fact that the police force tasked with investigating the man's death had put together a rather more sensitively-compiled one-hour montage of the incidents that the family claimed the IPCC *"had not bothered to show us"*.

Others complained of inefficiency, with one family member reporting that "*We found that we had to investigate ourselves – the IPCC took seven months to interview the police officers, and nine months to interview the ambulance call takers"*. Another family suggested that the *"IPCC report was not worth the paper it was written on"*. In a prison death the family observed that *"It took several months for notices to be put up in the prison asking for witnesses to come forward, by which time many had left prison and evidence was potentially lost"*. Another raised concerns about the delay in going into the prison and said that "*We thought they (PPO) would go in straightaway to complete the investigation, but they did not"*. Another family member complained about the lack of information given by the PPO investigator commenting that *"I had to ask all the questions I thought necessary and he answered them. I was expected to ask him questions. Although I asked the questions, I did not know what to ask. You need someone by you holding your hand"*.

Some examples of good practice did emerge. Families were impressed with some of the FLOs with whom they had contact, who were quick to put things right and apologise for mistakes where previous errors had been made. Others talked of the PPO being *"Very nice, they gave us information, and kept us fully informed of the investigation"*. This view is supported by the *PPO Family Feedback Survey* (Gauge, PPO 2010), which found that "[Families] *were more satisfied with the family liaison element of the service than investigation processes and outcomes*". Another person noted that "*There were so many people the family had to meet it was all very confusing. Our FLO (PPO) was involved in the investigation and kept us regularly updated with everything"*.

Most tellingly however, was the lack of trust in the institutions of detention and those entrusted with investigation. The delays, mistakes and lack of sensitivity were compounded by the notion that people were not being entirely straight with them. As one person noted "*If the police and IPCC had been more open, done things quicker and properly then we would have trusted them more"*. Another bereaved mother noted that "*The investigation was lengthy and traumatic. On two occasions I had to take the IPPC and the police to judicial review because of the way they conducted themselves during the investigation and the bias that was shown. We wanted the investigation to*

be carried out in a fair and just manner but found the process extremely exhaustive at a time of deep bereavement, as we were fighting a system that was still marginalising families of victims of deaths in custody. It took five years to reach the inquest".

2.6 Disclosure and Funding Legal Representation

In response to the theme of advance disclosure of information, the families were consistent in their use of the term "*drip fed"*. Reference was made to getting *"Little bits of information and summaries now and again"*. In some instances, as referenced in the previous section, information was granted insensitively or after legal representation was made on behalf of families.

In terms of having independent legal advice at an inquest, one family was told "*Well, you're very articulate, and more than half the families don't have representation at the inquest so it's not really necessary"*. Many spoke of the hardship and cost they had endured having been turned down for legal aid. The amounts spent ranged from £5,000-6,000 up to £54,000. In this latter case, the individual involved was 79 years old and the family were looking at the potential sale of the family home to cover the costs incurred so far. Others spoke of the difficulty of negotiating their way through the means-testing forms. It was felt this was intrusive and demeaning as questions were asked about savings, mortgage payments and redundancy money and in some cases members of the extended family became embroiled in the process of ascertaining the potential *"wealth"* of the families involved.

Firstly, families had a sense of anger at the injustice of the funding regime on offer. As one person observed, *"It is unjust to means test a family that didn't choose to have their son killed at the hands of the state. We faced the prospect of risking all our family's savings on this one fight"*. On a similar theme another stated *"Their* [the state's] *legal bills are paid by my taxes. If your loved one has died you must be legally represented"*. Secondly, the failure to secure funding can have a massive impact on the legal representation for families and the scrutiny of the death. One family member reported that "*We would not have been able to have the psychiatric reports if we were*

not legally funded, which would have meant that key evidence would not have been touched on in the case".

Of additional concern to families was the cost of funeral payments, with inconsistencies as to who contributed and the amount. In some cases, the Prison Service offered £1,000 towards the cost, in another £3,000 and in one case, the family's solicitor had ensured that the full costs were met. Some were not told that the institutions concerned should contribute at all. Travel to and from the inquest also presented financial difficulties. No money was usually made available for travel and subsistence to attend the full inquest. The families' place of residence was often miles away from where the inquest took place and this placed additional cost and worry on the families. The prohibitive cost of rail travel meant one person attended the inquest for weeks unaccompanied by any other family member.

3. Institutional Attitudes and Behaviour

3.1 Delays

The most common complaint expressed by families was delay in the investigation and inquest process. This underpins the whole process and can place a huge strain on individuals and the extended family unit. As was pointed out, *"It all takes so long for no reason. We were still grieving while we wait for it all to be over"*. Another family claimed their *"Grief was on hold until it's all sorted out"*. Evidence was heard of delays in being informed of the death and in the subsequent investigations. Reports were written and rewritten, adding time and cost to the cases. One family member reported that "*We were told (by the PPO) the report would be ready in six months, but it took a year and a half*".

Families spoke of delays in information disclosure, getting public funding and in setting a date for the inquest itself. One family explained that *"We were told our coroner was a very busy man and we would have to wait two years. It set us back a further eighteen months just trying to get legal aid"*. Another person described how the

start of the inquest could be delayed as little as six hours before it was due to begin in an effort *"to get more information.*" Further to this was evidence that once underway, inquests could be delayed for legal reasons with one family reporting that "*There was a big delay in our inquest because the coroner refused to explore the system being inadequate. He said this was outside the scope of the inquest. Our lawyer had to take the coroner to judicial review to get his decision overturned. Luckily we only had to wait two and a half years".*

3.2 Family Participation – The Need for Independent Advice and Support

Families suggested that they wanted to be kept fully informed at all levels of the investigation and felt it was important that they could participate in the process. In some cases, their involvement was undertaken because of a perceived failing on the part of the agencies charged with investigating the death. What was clear though was a desire to get the information they needed, in a standardised way and to be given the chance to personalise the cases. They had information, evidence and personal details that would allow the investigators, the police or prison and the coroner to see their relative in the whole.

Families had examples whereby medical records did not accompany their relatives when they were transferred from one institution to another or evidence that warnings about an individual's mental health or previous suicide attempts had not been passed on to the relevant authorities.

3.3 Imbalance of Power

For many of those represented on the day the inquest itself embodied the imbalance of power. Families spoke of the institutions of detention having numerous lawyers present at the inquest and the sense that without legal representation the inquest would have been a whitewash, an attempt to ignore responsibility and exonerate those involved. As one person said, *"It is impossible for a member of the public to go to an inquest and ask the right questions because you don't know what is admissible and what is not".*

Another stated that *"The various authorities had twelve barristers. I had my solicitor. The coroner allowed parties to put questions to the jury. The twelve joined together to object to ours"*. Another noted that *"Even with the Local Authority and NHS lawyers at loggerheads, I'd have hated to go in there on my own"*. Another felt that *"Our barrister bore a lot of the stress that would otherwise have fallen on us"*.

Family members explained that without their solicitor, the case would have concluded differently. One individual reported that *"Without the legal team we would have been done for. Everything was uncovered by the solicitors. We were told we couldn't see the CCTV footage by the IPCC, the first thing our solicitor asked about was seeing the footage, she made it happen*". A further family member said that they *"Felt safe in the lawyer's hands*,[they] *kept us up to date with everything"*.

What was also made clear was that the families felt that some coroners were unsympathetic, appeared to favour the police or prisons and gave the impression of only grudgingly accepting that the families had legal knowledge and expertise on their side. In one case, the jury present had two members sleeping whilst evidence was being given. When the family asked for the jury to be discharged, the coroner told them it would take another year or two to re-enlist a jury. The family at that point had been waiting three and a half years for the inquest to go ahead. There was also evidence given of lawyers representing the police and prisons being aggressive and unsympathetic and trying to restrict the scope of the inquest and the opportunity to establish system failings. One mother said that *"The prison barrister gave me some stick on the witness stand. It was very upsetting*". Another family described how lawyers representing the Prison Service and the Primary Care Trust sought to restrict the scope of the inquest.

3.4 Learning and Saying Sorry

Families commonly expressed a wish that lessons were learned so that others did not have to go through the same things in the future. One noted that *"We are frustrated that we can't make things safer for other people"*. Some spoke of the system failings that had resulted in death, such as the imprisonment of people with mental health

problems and the difficulties faced by prison staff. One family said "*We didn't blame the individual officers who seemed traumatised. We spoke to them and reassured them"*. Many of those who were present had suggestions for improving the system and were disappointed that the authorities had not taken on board their ideas, observations and experiences.

No family had received communication from the authorities with assurances or promises that their procedures were being looked at and where found to be at fault changed. Crucially though, when families were asked if anyone had said sorry for the death of a relative, none were able to say they had received an official apology. Prisons did not send letters of apology and those police officers who did say sorry did so off the record and in private. Some families reported that coroners had expressed their sorrow for the family's loss. One family was still waiting to hear from a prison following a rule 43 ruling given at the inquest. The authorities are required to respond within 56 days and in this case, the coroner had made the ruling in October 2009. Families were undecided on the merits of an apology. Some welcomed the idea, saying that *"It would be helpful, sorry goes a long way. It would show they are human and they care"*. Others however, felt it would simply be *"A PR stunt if not genuine"*.

4. Family Suggestions for Change

The following suggestions must be considered in light of a number of key factors. Firstly, they are as a direct consequence of the dialogue that took place between families and members of the IAP who were present on the day. As such, they are framed in a way that directly reflects those thoughts, observations and suggestions. Secondly, some of these suggestions should already be a part of and indeed in some cases are protocols for the investigative and coronial system, but are either patchily adhered to or not enforced.

Finally, the context for any suggestions are rooted in a changing political landscape and the on-going effects of a worldwide recession. Suggestions are reliant upon resources as well as institutional will and as such will be open to question and

budgetary constraint. However, it is the families' hope that the system can be improved and made as robust as is possible and as such the suggestions that require a financial commitment have not been omitted.

Families made the following suggestions for change:

Overall Process

1. A systematic approach to giving information
2. Greater transparency in the system
3. An end to delays
4. Procedures that work well in one area should be shared and implemented within others
5. When information is conveyed or communication takes place it is done so in a humane and compassionate way, thus respecting the families' traumatic grief

Before the Death

6. Papers and notes relating to an individual to be moved with them or sent ahead of a transfer from one institution to another

After the Death

7. A standardised procedure for informing a family as soon as possible of the death of a relative
8. Families to be informed immediately about the whereabouts of the deceased and their right to see the body and given the chance to do so at their convenience
9. Families to be advised by the coroner's officer, Family Liaison Officer (FLO) or other agent of the date and time of the post-mortem examination and their rights to a second examination if required
10. Information about the death to be delivered by properly-trained staff with sensitivity and compassion.

11. Families to be given clear guidance on bereavement services and independent sources of advice and help as soon as possible after the death - currently vital information is often bundled up with other information and families can sometimes miss crucial information
12. Families to be informed about and signposted to appropriate sources of advice and support so that they can arrange adequate legal advice and representation, which will ensure they have a choice about how they participate in the investigation and inquest
13. All information relating to the investigation and inquest and sources of support to be re-iterated after the initial advice is given. This could happen two weeks after the initial meeting and at other key points in the process to enforce and ensure the families are able to take in the information.

The Investigation

14. That the Prisons and Probation Ombudsman (PPO) and the Independent Police Complaints Commission (IPCC) are more systematic, thorough and sensitive to the families' needs
15. That investigating bodies and institutions share information more effectively
16. Investigating agencies to contact the family in person and in writing promptly
17. Investigators to be trained to a national standard, thus ensuring a consistent delivery of advice, support and information exchange
18. Families to receive an on-going flow of information, keeping them up to date at every juncture of the investigation
19. Realistic time scales to be established from the outset, laying out the possible pitfalls and delays to the investigation and subsequent inquest

The Inquest

20. Non means tested funding to be available for families legal representation
21. The coroner's office to assign an officer of the coroner's court to work directly and consistently with the family and advise them of the process

22. Families to be given the earliest opportunity to meet the coroner, see the court and familiarise themselves with the environment
23. Open and transparent timescales for the inquest to be set shortly after the death by the coroner, with the opportunity to review, hear any reasons for delay and reset timescales
24. Funding for travel and subsistence to be made available so that family members can attend the full inquest

Post Inquest

25. A post-inquest protocol to be established whereby families are kept informed of subsequent actions and changes to policies and procedures as a result of the death, the investigation and inquest
26. Recommendations made by coroners in Rule 43 Reports to be taken up by the authorities and enforced
27. Any information and action taken relating to a Rule 43 Report to be communicated to the family in writing and within an allocated timeframe. This is already expected, but is patchily enforced
28. Recommendations from existing Rule 43 Reports should be routinely observed and acted upon
29. That the process permits accountability for those whose actions may be in part responsible for a custodial death

References

Transcribed notes from the Listening day event held on 30 March 2010.

Bereaved Families' Feedback Survey 2009 (Sue Gauge, Head of PPO Research & Analysis, Prisons and Probation Ombudsman February 2010)

Further Reading

Draft Coroners Bill: Analysis of Scrutiny by Bereaved People's Panel 9 November 2006: Department of Constitutional Affairs

Home Office Research Study 241: Experiencing Inquests (Davis, Lindsey, Seabourne and Griffiths-Baker, Home Office 2002

Unlocking the Truth: Families Experiences of the Investigation of Deaths in Custody, Shaw and Coles, INQUEST 2007

Appendix 1: Non- Family Attendees

IAP Members and staff

Lord Toby Harris	IAP Chair
Philip Leach	IAP Member
Stephen Shute	IAP Member
Alice Balaquidan	IAP Secretariat
Jane Boys	IAP Secretariat
Matthew Leng	IAP Secretariat

INQUEST Team

Deborah Coles	Co-Director – Workshop Facilitator
Damilola Eniola	Volunteer - Reception
Scarlet Granville	Caseworker – Workshop Note Taker
Maninder Jalaf	Caseworker – Workshop Note Taker
Helen Shaw	Co-Director – Workshop Facilitator
Chris Tully	Freelance Consultant – Workshop Facilitator and Report Writer
Nik Wood	Volunteer – Workshop Note Taker

Appendix 2: Agenda

IAP FAMILY LISTENING EVENT AGENDA

11.00	Tea and coffee
11.30	Introduction from Lord Toby Harris and Helen Shaw Questions and Initial Discussion
12.00	Facilitated Small Group Discussion – Immediately After the Death, Obtaining Advice and Support and Experiences of the Investigation.
13.00	Lunch
13.45	Facilitated Small Group Discussion – Waiting for the Inquest, the Inquest and Afterwards.
14.45	Final Plenary (Facilitated by Helen Shaw) Closing Remarks by Lord Toby Harris
15.30	Tea and Coffee
16.00	Close

Appendix 3: Follow Up Questionnaire to Families

Families were given a short questionnaire including the following questions at the conclusion of the day to give them the opportunity to make any additional comments

IAP Family Listening Event Questionnaire 30 March 2010

We hope that today's event gives everyone an opportunity to speak about their experiences. As there may be other things that you would like us to consider for inclusion in the report for the IAP, we have prepared this small questionnaire. Please fill it in if you would like and return to INQUEST in the stamped addressed envelope provided.

Name (optional):

Please add anything else you would like to about:

1. How you were informed of the death and access to your relative's body and the post mortem examination
2. What information you were given about access to independent advice and support
3. Your experience of the investigation
4. Your experience of legal advice and obtaining funding
5. Your experience of the inquest
6. Your experience after the inquest
7. Anything else you would like to add including whether there were any system and/or individual failings identified at the inquest or during the investigation that you want draw our attention to?