The impact of bereaved family participation in the inquest process in England and Wales following a death in custody

J.E Easton

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Department of Human Rights Centre, School of Law

University of Essex

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Abstract

This thesis studies the participation of bereaved families in inquests following deaths in custody in England and Wales. When a member of their family dies in custody, a family will usually want to understand when, where and how they died. When there is a possibility of negligence or culpability on the part of the State, it is even more important for a family to understand the circumstances surrounding the death. In those situations, it is also important for mistakes to be identified so that lessons may be learned and the State is held to account for its actions. Often preventing further deaths is as vital to the family as getting answers for their own peace of mind. An inquest is inquisitorial and the role of the coroner is to find the facts; so it can be argued that the participation of the family is primarily for their own closure and does not necessarily benefit the overall effectiveness of the investigation. This thesis shows that effective participation of a family (which includes ensuring they are legally represented and have access to all evidence) is vital to achieving accountability, as well as increasing the legitimacy of the process. The legal framework governing family access to an Article 2 investigation is considered, as well as the relevance of procedural justice theory for such investigations. Individuals with personal experience of inquests into deaths in custody including legal representatives, coroners, police officers and bereaved family members were interviewed to gather their views about the impact the participation of a bereaved family has on the effectiveness of the process. Perspectives described by these interviews are analysed within both legal and theoretical frameworks to take forward an understanding of why family participation in complex inquests is so important.

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CHAPTER 1: INTRODUCTION

Article 2(1) of the European Convention on Human Rights (ECHR) emphasises that a person's right to life "*shall be protected by law*." In 1978, the European Court of Human Rights (ECtHR) found that Article 2 of the ECHR not only prohibits the State from taking life but also places on it a positive duty to protect life.[1] This protective aspect to the right to life has been re-affirmed and expanded upon through numerous decisions of the ECtHR: elucidating on when and what steps must be taken by a State to protect life. In 1995, the ECtHR found in *McCann*[2] that in order to protect life, the State is required to ensure there is a proper investigation into any deaths caused by the use of force by State agents. Any investigation must be "independent, prompt, contain a sufficient element of public scrutiny, and be capable of leading to a determination of whether State agents are liable".[3] The investigation must consider not just the actions of agents of the State but also the planning and organisation of the operation governing those actions. European case law has since clarified that situations where a death may have resulted due to a failure on behalf of the State to protect life should also be investigated; this includes deaths in State custody. The ECtHR has also laid out certain minimum requirements which are necessary for an investigation to be seen as compliant with Article 2; including the opportunity for a bereaved family to participate in the process.

In England and Wales, an inquest is carried out into any death that occurs in custody or where the actions of a State agent might be found to be a causal factor in the death. Unless an inquiry is set up,[4] an inquest is the mechanism for fulfilling the requirements of an Article 2 compliant investigation. An inquest differs from other domestic jurisdictions as it is inquisitorial instead of adversarial: a coroner

[1] *Association X v United Kingdom* (1978) DR 14 (European Commission (Plenary))
[2] *McCann v United Kingdom* (1996) 21 EHRR 97 (European Court of Human Rights)
[3] Ibid, para 201
[4] For example The Bloody Sunday Inquiry into an incident in Northern Ireland where 13 people were killed by security forces during a demonstration. See http://www.bloody-sunday-inquiry.org.uk/

presides over the process which has the aim of finding facts.[5] The law establishes a right for families to participate in the inquest system following a death in custody[6] in order to protect their "legitimate interests". The right of family participation has evolved in UK law via common law, domestic legislation and UK case law reflecting ECtHR judgements. However, families still appear to have negative perceptions of the system and their own participation within it.

The organisation INQUEST has been working to support bereaved families through the inquest system of England and Wales for over thirty years. As well as reporting on specific cases and highlighting ongoing issues relating to deaths in custody, INQUEST represents the voice of families who struggle to participate in the complex investigations.[7] Academics such as Professor Scraton have also written about the difficulties families have experienced negotiating the inquest system following incidents such as Hillsborough.[8] Some families have told their own stories publically, including Audrey Edwards' book about the death of her son[9] and Sean Riggs' family giving evidence to parliamentary committees.[10] These stories illustrated not just the grief of families or their frustration at the State failing to protect the lives of their loved ones but also their negative experiences of the inquest system itself. Research has also indicated that a lack of consistency in how decisions are made results in an inconsistency in how families experience the inquest system.[11] The Government identified lack of consistency as a reason for why the inquest system needed to be reformed through the Coroners and Justice Act 2009, which came into force in 2013.[12] In response to a consultation on the implementation of the changes set out in this legislation, INQUEST stated there were still serious concerns in relation

[5] References to the inquest process throughout this thesis cover the period of time from when the coroner is notified about a death to the point at which an inquest verdict is given.
[6] This thesis is using the term "death in custody" as a shorthand to refer to all deaths in state detention including in prisons, secure training centres, police custody, immigration detention centres and psychiatric detention and those deaths involving contact with State agents; as described by INQUEST. http://www.inquest.org.uk/issues/home
[7] INQUEST, *How the Inquest System Fails Bereaved People* (2003)
[8] P Scraton, *Hillsborough: the truth* (Mainstream Digital 2010)
[9] A Edwards, *No Truth, No Justice* (Hampshire: Waterside Press 2002)
[10] Home Affairs Committee, *Independent Police Complaints Commission: Eleventh Report of Session 2012-3. HC494* (2013); Ev16-9
[11] John Cooper, *Inquests* (Oxford and Portland, Oregon 2011)
[12] Home Office, *Reforming the Coroner and Death Certification Service: Position Paper* (Cm 6159, 2004)

to lack of consistency of practice by coroners, poor communication with families and issues with disclosure of evidence to families.[13]

The evidence compiled by Professor Scraton, INQUEST and others[14] indicates that families experience huge challenges in accessing their right to participate in Article 2 inquests.[15] The previous work has illustrated problems with the law, policy implementation and differing practice around England and Wales; all of which contribute to families' negative perceptions. Firstly, although the law ensures each family have the right to be legally represented, the lack of equity in funding for said representation is a gap in the law that leaves families struggling to find and pay for adequate legal support. Secondly, policy directives to relevant police and prison investigative agencies require them to provide families with access to all relevant evidence related to an investigation; but in practice there can be delays before families are given the documents, if they even receive them at all without the intervention of their legal representation forcing disclosure. Thirdly, although family access to the inquest process is legally protected, in practice lack of information about the process as well as a lack of support provided to families prevents them participating fully. Access depends on decisions taken by coroners, their officials as well as other State agencies; and although there are examples of good practice, many do not take a process value approach which would ensure positive engagement with families. Even where families are able to participate effectively with the support of INQUEST and legal representatives, where they feel they have had to fight for their rights, families are left with negative perceptions about the process and the State actors involved. Campaigns by organisations such as INQUEST highlighting the negative perceptions of families to encourage change have still not been completely successful in improving families' experiences of the inquest system. This thesis takes an alternative approach of

[13] INQUEST, *Response to Ministry of Justice consultation: Post-implementation Review of the Coroner Reforms in the Coroners and Justice Act 2009* (2015)
[14] L. Thomas and others, *Inquests; a practitioner's guide* (3rd edn, Legal Action Group 2014)
[15] For all the negative experiences expressed by these families, it should be noted that the families who engage with the media are often supported by INQUEST as well as experienced legal representatives but the majority of families have to negotiate the system with no support at all and their voices are rarely heard.

looking at why participation is important, what benefits are possible to families and the wider system and how these benefits can be achieved.

A legal system, it may be argued, frames moral values agreeable to society; therefore compliance with the laws associatively ensures moral behaviour.[16] Consequently, there is a moral necessity in complying with the principles set out in law; and therefore a process complying with principles of justice is intrinsically important. Gray points out that law may be set out in legislation but tested and applied by courts and other agents of the State.[17] Therefore to evaluate any rule against norms, it is important to consider how it is applied in society, not how it is set out in legislation. In considering the implementation of Article 2 requirements via the inquest system, it was decided to collect the views of varied stakeholders who have experienced Article 2 inquests. In order to identify what benefits could result from family participation, it was important to hear from people with experience of participating in the inquest system following deaths in custody. Bereaved family members were the primary focus of the interviews but it was also important to hear from State officers. In addition to the perceptions of families and State officers, who are usually only involved in one inquest; other interested parties with experience of many such inquests were also interviewed. This included coroners, legal representatives for families and representatives of the two investigatory bodies responsible for investigating deaths in prison and police (Prisons and Probation Ombudsman (PPO) and Independent Police Complaints Commission (IPCC)[18] respectively). Analysis of those views were then used to reflect experiences of the practical implementation of families' participation in the inquest system.

The right for families to participate in an Article 2 inquest has been established to protect their legitimate interests; which are set out as learning the truth, being confident any State failings have

[16] L.L. Fuller, 'The Morality of Law, rev. ed' (1969) 33 New Haven and London, p 205
[17] RC Gray, *The nature and sources of the law* (2nd edn, Macmillan 1948)
[18] Section 33 of the Policing and Crime Act 2017 changed the title of the agency responsible for investigating police from IPCC to Independent Office for Police Conduct but IPCC will be used throughout this thesis.

been identified and future deaths prevented.[19] This thesis argues family participation also benefits the legitimacy of the process itself in two ways; firstly by scrutinising the evidence and actions of the State, families can maximise the opportunities for an accurate outcome and ensuring accountability. Secondly, there is intrinsic value to ensuring fair and effective participation for families. Richardson explains a legal right as "an undertaking from society that certain interests will be protected" so any infringement of an individual's rights can be considered as treating them unfairly.[20] In considering the impact of treating individuals unfairly in relation to participation in a legal process, this thesis looked to procedural justice theory to understand the impact families being left with negative perceptions about participating in an inquest process. Tyler has lead research on procedural justice theory which considers the impact of negative perceptions of participants in varied criminal justice procedures including police interactions, criminal prosecutions and prison adjudications.[21] The research shows negative experiences relating to how unfairly an individual feels they were treated during a process lead to negative perceptions about the legitimacy of the process, which are then linked to reduced confidence in and compliance with the outcome. This thesis gathered evidence to show the same impact occurs in relation to families' participation in an inquest process.

It was important to look to theoretical frameworks to establish why participation is important because if the benefits can be understood, decision-makers can interpret the rules in a way which ensures the benefits are optimised. In relation to the inquest system, important aspects relating to family participation are left to the discretion of decision-makers. An individual coroner adjudicates over an inquest and as it is an inquisitorial system, the coroner has considerable discretion to make decisions

[19] *R (Joanna Letts) v Lord Chancellor* [2015] EWHC 402 (Admin) (England and Wales High Court (Administrative Court)), para 70

[20] G. Richardson, *Law, process and custody: prisoners and patients* (Weidenfeld and Nicolson 1993), p 28

[21] E.A. Lind and T.R. Tyler, *The social psychology of procedural justice* (Springer 1988); T.R. Tyler, *Why people obey the law: Procedural justice, legitimacy, and compliance* (New Haven, CT: Yale University Press 1990); T.R. Tyler and Y.J. Huo, *Trust in the law: Encouraging public cooperation with the police and courts* (Russell Sage Foundation Publications 2002); Tom R Tyler, 'What is procedural justice?: Criteria used by citizens to assess the fairness of legal procedures' [1988] Law and Society Review 103; Michael D Reisig and Gorazd Mesko, 'Procedural justice, legitimacy, and prisoner misconduct' 15 Psychology, Crime & Law 41; Jonathan Jackson and others, 'Legitimacy and procedural justice in prisons' (2010) 191 Prison Service Journal 4

about aspects important to family participation. Another important aspect to participation is access to legal representation, but unless families can fund this themselves, the decision of whether to provide funding is left to the discretion of the Legal Aid Agency. The aim of this thesis is for where there are discretionary powers exercised relating to family participation, decisions will be made in a way that ensures family participation is effective and they therefore result in positive perceptions about the process itself.

Chapter 3 begins by discussing the legal protections in place relating to the participation of bereaved families in Article 2 compliant investigations, setting out the framework within which the inquest system works in relation to deaths in custody. The benefits of a fair process, specifically participation of interested parties, are then considered in Chapter 4; focusing on the impact on optimising a fair outcome and legitimatising the process itself. These two chapters set out relevant norms against which the perceptions of stakeholders with experience of complex inquests can then be assessed. The findings from the interviews of participants are analysed in three distinct chapters, Chapter 5 considers the purpose of family participation in protecting their legitimate interests. Chapter 6 considers how family participation can also benefit the process itself; both in terms of ensuring a fair outcome which can identify any culpability of State agents relating to the death investigated and also in improving perceptions of the legitimacy of the system. Chapter 7 analyses what participants felt were necessary factors to ensure effective participation and therefore maximise the likelihood that the benefits presented in the previous two chapters could be achieved. Chapter 8 discusses the analysis of the views presented during the interviews against both the legal and the theoretical norms. Chapter 9 summarises the key benefits of family participation as protecting their interests, impacting on their grief process as well as improving the legitimacy of the process through influencing the outcome and leading to more positive perceptions about the process. Important aspects that ensure fair and effective participation for families are set out; including access to the process, provision of expert legal representation and access to relevant evidence. The need for decision-makers to treat

families with respect and openness is also key. Recommendations are also made which highlight positive changes that can be made to the inquest process.

CHAPTER 2: METHODOLOGY

2.1. Introduction

This dissertation considers the effect of the participation of bereaved families in the inquest process following a death in custody. The researcher takes the humanist approach that natural and social worlds are too different to be studied in the same way.[22] There are some similarities in that human behaviour is in some way rule governed;[23] and underlying structures and mechanics are involved in causal processes that occur.[24] However, society is complex and theoretical concepts only tell part of the story; in reality concepts are transformed in practice in subtle but relevant ways.[25] Studying the rules or underlying structures will not uncover the complete picture of the social world. Events can have context-specific meaning which goes beyond generalisations of causal behaviour.[26] Consequently this thesis assumes an interpretative rather than a positivist approach to empirical research.

In order to reach a deeper understanding of context-specific events, the researcher used a qualitative methodology of gathering perceptions from individuals who had direct experience of inquests into deaths in custody through semi-structured interviews. Qualitative research is generally concerned with interpreting rather than quantifying data and looks to personal experiences to make sense of the social world.[27] Qualitative research allows the interpretation of experiences which Heidegger describes as the fundamental process in providing understanding of the world around us.[28] The

[22] Ted Benton, *Philosophical foundations of the three sociologies* (Routledge & Kegan Paul London 1977), p 12
[23] Peter Winch, *The Idea of a Social Science and its Relation to Philosophy* (1958), p 52
[24] Russell Keat and John Urry, *Social Theory as Science (Routledge Revivals)* (Routledge 2011)
[25] Roy Bhaskar, 'On the possibility of social scientific knowledge and the limits of naturalism' (1978) 8 Journal for the Theory of Social Behaviour 1, p 130
[26] Peter Burnham and others, *Research methods in politics* (Palgrave Macmillan Basingstoke 2004), p 36
[27] Jonathan A Smith, *Qualitative psychology: a practical guide to research methods* (Sage 2007), p 2
[28] Martin Heidegger, *Being and time, trans. J. Macquarrie and E. Robinson* (New York: Harper & Row 1962)

benefits of qualitative research are that, by collecting a range of views, it can provide a more detailed, descriptive account of a situation.[29] This thesis obtained personal experiences of the inquest system in an approach similar to a case study methodology which utilises specific situations or experiences to create a theory or concept.[30] Gathering different insights into the inquest system allowed the researcher to collect a range of views. Commonalities could therefore be interpreted as likely generalities in terms of the specific situation being studied; in this case inquests following deaths in custody in England and Wales. Generalities which in this thesis are taken from perceptions common to all or most participants interviewed cannot necessarily be translated to the wider population who have not had direct experiences of these inquests, but can be considered as valid for those who have experienced complex inquests.[31] Twenty interviews were carried out; five interviewees were bereaved families (FA), six were legal representatives specialising in complex or Article 2 inquests (LA), four were coroners (CO), three senior policeman (SP and two recently retired officers who were classified as Ex-Senior Policeman (ESP)), and two representatives from relevant investigatory bodies (PPO and IPCC).[32]

This chapter begins by setting out the general reasoning why a qualitative research methodology was used for this research (section 2.2); and providing background on the Interpretative Phenomenological Approach (IPA) followed by the researcher (section 2.3). The specific methodology followed by the researcher in relation to selecting participants and the collection then analysis of data is then described in sections 2.4, 2.5 and 2.6.

[29] Burnham and others, p 65-6
[30] Ibid, p 63
[31] Ibid, p 66
[32] Details about how participants were selected will be discussed in Section 2.4.

2.2. Qualitative research methodology

In terms of evaluating a research project; reliability and validity are both important.[33] Generally qualitative research is seen as valid but not necessarily reliable as it is not repeatable.[34] Reliability of research tends to look at whether it is repeatable and static.[35] In terms of qualitative interviews, although they could be repeated, it is highly unlikely that the data collected would be the same. Qualitative research through interviewing is a dynamic process with the researcher playing an active part.[36] Interviews collect data that is context-specific; a snap-shot of a particular event or experience. Although not repeatable, the information that can be gathered through detailed interviews is invaluable in identifying individual perceptions about a specific experience. In fact, qualitative interviews are the best way to collect views and opinions which allow the researcher to dig behind statistical data. In gathering opinions and perceptions, this approach must acknowledge that these are likely to change over time. For example, all the evidence gathered for this thesis related to experiences of the inquest system before the Coroners and Justice Act 2009 came into force; it is likely this new legislation will have repercussions about how the system is experienced. In terms of participants who continue to work in the inquest system (such as coroners and legal representatives), as well as likely changes due to the Act; each case will bring new insight and experience. Although it is to be hoped that bereaved family members and individual State officials (not including representatives of PPO or IPCC) will not experience inquests again, their memory and therefore perception of the experience is likely to continue to change over time. It is also true for some of the bereaved family participants that the process is still ongoing (in terms of appeals, judicial reviews etc.).

[33] Burnham and others, p 39
[34] D Marsh and G Stoker, *Theory and Methods in Political Science* (London, UK, Palgrave Macmillan 1995)
[35] Ibid
[36] Jonathan A Smith and Mike Osborn, 'Interpretative phenomenological analysis' in *Qualitative psychology: A practical guide to research methods* (Sage Publications Ltd 2003), p 51

Validity is tested through the honesty and specificity of the data collected.[37] Specific data was collected in this project by gathering personal experiences, not just relying on anecdotal examples. The honesty of the data can be established in a number of ways. Firstly, there was no reason for participants to lie as there was no benefit to be gained. Almost all the participants were self-selecting so there was no requirement or pressure to take part if they did not feel they had any thoughts or experiences to share. This was true apart from representatives from the PPO and IPCC which will be discussed later.

Secondly, the interviews were conversational in approach, which allowed participants to lead the direction taken and therefore the issues covered.[38] Participants only answered questions they were comfortable with, so if they were unsure or had nothing to say in response to a question they could say so and move on. The interviews collected each participant's perceptions about their experiences and how they had contextualised their involvement in complex inquests over time. It must be noted that participants were often referring to their response to a situation in the past but the views they represent during the interviews will actually be their opinion interpreted through a prism of everything that has happened since that situation. So they may say they felt anger at a particular point, but may actually be remembering anger which formed gradually over time rather than being felt at that point. Where participants acknowledged a change of their own opinion over time, this was referenced during the analysis of the interviews.

Concepts of validity and reliability were established in relation to natural science research; in particular quantitative approaches. Qualitative researchers look beyond validity and reliability to concepts such as credibility and dependability.[39] The data collected in this project relies on the relevance and specificity of the experiences of participants to ensure credible and dependable data. Participants from each group had specialised knowledge; families through their experience; coroners

[37] Marsh and Stoker

[38] Details setting out the themes and skeleton questions used for the interviews are to be found in Sections 2.2.1.2 and 2.5.

[39] Irving Seidman, *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (Teachers College Press 2012), p 23

as they all had extensive experience of custody inquests; and the legal representatives interviewed were experts in their field. In terms of qualitative interviews, the objective is to make sense of an individual's experience so the data collected in this project should be seen as valid. [40]

2.2.1. Benefits of interview based research[41]

The purpose of interviewing is to understand "the lived experience of other people".[42] One to one interviews allow the exploration of opinions and perceptions in relation to situations or experiences that are either complex or sensitive.[43] Collecting a wide range of views, especially across groups with distinct perspectives, ensures a complete account is given.[44] Although it can be considered a limitation to valid research if participants are self-selecting, where lengthy interviews asking for participants to share personal experiences are utilised to gather detailed perceptions, it is beneficial to use self-selection. Similarly, for a project where experience is needed of a specific situation or circumstance which is rare, sample size is necessarily small. This is why detailed interviews with a small number of participants were chosen for this particular thesis, which relies on perceptions of complex inquests following deaths in custody.

2.2.1.1. Role of interviewer

The position of the interviewer is also recognised in this type of research as an instrument to improve the quality of the data collected; the interaction between the interviewer and the participant is

[40] Ibid, p 24
[41] Details of how the interviews were carried out for this thesis are described at Sections 2.4 and 2.5.
[42] Seidman, p 9
[43] Wendy Hollway and Tony Jefferson, *Doing qualitative research differently: Free association, narrative and the interview method* (Sage 2000)
[44] Burnham and others, p 65-6

therefore crucial and must be acknowledged as unique to this research project.[45] It was important that the interviewer had expertise and knowledge relevant to the issues under discussion.[46] This ensured the flow of the interview as the interviewer understood the background to much of the answers given as well as references to specific cases or practices and policies specific to custodial institutions. This allowed participants to give more detailed answers without feeling the need to simplify issues or provide detailed explanation to the context. The role of an interviewer is to create a space within which the participant feels comfortable to share personal experiences and perceptions.[47] One way that this was done was to give each participant control over when and where the interview occurred. Participants were also asked if they would prefer others to be present; FA4 took up this offer and their father (FA4 Father) was included in the interview.

It is also important in conducting semi-structured interviews that rapport between interviewer and participant is established to produce rich data.[48] This was particularly true in relation to the bereaved families who participated in this project. The researcher had previous experience working with families at INQUEST which was useful to establishing a trusting relationship with participants; allowing them to share very personal and painful experiences. The researcher's previous role at INQUEST was to provide families with information and support; so they had experience of listening to people's painful stories in a respectful manner. The aim of this research was not to provide a service or support to the families but collect their views and perceptions so the researcher had to prepare for the interviews appropriately. However, the researcher valued what each participant had to say which was also important in gathering detailed data.[49]

[45] Seidman, p 23
[46] Burnham and others, p 185
[47] Smith and Osborn, p 57
[48] Ibid, p 57
[49] Seidman, p 9

2.2.1.2. Themes of Interviews

In semi-structured interviews, researchers use an established schedule for all interviews but the process must also be flexible, allowing the interviewer to respond to each participant's specific experience.[50] The researcher followed a semi-structured interview approach, with only a skeleton framework covering a handful of issues which were most relevant to the research question. Generally, participants were encouraged to talk about whatever they felt was most important; with the interviewer only interjecting to either clarify or examine an issue raised or to guide them towards the skeleton framework if necessary. This was especially important in relation to introducing sensitive issues and ensuring the interview flowed while discussing complex and sometimes controversial topics.[51] The questions were used as a general guide, with each participant being encouraged to only answer questions if they had relevant personal experiences or opinions. This ensured each participant was allowed the space to talk about their own experiences.[52] This did create some disparity between all the interviews as each participant did not necessarily cover exactly the same ground. It did, however, ensure that the data collected was specific and contextual to each individual.

Each interview followed four broad themes:

1. Participants perceptions of the inquest process;
2. What participants considered to be important aspects to involvement of bereaved families;
3. What participants considered to be the effect of family involvement;
4. How participants felt the inquest system related to ensuring accountability.

The questions were neutral rather than leading and open rather than closed to encourage detailed responses.[53] The interviewer encouraged more detailed answers by asking for clarification or more

[50] Smith and Osborn, p 56
[51] Ibid, p 57
[52] Ibid, p 57
[53] Ibid, p 61-2

details as appropriate, without directing the conversation.[54] Probes were used as minimally as possible to limit how much the interviewer lead the conversation while encouraging the participant to continue sharing.[55]

2.2.1.3. Appropriateness of interview for this research

One argument is that there is a fundamental problem with an approach that relies on descriptive inferences or interpretations of interviews in that it is impossible to use placebos or controls with interview based research.[56] It means that what is called unit homogeneity cannot be shown; because any effect described cannot be proved to be due to a specific stimulus or cause present in one situation but not another. This is particularly relevant in relation to one important issue raised through this research; that legal representation makes a vital difference in terms of the effective participation of families. All the family participants were either contacted through INQUEST, legal representatives or a support group and all families involved with either INQUEST or the support group had legal representation. Therefore, this project cannot show categorically how families' experiences might be altered by the fact that they had legal representation as there was no control group of families not represented. It is unfortunately true that unrepresented families often do not find their way to INQUEST or the support group or conversely if they do; they are encouraged to follow advice and find a suitable lawyer. It is also true that interviews cannot be replicated, only corroborated (as discussed above in relation to repeatability).[57]

[54] Burnham and others, p 123
[55] Smith and Osborn, p 63
[56] Burnham and others, p 178
[57] Gill Valentine, 'Tell me about…: using interviews as a research methodology' (1997) 2 Methods in Human Geography 27, p 111

Burnham and others argue that the interviewer effect might result in participants giving different responses depending on the perceived sympathy of the interviewer.[58] This would obviously be relevant in respect of this researcher as participants may have perceived the researcher to be sympathetic towards families in relation to complex or conflicted inquests both due to the research question and the researcher's previous role at INQUEST. The role of INQUEST was to support bereaved families which often put them in conflict with State officials. However, generally the authorities respect the role INQUEST performs and trust the organisation to be fair and representative; INQUEST has positive working relationships with all institutions including Government officials, the PPO and IPCC.

Understanding for the position of a participant can arguably gain more honest and full answers and the interviewer's previous experience was linked to supporting bereaved family members. It is therefore possible that the views of the families and those that support them through inquests are more strongly represented than the voice of State parties in this thesis. However, direct comparisons were not being made between the groups unless clearly stated which would off-set any disparities in the quality of the interviews achieved with the different groups. It is also true that there is a large diversity in approaches and attitudes among coroners (confirmed by the interviews[59]) but as participants were well aware of the issues covered by the thesis before agreeing to take part, it is possible coroners with more interest or empathy in relation to families' participation were more likely to offer to be interviewed. In addition, it should be noted that research has indicated if an interviewer is perceived as sympathetic by a participant, they might offer "additional information on sensitive topics" but not false information.[60] So while the interviews with family members, legal representatives and coroners might have provided fuller and more complex perceptions, it is unlikely they are invalid.

[58] Burnham and others, p 124
[59] It is important to note that interviews were carried out when the Chief Coroner had only been in post for a couple of months and greater consistency among coroners may well be a consequence of this statutory position.
[60] Burnham and others

2.3. Interpretative Phenomenological Analysis Approach

Qualitative interview research includes many different approaches both in terms of how participants are questioned and how the data is analysed.[61] This thesis utilised the Interpretative Phenomenological Approach (IPA) methodology which is most commonly used in psychological research to interpret first person accounts phenomenologically (using first person experience).[62] IPA is a useful tool to explore a complex situation in great detail using perceptions of relevant participants.[63] IPA is used to analyse personal accounts of a situation which provide rich, detailed data from a small sample size; so it was an appropriate approach for this project, as only a small number of people have experience of complex inquests into deaths in custody but they can provide detailed information. IPA is most appropriate to answer open and exploratory questions by focusing on the experiences of individuals to identify patterns and themes. IPA is a commonly used methodology in psychological and forensic psychiatric research but over the last few years it has also been used by researchers working in secure settings such as prisons, as well as being used to gather perceptions about participating in legal systems. [64] IPA was used by said researchers as the aims of the projects were to gather personal experiences from potentially vulnerable individuals. IPA allows the interviewee to "tell their own stories in ways that were meaningful for them".[65] IPA also allows the interviewer to engage positively with the interviewee and the issues being raised, which, can be

[61] Smith
[62] Michael Larkin, 'Interpretative phenomenological analysis - introduction' (2013)
[63] Smith and Osborn, p 53
[64] Anna Gekoski, Joanna R Adler and Jacqueline M Gray, 'Interviewing women bereaved by homicide: Reports of secondary victimization by the criminal justice system' (2013) 19 International Review of Victimology 307; Niamh Kennedy, 'An interpretative phenomenological analysis of prisoners' experience of riotous behaviour in an adult male prison' (2014) 16 Journal of Forensic Practice 203; Christina Back, Per A Gustafsson and Carina Berterö, 'Sexually Abused Children–Prosecutors' Experiences of their Participation in the Legal Process in Sweden' (2013) 20 Psychiatry, Psychology and Law 273
[65] Gekoski, Adler and Gray

argued, ensures the interview is more focused towards the needs of the interviewee.[66] It was therefore suitable for the research questions posed by this thesis.

Phenomenology considers how people make sense of their experiences; it describes how individuals perceive the world through interacting with it and what meaning is given to that engagement by each individual.[67] IPA understands personal experiences to reflect an individual's interaction with society through a prism of their own understanding.[68] It allows that an individual will have a unique experience, but goes further in suggesting some aspects can transcend that unique and specific context and provide universal concepts which can be used to explain or describe the experience to others.[69] Shutz describes this as "reciprocity of perceptions" where a shared framework of meaning allows us to approximate others experiences such as colour.[70] Contentious inquests following deaths in custody involve a relatively small number of people but detailed interviews with people with experience of such inquests can provide insight that can be understood and appreciated by those who have not had a similar experience.

IPA requires the collection of first person accounts through semi-structured interviews in order to gather a rich and detailed record of an individual's perceptions about an experience.[71] The researcher then interprets those experiences in order to gather insights into a particular event or situation. IPA therefore involves two different strands of analysis: the first describing the participants interpretation, the second is the researcher's analysis of that interpretation.[72] Hermeneutics relies on language as the means to shared understanding and conversation can be a form of negotiation to establish that understanding.[73] So allowing for two different analysis strands is known as double hermeneutics. IPA

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[66] Rebecca Campbell, *Emotionally involved: The impact of researching rape* (Psychology Press 2002)
[67] Smith and Osborn
[68] Ibid, p 52
[69] Husserl as referenced by Larkin; Peter Ashworth, 'Conceptual Foundations of Qualitatitive Pyschology' in Jonathan Smith (ed), *Qualitative psychology: A practical guide to research methods* (Sage Publications Ltd 2003), p 23
[70] Alfred Schütz, *The structures of the life-world*, vol 1 (Northwestern University Press 1973), p 60
[71] Smith and Osborn, p 55
[72] Ibid, p 51
[73] Larkin

benefits from small sample sizes with purposive recruitment of participants who have specific insight into a situation and homogeneity across the groups in terms of experiencing similar situations. This allows insights into common understandings as well as identification of differences of specific contexts.[74] This thesis used data collected by carrying out one to one interviews with people who have personal experience of inquests. Inquests involve different parties who have distinct roles and in order to gather a complete picture of the system, interviews were carried out with individuals from the different groups. The groups identified were coroners, bereaved families, State officials and legal representatives. The aim was to interview four to five individuals from each group; following the IPA approach of small samples sizes for each homogenous group. Each group has a different role to play in the system, so it was important to allow for potential commonalities and differences in perceptions between each group as well as within a group. In that way, descriptive inferences could be used to create generalisations from unique perspectives; using observations to establish agreed themes and issues.[75]

2.4. Participants

2.4.1. Selecting participants

Interviews allow understanding of context, experiences and meaning so participants should be selected who have particular insight and can provide illustration of an issue, rather than attempting to find participants who are diverse and representative.[76] This research therefore used purposeful selection in identifying sample groups.[77] A combination of gatekeepers and snowballing[78] were

[74] Ibid
[75] Burnham and others, p 172
[76] Valentine, p 112
[77] Seidman, p 43
[78] Snowballing is a technique which relies on one participant leading the researcher to another participant with relevant experience; see Alan Bryman, *Social research methods* (Oxford University Press 2015), p 415-6

followed to select participants. It is important in using gatekeepers that they are seen as legitimate authorities or representatives; so only respected authorities or membership groups were contacted.[79]

1. A gatekeeper approach was used for contacting coroners through the Coroner's Society. The secretary of the Society was contacted with a brief explanation of the research and they were asked to disseminate details of the research through the Society. The secretary agreed and sent the information sheet to all coroners, asking those with particular experience of custodial inquests to contact the researcher if they were willing to participate.[80] At the time of the request for coroners to take part in this thesis there were about 110 coronial areas but deputy coroners are also members of the Society so the request was sent to about 150 people.
2. State officials were contacted in two ways:
    a) Relevant institutions were identified as the two independent investigating bodies whose reports are the basis for inquest proceedings: the PPO and the IPPC. These were contacted and in each case, representatives of the organisation agreed to be interviewed. These representatives were chosen by the organisation and these were the only instances where participants were not necessarily self-selecting. The researcher was not privy to discussions within the organisations and therefore had no way of knowing whether the individuals volunteered or whether they were chosen and if designated, whether they had the option to refuse. It should therefore be acknowledged that it is possible they had no option and were told to participate by their superiors.
    b) Other participants within this group were individual police officers: one was still an active officer and the others were ex-officers. Initially the information about this project was sent to a number of national representative bodies related to both police and prison officers but this did not result in any response from possible participants. Ultimately the

[79] Seidman, p 43
[80] It should be noted that some coroners may have little or no experience of holding custodial inquests: coroners with a prison within their geographical remit are most likely to have this experience.

police officers were all obtained through the snowballing approach of meeting one individual and that participant suggesting others. The researcher met the first officer at an academic conference; they then suggested another individual. The other participant was contacted through a coroner interviewed as part of the project. All freely chose to participate and had specific experience of custody inquests.

3. Legal representatives were identified through membership of the Inquest Lawyers Group which is open to any lawyer who works in the area of inquest law. All therefore have specialised knowledge and experience but the group is predominantly for those who represent families, so in general this group had less experience representing State parties. This approach was taken for two reasons, firstly, the Inquest Lawyers Group is the only group for those lawyers with a specialist knowledge and therefore experience of custodial inquests and there is no comparable body for those who represent State bodies. Secondly, two of those interviewed did have previous experience of representing groups other than families; including insurance companies and hospital trusts. In addition, one of the coroners interviewed represented State bodies as a solicitor, where their views were as legal representative to the State, this was clearly stated as part of the analysis chapters. Twenty of the most experienced legal representatives were identified; guided by the researchers own personal knowledge and expertise in the sector; ten solicitors and ten barristers (as they perform different roles in representing families). They were all contacted, and the first six who responded all agreed to participate.
4. Families were contacted in four different ways:
    a) INQUEST shared the research with families who they had either supported or continued to support via their regular newsletter;[81]

[81] It should be noted the newsletter is actually available on INQUEST's website, so families who did not have direct contact with INQUEST but were looking for information about inquests might have found information about the research. No family participants were identified this way.

b) Details about the research were shared with a support group via their closed Facebook page (called NO MORE DEATHS IN CUSTODY). This group is open to any family or friend of an individual who has died in custody; membership is only agreed for people known by other members;

c) One of the lawyers interviewed shared the research with a family member who they thought would want to take part;

d) One participant was known to the researcher from their time at INQUEST, and contacted the researcher directly when they heard about the research.

The researcher was keen to engage with families who had not necessarily been in the public eye for two reasons, firstly it is likely that such cases have already been analysed in previous work and secondly because where families have either given extensive interviews or evidence (such as in the case of Sean Rigg) or written about their experiences (for example Audrey Edwards) information about their experiences could be accessed from the public domain.

All initial contact was via email; first contact with participants involved them being sent an information sheet,[82] explaining the purpose of the research and that interviews would be carried out face to face. First contact between the interviewer and participants was very important in establishing a rapport which was vital in ensuring detailed interviews.[83] No one refused to participate having been initially contacted by the researcher. Once people had agreed to participate, the interview process was explained in detail, including the fact participants could suggest locations where they felt most comfortable, interviews would be recorded and participants would be asked to sign a consent sheet (which was sent to them prior to the interview taking place). Participants were able to ask more questions about the research before interviews took place. All participants were offered anonymity but were allowed to wait until the interview was completed before deciding whether they would prefer to remain anonymous. Most participants took advantage of this; with two people initially

[82] Annex I
[83] Seidman, p 46

signing a consent sheet saying they were happy to be named but on completion of the interview, asking if they could change their minds. In those cases, the initial consent form was torn up and returned to the participant and a replacement consent form was signed. In terms of the locations of interviews; most coroners, State officials and lawyers chose their own offices, a couple chose cafes and one State official was interviewed in their home. All but one family participants invited the researcher to their own homes; the other person asked for the researcher to book a suitable office space near their work place.

2.4.2. Ethics

The researcher completed a detailed application for ethical approval for research involving human participants from the University of Essex, Law Department's Faculty Ethics Committee before beginning the empirical research. The application included details of which participants would be contacted to take part in the research, any particular vulnerabilities of proposed participants, how informed consent would be obtained, arrangements for ensuring confidentiality if requested, how the data would be securely stored and any possible risks to either participants or the researcher. Ethical approval was granted in July 2012.

1. Bereaved families could be considered as being in a vulnerable position through both their grief and the possible impact the inquest procedure may have had on their life. It must be appreciated that those who were willing to participate were more likely to have only recently gone through the inquest or were continuing to campaign on some of the issues raised by the death of their loved ones. So it is likely the case was still very raw for them.
2. There are two reasons that families may have felt obliged to take part:

a) Firstly, if initial contact was through INQUEST, who supported them throughout the process. It was clearly explained that the service supplied by INQUEST was completely unconnected with this research and would still be available to them regardless of their willingness to participate. It was explained that this project was unrelated to the work that INQUEST undertakes on families' behalf.

b) Secondly, as mentioned above, families may still be involved in ongoing campaign work relating to the death and they had to understand that this project would not be used to lobby or campaign on any individual case. It was important the families did not have any expectations in relation to possible outcomes to this research.

2.4.3. Informed Consent

Participants shared personal and sensitive information with the researcher, which puts them in a position of vulnerability.[84] In allowing the researcher to interpret their experiences, participants were putting themselves in a position where they could be embarrassed or misrepresented. It was therefore vitally important for each participant to give informed consent, not just to be interviewed but for the data to be used. Each participant was given an information sheet,[85] which included a brief synopsis of the research, possible benefits and risks of participating as well as details of how their anonymity and confidentiality would be maintained.[86] Each participant was given not just the contact details of the researcher but also the name and emails of supervisors so they could corroborate any details about the thesis. All participants were given an anonymous code number that only identified which group they belonged to but not their name or gender. The identifying data was only saved in one database which linked the participants to their code number with all other data relating to these participants

[84] Ibid, p 61
[85] See ANNEX I
[86] As described by Seidman, p 61-2

(such as recordings and transcripts) being saved under the code number only. It was also necessary to ensure that any references to particular cases were not sufficient to allow identification of the participants who wished to remain anonymous.

Participants also had the opportunity to revoke their consent at any stage during the interview process. All participants will be sent an electronic copy of the completed thesis, unless they asked not to be kept informed about the project.

2.4.4. Risks

It might be that there would be repercussions for any State officers reporting negative perceptions of their respective management during an inquest process; this possibility was limited by guaranteeing anonymity for participants.

Only interested parties who had already gone through an inquest were interviewed, however it was a possibility that there were still ongoing legal proceedings relating to a case. All bereaved families who participated were asked whether there were still any appeals, challenges, criminal or civil actions outstanding in respect to their case. In those instances, the families were asked to check with their legal representatives before they participated. No one pulled out from participating at this stage. The research collected perceptions about the process, rather than details about individual cases so it was not expected that there would be legal problems as a result of people participating.

It was important to acknowledge that interviewing bereaved families and asking them to talk about a painful period could be emotionally draining and stressful. The researcher's experience at INQUEST (including acting as first point of contact with families, assisting in the facilitation of family forums and general contact with families over a period of four years) ensured they had the skills and understanding to carry out this research. During the initial contact period before the interviews took

place, families were asked to consider whether there might be possible repercussions in their being interviewed: specifically, the possibility it would open up old wounds.

2.4.5. Data protection

Personal data was stored on the researcher's personal computer which has comprehensive software security including password only access. No one other than the researcher had access to the computer. All data was backed-up with an external encrypted hard drive, which was stored at the researcher's home in a locked filing cabinet. All personal details of participants were stored in a database but responses were stored by participant group only and the data was not identifiable to specific participants.

The data collected was only for use within this PhD thesis and will not be used for any further projects. It will only be kept as long as necessary for the completion of this thesis and any publications of this work.

Any data was only used once the researcher was confident the participant's personal information could not be identified unless they gave express permission otherwise.

2.5. Data Collection

General information about the research was provided to each participant so they would have an expectation of what would be discussed during the interview. However, specific questions were not provided as the purpose was to gather insights and perceptions rather than objective knowledge.

Each participant who agreed to be interviewed was added to a database where the date, time and location of the interview was added. As each interview was completed, this was noted in the database.

The data collated in this database was stored and encrypted on the researcher's personal computer as described above.

Each interview was carried out face to face; which has been shown to the most effective approach for encouraging exploration of opinions and perceptions on very complex and sensitive issues.[87] Each interview was recorded to ensure a better flow of conversation and a more relaxed atmosphere as well as an accurate recording for analysis.[88] A skeleton interview schedule was used to guide the conversation with bullet points to be used as prompts if appropriate:

Skeleton Questions for Interviews

1. Experiences of complex inquest process:
    - First contact of bereaved families with coronial staff;
    - How does inquest process compare/differ from expectation/experiences of criminal court processes?
2. What is family experience of participating?
    - Identifying next of kin;
    - Families at the centre;
    - How are families heard;
    - How does the process respond to families?
3. What is impact of families participating?
    - What are possible benefits/problems with families participating;
    - Impact on families themselves;
    - Impact on outcome;
    - Experiences of inquests with no family involvement.
4. What affects family participation?

[87] Hollway and Jefferson
[88] Valentine

- Involvement early in process;
- Access to information;
- Legal support.

5. What role do inquests have in holding the State to account?
    - Rule R43's;
    - Prevention of other deaths;
    - Media interest.

Each interview was then transcribed verbatim in line with the necessary approach for IPA.[89] Verbatim transcription allows detailed analysis of the data line by line; including the interview questions and comments is vital for providing context.[90] Transcription for IPA is done at a semantic level so significant pauses, repetitions and false starts are referenced.[91] Prosodic details such as the tone or emphasis of the conversation are not required for IPA as they are for conversation analysis.[92] This approach also allows for use of quotations so readers can "see for themselves" and therefore scrutinise the validity of any interpretations made of the data.[93] In order to allow comparability between open interviews, equivalence must be found in meaning, not precise words which requires interpretation on the behalf of the researcher.[94] However is must be clarified that in interpreting the interviews, a double hermeneutic effect is produced as the researcher's own interpretations are added to those carried out by the participants.[95]

[89] Larkin
[90] Smith and Osborn, p 63-4
[91] Ibid, p 64
[92] See Paul Drew, 'Conversation analysis' [2005] Handbook of Language and Social Interaction 71
[93] Harry F Wolcott, *Transforming qualitative data: Description, analysis, and interpretation* (Sage 1994)
[94] Norman Kent Denzin and Yvonna Sessions Lincoln, *The Sage handbook of qualitative research* (Sage 2005)
[95] Larkin

2.6. Analysis

Good quality qualitative research must be systematic and transparent so the detailed steps taken during the analysis process are set out below. The qualitative software analysis tool NVivo was used to assist with the coding, comparison and analysis of the transcripts of the interviews. The analysis process included a number of steps carried out over a period of months.

Step 1: Free coding to reflect researcher perceptions on reading transcriptions.

Step 2: Line by line coding to identify:

- Issues that matter to participant;
- Meaning of those issues (experiential);
- Characterise participants' stance in relation to identified issues.

Step 3: Identify patterns (commonalities).

Step 4: Interpretation of patterns to identify themes.

Step 5: Structuring of themes.

Step 6: Development of a narrative using detailed data extracts to take reader through interpretation.

Each interview was read in detail three times group by group; starting with the bereaved families followed by the lawyers then the coroners, ending with the State officials. During the first reading, the researcher noted down ideas and perceptions as they arose. During the second reading, issues raised by the interviews were coded via the software linked to the specific section on the transcript. Once all the interviews had been read twice and issues had been noted, the process was repeated so that the researcher incorporated the impressions gained from the second reading of the interviews. So if an issue had arisen in one of the final interviews read, the researcher looked for it in all the interviews and coded appropriately. At the end of this first layer of coding, all the relevant text was coded as per

issues that arose from the interviews. Some of the text was labelled under more than one issue, so the text might be identified as relevant to different issues.

The second layer of coding was then carried out by firstly taking all the text coded under specific issues and separating them into patterns identifying commonalities and differences. Next the patterns were interpreted by the researcher into subject matters or themes, labelling perceptions under specific sub-themes of issues such as “bereavement” or “benefit of legal representation”. This stage represented the researcher engaging with the issues identified and designating them as descriptive themes. This left the researcher with selected paragraphs or phrases from each interview collected under specific issues that had been identified as strong themes.

The two research questions were why effective participation of bereaved families was important in complex inquests and what was important in ensuring the benefits of participation were possible. The empirical data was therefore divided into two chapters, each dealing with one of the questions posed. The first looked at why participants thought families should be involved in the inquest process and the second used their experience and perceptions to describe what were important aspects to ensure that involvement was fair and effective. The first chapter was then sub-divided into two separate chapters which identified how family involvement benefited families themselves (linked to protection of their legitimate rights) and how it was argued to provide intrinsic benefit via increasing legitimacy. The identified themes from the coding process were linked to the key issues identified in both the legal and theoretical chapters to draft chapter outlines with headings and sub-headings. The last layer of analysis involved going through the highlighted text and feeding relevant parts into the appropriate subheading of the chapter outlines. So each chapter outline became a large document with relevant sections from each interview collected together under appropriate sub-headings. The data from the interviews was then edited to produce an analysis of key perceptions identified by participants. The views of participants were summarised within different sections indicating themes which were

identified during the coding process. Quotes were used to illustrate specific points raised during the interviews.

All participants were referred to anonymously, as this was the best way to both ensure anonymity and that the narrative provided by those participants who were happy to be named did not come across more strongly than the anonymous participants. Each participant was identified by group:

FA= Family members

LA = Legal representatives

CO = Coroners

SP/ESP = Police officers/Ex-police officers

The only exception to this coding was to the two representatives of the investigatory bodies which were identified by the acronym of their respective organisation (IPCC and PPO) throughout. This was done for a number of reasons. Firstly, they had both agreed to be named, secondly, they provided perspectives unique to their positions within those bodies, and, thirdly, they were selected on a representative basis, whereas all other participants were not taken to be representing their identified group but just an example of that group.

Other than the IPCC and PPO individuals, participants were not taken as representatives of their groups which is why the views were not generally referenced by group (for example, “families said this”) or compared across groups as this would entail endowing participants with a representative function such as families members think something but coroners did not. It also allowed for the fact that with open-ended responses from semi-structured interviews, different issues arose organically and therefore strong inferences should not be made from the fact that a theme came up in one interview but not another.

Chapter 3: LEGAL FRAMEWORK RELATING TO FAMILY PARTICIPATION IN AN ARTICLE 2 INVESTIGATION

3.1. Introduction

Article 2 of the ECHR protects an individual's right to life. Substantial European case law has established distinct duties on a State under Article 2; described in this thesis as substantive and procedural duties. Substantive duties on the State are not to take life and take reasonable steps to protect life. The substantive duties on the State to protect life include administrative and operational duties; administrative duties are systemic in nature and seek to ensure that appropriate procedures and systems are in place; operational duties relate to protecting an individual or individuals in a specific situation and relate to proactive steps that the State must take in individual situations to protect life. Procedural duties are a consequence of substantive duties and require a State to ensure causes of death are investigated thoroughly to ensure the State has not failed to protect life and also that lessons are learnt to prevent future deaths. Procedural duties are linked to identifying how deaths occur and in appropriate cases who should be held liable for the death, so in all cases of sudden and unexpected death, the State must ensure there are systems in place to ensure causes for a death can be identified through investigation; systems would include criminal and civil justice jurisdictions. However, in cases where there is possible State liability, case law has established what is sometimes called an enhanced procedural or investigative duty which involves additional requirements beyond merely ensuring a criminal or civil justice system is in place and can identify liability for a death. This enhanced procedural duty requires the State to initiate the investigation following a death, and allow family participation in the process. Further case law is needed to clearly establish what situations lead to this enhanced procedural duty; for example, a natural death in custody does not trigger the

enhanced procedural duty unless there is reason to suspect State failures contributed to the death.[96] However, even if cause of death is known as natural causes, it can be difficult to judge whether lack of poor medical care might have been a contributory factor.[97] Sudden or unexpected deaths in custody will always require a State-initiated investigation with the opportunity for family involvement.

This chapter will set out the evolution of Article 2 through case law, and as domestic law evolved distinct from (although taking account of) European jurisprudence, European and England and Wales jurisprudence are considered separately. Under England and Wales law, an inquest is the primary route by which Article 2 enhanced investigative duties are discharged. An inquest is opened within days of a death but then is adjourned to allow other jurisdictions (including criminal, civil and disciplinary proceedings) to take precedence. In relation to deaths that occurred in custody, a coroner must then decide whether other processes have adequately investigated the death; if there remain unanswered questions, the inquest is re-opened. It is here that a coroner must ensure Article 2 requirements have been met. An example would be a murder in prison, where a criminal case identified and punished the killer but further questions about possible systemic failings in the prison would need answering.[98]

This chapter sets out the legal protections in relation to family participation in an Article 2 inquest. The first section sets out how Article 2 has evolved from protecting life to requiring an investigation in certain situations where there is possible State involvement either in causing a death or failing to take adequate steps to protect life. The second section looks at the specific domestic legal framework relating to the inquest system, especially for deaths that occur in custody. The third section considers

[96] *Tyrell v Hm Senior Coroner County Durham and Darlington* [2016] EWHC 1892 (Admin) Divisional Court

[97] For discussion about coroners decision-making in relation to identifying cases where natural deaths require further investigation see: Maxwell Mclean, 'Contradictory coroners? Decision-making in death investigations' [2017] Journal of Clinical Pathology; Andrew Harris, ''Natural'and 'Unnatural'medical deaths and coronial law: A UK and international review of the medical literature on natural and unnatural death and how it applies to medical death certification and reporting deaths to coroners: Natural/Unnatural death: A Scientific Review' (2017) 57 Medicine, Science and the Law 105

[98] See the murder of Zahid Mubarek; Brian Keith, *Report of the Zahid Mubarek Inquiry (Vols. 1 and 2)* (2006)

relevant legal requirements which relate to the purpose of an inquest, the role of bereaved families and specific rights that exist to allow their effective participation.

3.2. Evolution of Article 2 of the European Convention on Human Rights

Article 2(1) of the ECHR states

> Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.[99]

Over the last thirty years the ECtHR has developed extensive jurisprudence on the nature of the rights established by Article 2: specifically, the responsibilities that it imposes on States. Article 2 sets out two substantive requirements for States: first, the duty not to take life except where permitted by law, and, second, the duty to take reasonable steps to protect life. The duty to not take life is sometimes referenced as a negative obligation as it relates to actions the State cannot take or situations when the State cannot use force.[100] The duty to protect life is considered to be a positive obligation as it relates to steps States must actively take to prevent death.[101] This second substantive duty has evolved in ECtHR judgements to create distinct obligations to prevent deaths in certain

[99] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR)

[100] Marko Milanović, 'From compromise to principle: clarifying the concept of state jurisdiction in human rights treaties' (2008) 8 Human Rights Law Review 411; David Harris, 'The Right to Life under the European Convention on Human Rights' (1994) 1 Maastricht Journal of European and Comparative Law 122

[101] Alastair Mowbray, 'The Creativity of the European Court of Human Rights' (2005) 5 Human Rights Law Review 57, p 78

situations as well as a duty to investigate deaths to ensure anyone responsible for the death is held to account (a procedural obligation).

In general, the substantive duties relate to actions a State should take prior to any death occurring: the State must take steps to ensure force is only used when "absolutely necessary" and if there is a proven duty of care; the State should take steps to prevent death. The procedural duty relates to actions the State must take following a death: a State must provide a system of investigation allowing any culpability for the death to be established. This obligation was originally considered to only be engaged following a possible substantive breach of Article 2 but is now considered as a stand-alone duty.

In the UK, the Court of Appeal set out the obligations provided by Article 2 in the *Amin* and *Middleton* cases, "Article 2 imposes two distinct but complementary obligations on the State."[102] The domestic courts considered the first substantive duty on States was "not intentionally to take life" as well as taking any reasonable measures necessary to protect someone whose life was at risk. A procedural duty to investigate deaths where there may have been a violation of the first obligation was also established.

3.2.1. Substantive aspect

3.2.1.1. State must not take life

European Court of Human Rights Jurisprudence

Article 2(2) states that deprivation of life does not constitute a violation when the force used by State agents is "absolutely necessary" in order to either defend themselves or someone else, ensure a lawful

[102] *R. (on the application of Amin (Imtiaz)) v Secretary of State for the Home Department* [2003] UKHL 51 (UK House of Lords) ; *R. (on the application of Middleton) v HM Coroner for Western Somerset* [2004] UKHL 10 (House of Lords)

arrest or stop a riot. The *McCann* case involved the shooting of three alleged terrorists by the British army and was the first in which the ECtHR considered the intentional taking of life by a State.[103] The European Court noted that the term "absolutely necessary" required a stricter test than "necessary in a democratic society", which is normally used to judge State actions under ECHR provisions.[104] However, Article 2 does not just consider when it is permissible to intentionally take life, but also when and how much force is allowed to restrain an individual when such restraint may unintentionally cause death (such as cases involving positional asphyxia[105]).[106] A State agent using force must hold a reasonable belief that it is necessary and proportionate to one of the three aims listed within the article; in defence of someone from violence, to obtain or maintain a lawful arrest or to quell a riot.[107] If the belief was unreasonable, use of force has been found to constitute a violation of Article 2.[108] Actions of State agents which may unintentionally result in the death of others (such as dangerous driving[109]) have been considered by the ECtHR to be possible substantive violations.

If an individual dies while in State custody, and the facts of the deaths are unclear, it cannot be judged whether the State violated substantive duties, so it is incumbent on the State to provide a reasonable explanation for injuries or deaths that occur to individuals in their care.[110] A failure of the State to provide a reasonable explanation may be considered a substantive violation of Article 2, even if there is no proof that State actions or inactions were causally linked to the death. In the case of *Salman*, an individual entered into State custody "in apparent good health" but died of heart failure following a period of detention with evidence of injuries to his ankle and chest.[111] The ECtHR judged the State's

[103] *McCann v United Kingdom*
[104] Ibid. para 1b
[105] Positional asphyxia was causal to the deaths of Gareth Myatt and Jimmy Mubenga; it will be referenced later in the thesis in Section 8.3.1.
[106] See *McKerr v United Kingdom* (2002) 34 EHRR 20 (European Court of Human Rights); *Bures v. The Czech Republic* [2012] ECHR 1819 (European Court of Human Rights)
[107] European Convention on Human Rights, as amended; *Ramsahai v The Netherlands* (2008) 46 EHRR 43 (European Court of Human Rights), paras 376-7
[108] *Gul v Turkey* (2002) 34 EHRR 28 (European Court Human Rights), para 82
[109] *McShane v United Kingdom* (2002) 35 EHRR 23 (European Court of Human Rights)
[110] *Aksoy v Turkey* (1997) 23 EHRR 553 (European Court of Human Rights); *Salman v Turkey* (2002) 34 EHRR 17 (European Court of Human Rights)
[111] *Salman v Turkey,* para 102

assertion that the injuries were caused during arrest and later during cardiac massage was not proven; consequently, even though it was not proven that State actions caused the death, the ECtHR judged the State responsible for the death.[112]

In order to ensure the use of force by State agents was subjected to the "most careful scrutiny", the ECtHR stated in *McCann* that systemic issues such as the planning of operations, as well as direct actions that resulted in death, should be scrutinised.[113] This was reaffirmed when the ECtHR considered the planning of a rescue operation in which people died, before deciding there had been no violation of Article 2.[114] This clarified the substantive aspect of Article 2 obligations beyond ensuring State agents actions were lawful and necessary; States must show that adequate training and planning was part of any operation where agents may be prescribed to use force.[115] This was the first progression of the substantive duty not to take life to incorporate operational obligations to take steps to protect life. This aspect will be discussed in more detail below.

England and Wales Jurisprudence

Prior to the enactment of the Human Rights Act (HRA), use of force by State agents was primarily governed by common law provisions of self-defence.[116] On the issue of self-defence, domestic courts relied on the reasonableness test to judge whether force was permitted.[117] The test would look at whether the actor reasonably perceived force to be necessary and proportionate.[118] In addition to common law provisions, Section 3(1) of the Criminal Act of 1967 permitted State agents to use force

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[112] Ibid, para 103
[113] *McCann v United Kingdom,* paras 149-50
[114] *Andronicou v Cyprus* (1998) 25 EHRR 491 (European Court of Human Rights)
[115] The issue of planning operations is one that must be investigated fully in order to comply with the procedural obligation which will be discussed later.
[116] Association of Chief Police Officers, *Manual of Guidance on Police Use of Firearms* (2003), p 9
[117] *R v Williams (Gladstone)* 1987 3 ALL ER 411 (Court of Appeal), p 411-9; *Beckford v R.* 1987 3 ALL ER 425 (Privy Council), p 425-33
[118] C.A. Gearty and J.A. Kimbell, *Terrorism and the rule of law: a report on the laws relating to political violence in Great Britain and Northern Ireland* (London: King's College, London, Civil Liberties Research Unit. 1995), p 59

that was reasonable to prevent a crime or make an arrest.[119] This Act provided State agents with legal justification for using force even under an unreasonable belief as long as it was honestly held.[120]

The HRA provides that public authorities must act in a way that is compatible with ECHR rights under Section 6 of the Act.[121] It could be argued that domestic law provides less stringent requirements on the permitted use of force and policy relating to armed police officers indicates their need to adhere to the higher Article 2 standards.[122] Domestic courts have similarly used the test of absolute necessity when considering force which was used either with the intention of killing or when death was a likely result.[123]

3.2.1.2. State must protect life

European Court of Human Rights Jurisprudence

Article 2 sets out a positive obligation on states to protect life, which has been developed through ECtHR case law. In 1978, the European Commission judged that Article 2 goes further than prohibiting the State from taking life and placed on it a positive duty to protect life.[124] This case related to State obligations to inform parents as to the risk encompassed in immunising children.[125] The Commission judged any deaths or injuries as a consequence of immunisation were not due to an intention by the State to cause the deprivation of life. The Commission also considered the obligation to ensure the right to life be "protected by law" should be interpreted in a broader context than the prohibition not

[119] Criminal Law Act 1967
[120] Fiona Leverick, 'Is English self-defence law incompatible with Article 2 of the ECHR?' [2002] Criminal Law Review 347, p 361
[121] Human Rights Act 1998
[122] Officers, p 10
[123] *R (ex parte Beckett) v HM Coroner for Inner South London & Ors* 2006 EWHC 196 (Admin) (England and Wales High Court (Administrative)), para 23; The judge stated that to "kill when it is not absolutely necessary to do so, is surely to act unreasonably", para 25
[124] *Association X v United Kingdom*
[125] It was brought on behalf of parents whose children had died or been harmed as a result of immunisation.

to intentionally take life; judging that States were required to take proactive steps to protect life (although in this case it was judged steps taken by the State to inform parents about immunisation were adequate).[126]

The positive obligation to protect life has now been defined by ECtHR case law as imposing two distinct duties on a State. One is a general duty to ensure effective systems are in place to allow the enjoyment of rights set out in Article 2 (this will be referred to as an administrative duty).[127] The second is a more specific duty evolved in situations where states have a duty of care to protect individuals (this will be referred to as an operational duty).

The administrative duty arises in part from the explicit reference in Article 2 to protect life but also reflects ECtHR case law in relation to other rights which do not explicitly impose a positive obligation on States.[128] Generally many of the rights set out in the ECHR only explicitly refer to negative obligations (i.e. what States must refrain from doing rather than actions States must take). The ECtHR has developed implied positive actions States must take to ensure all Convention rights are protected.[129] Keir Starmer QC set out a theoretical basis for these positive obligations beyond those explicitly stated in the ECHR as a combination of three principles.[130] Firstly, Article 1 of the ECHR requires States to secure the rights set out in the Convention for everyone within a State's jurisdiction.[131] Secondly, the ECtHR has read into Convention rights implied positive obligations to ensure rights are "practical and effective".[132] Thirdly, Article 13 requires that domestic remedies must

[126] In respect of this case, the Commission declared the steps taken to educate parents were adequate.
[127] *Association X v United Kingdom*
[128] Alastair Mowbray, *The development of positive obligations under the European Convention on Human Rights by the European Court of Human Rights* (Bloomsbury Publishing 2004)
[129] John Graham Merrills, *The Development of International Law by the European Court of Human Rights* (Manchester, Manchester University Press 1993); p 102-3.
[130] Keir Starmer, *European Human Rights Law: The Human Rights Act 1998 and the European Convention on Human Rights* (Legal Action Group 1999), Chapter 5
[131] European Convention on Human Rights, as amended. Article 1
[132] *Dodov v Bulgaria* (2008) 47 EHRR 41 (European Court of Human Rights), para 83; *Oneryildiz v Turkey (No.2)* (2005) 41 EHRR 20 (European Court of Human Rights (Grand Chamber)), para 69; *X and Y v Netherlands* (1986) 8 EHRR 235 (European Court of Human Rights), para 23

be applicable for any breaches of rights set out in the ECHR.[133] Taken together these principles have been used to imply a positive obligation on States to ensure legislative and administrative frameworks are in place to protect convention rights by providing deterrence for actions that might infringe those rights.[134] In relation to Article 2, this involves ensuring systems are designed to deter the taking of life (for instance effective criminal justice systems) and protect life (for example health and safety regulations).[135] This can inter-relate with the procedural duty to investigate deaths effectively, which will be considered in Section 3.2.2. Administrative systems must be in place (a proactive and substantive duty on States) as deterrence but the ability to effectively find and hold to account those culpable for a death is part of the separate procedural obligation. So ensuring effective administrative and legislative systems act to discharge two obligations: the first to prevent deaths (substantive duties) and the second to investigate deaths (procedural duty).

The administrative duty does not require a State to be aware of a specific or known risk but requires measures to be in place to address any inherent risks which may be present. This may relate to general systems necessary to protect life or deter the taking of life.[136] However, where there is inherent risk to life, States may be required to provide information to those at risk so that they may either avoid or mitigate the risk.[137] Various situations have been assessed by the ECtHR in which States should ensure systems are in place to safeguard life including the provision of health care services,[138] the disposal of dangerous waste,[139] health and safety on a ship[140] or a building site.[141]

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[133] European Convention on Human Rights, as amended

[134] *Z v United Kingdom* 2002) 34 EHRR (European Court of Human Rights), paras 73-5 (Article 3); *X and Y v Netherlands,* para 27 (Article 8*)*; *Airey v Ireland (A/32)* (1979-80) 2 EHRR 305 (European Court of Human Rights), para 32 (Article 8)

[135] *Oneryildiz v Turkey (No.2),* paras 69-70; *Osman v United Kingdom* (2000) 29 EHRR 245 (European Court of Human Rights), para 115; *Tarariyeva v Russia* (2009) 48 EHRR 26 (European Court of Human Rights), para 74

[136] See Application 32967/96 *Calvelli and Ciglio v Italy* [2002] ECHR 3 (European Court Human Rights); Court found regulations must be in place to require hospitals to take measures to protect life of patients

[137] *Koladenko and Others v Russia* (2013) 56 EHRR 2 (European Court of Human Rights)

[138] *Association X v United Kingdom*; *Dodov v Bulgaria*

[139] *Oneryildiz v Turkey (No.2)*

[140] *Leray and Others v France* [2001] ECHR 880 (European Court of Human Rights)

[141] *Pereira Henriques v. Luxembourg* [2009] ECHR 2244 (European Court of Human Rights)

The second substantive duty under the protective element of Article 2 can be described as an operational duty as it relates to specific and proactive steps the State must take in response to individual situations in order to protect life. This obligation covers situations where the State might be considered to have a duty of care to safeguard life by preventing a death. It can relate to omissions by a State agent (for example failure to provide sufficient health care[142]), actions of third parties (such as cases where threats have been made against individuals[143]) or individuals within the control of the State (such as people detained in prison, police or other custody) who are risk of taking their own lives through self-harm;[144] as well as environmental damage (such as pollution[145] or radiation[146]).

The ECtHR stated in *Oneryildiz* that the obligation on a State to take steps to protect life could apply in any situation where an individual's right to life might be at risk.[147] The operational duty is only engaged where "authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals".[148] States then have a duty of care and a consequent responsibility to take steps to protect the individual or individuals known to be at risk.[149] In such situations, States must show they "took measures which, judged reasonably, might have been expected to avoid said risk" to discharge their duty.[150] It would violate the operational duty to protect life under Article 2 if States knew or should have known of a real and immediate risk to life and reasonable steps to prevent death were not taken.[151]

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[142] *Powell v United Kingdom* (2000) 30 EHRR CD362 (European Court of Human Rights)
[143] *Osman v United Kingdom*
[144] *Keenan v United Kingdom* (2001) 33 EHRR 38 (European Court of Human Rights); *Renolde v France* (2009) 48 EHRR 42 (European Court of Human Rights)
[145] *Guerra v Italy* (1998) 26 EHRR 357 (European Court of Human Rights)
[146] *LCB v United Kingdom* (1999) 27 EHRR 212 (European Court of Human Rights)
[147] *Oneryildiz v Turkey (No.2),* para 71
[148] *Osman v United Kingdom,* para 116; reaffirmed by: *Keenan v United Kingdom,* para 90; *Banel v Lithuania* [2013] ECHR 558 (European Court of Human Rights), para 65
[149] *Ergi v Turkey* (2001) 32 EHRR 18 (European Court of Human Rights)
[150] *Osman v United Kingdom,* para 116; reaffirmed by: *Keenan v United Kingdom,* para 90; *Banel v Lithuania,* para 65
[151] *Mahmut Kaya v Turkey* [2000] ECHR 129 (European Court of Human Rights); *Osman v United Kingdom*; *LCB v United Kingdom*

The ECtHR has judged Article 2 obligations may apply in cases where death is caused by non-State actors but the threshold of when a State would be expected to have known about the risk and taken measures to prevent the death in these cases is high. The ECtHR has noted this obligation should not be interpreted in such a way that authorities are put under an impossible or disproportionate burden to respond to every claim involving a risk to life.[152] The importance of allowing authorities discretion to make operational decisions in line with identified priorities and available resources is a principle supported by the ECtHR.[153]

The operational duty has been clarified in a number of important cases before the ECtHR.[154] In *LCB,*[155] the ECtHR judged that the State had not violated Article 2 by failing to prevent an individual being exposed to radiation, as at that time there was no evidence the radiation could cause leukaemia.[156] In *Osman*, where a family claimed failures in police investigations left a man free to kill Ali Osman, amounting to a failure to protect life, the Court found no violation as it had not been obvious there was a real and immediate risk to life.[157] The ECtHR used the same criteria in deciding Turkey had violated Article 2 in the case of a doctor who had been kidnapped, tortured and killed.[158] The brother of the deceased took the case to the ECtHR, which found "the authorities failed to take reasonable measures available to them to prevent a real and immediate risk to the life of Hasan Kaya".[159] In finding a violation, the ECtHR highlighted there had been firm evidence the State was aware of a particular risk to the victim.[160] The existence of (three) defects in the criminal justice system were also found to

[152] *Osman v United Kingdom,* para 116
[153] Ibid
[154] *LCB v United Kingdom*; *Osman v United Kingdom*; *Mahmut Kaya v Turkey*; *Keenan v United Kingdom*
[155] The case involved a teenager who claimed her leukaemia was caused by her father's exposure to nuclear radiation while serving in the army before she was born.
[156] *LCB v United Kingdom*
[157] The court did judge there had been a breach of Article 6(1) as the Court of Appeal relied on the Hill defensive principle which precludes any finding of negligence against the police in respect of a failure in an investigation being consequential to death: *Hill v Chief Constable of West Yorkshire* [1989] AC 53; [1988] 2 WLR 1049 (House of Lords)
[158] *Mahmut Kaya v Turkey*
[159] Ibid
[160] Ibid, para 90

amount to a failure to ensure adequate systems to deter killings were in place; this relates to the procedural duty which is discussed in Section 3.2.2.[161]

In terms of deaths that occur in custody, there can be an implied duty of care on the State as being in control of the individual; the ECtHR has stated "Persons in custody are in a vulnerable position and the authorities are under a duty to protect them."[162] This duty has been established in respect to State agents failing to act as well as using force which was not absolutely necessary. As discussed above, under the substantive obligation to not take life, the ECtHR may not differentiate between the two substantive obligations on the State to either not take life or to protect life of individuals under their control.

Failure to act can relate to the obligation to protect individuals in the care of the State by taking steps to prevent an individual taking their own life.[163] *Keenan* involved a suicide in prison where the ECtHR found the protective element of Article 2 extended to cover the prevention of suicides in State custody, if there had been a "real and immediate" risk of self-inflicted death.[164] In this case, it was judged, even if the immediacy of the risk was not clear, the State had been aware of the risk of suicide.[165] However, ECtHR found reasonable steps were taken to protect life; so although there were some failures in terms of the way the individual was treated (he was kept on segregation and the alarm buzzer in his cell was not functioning), these were considered under Article 3 and no violation of Article 2 was found.[166] In line with other judgements requiring a high threshold before deciding a State should have known about a risk to life; the ECtHR has found there had to be evidence indicating there was an imminent threat of suicide before judging the State "could have reasonably foreseen" a risk to life.[167]

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[161] Ibid, paras 95-8
[162] *Salman v Turkey,* para 99
[163] *Keenan v United Kingdom*
[164] Ibid, para 90
[165] Ibid, paras 96-7
[166] Ibid, paras 101-2
[167] *Trubnikov v Russia* [2005] ECHR 462 (ECHR), paras 72-6

Renolde[168] is a more recent case where a violation of the obligation to protect life was found following a suicide in custody. The ECtHR referenced a number of issues which showed the State should have been aware of the risk of the individual taking their own life, as well as a lack of steps taken to prevent this from happening. In this case the individual had attempted suicide only eighteen days before he died and continued to mention taking his own life: which indicated there was a known and real risk to his life.[169] The ECtHR judged the State to have failed to take reasonable steps to protect life in three ways: firstly by failing to place the individual in an appropriate psychiatric institution; secondly by not providing effective medical treatment (including failing to ensure he took his medication).[170] Thirdly, three days after his previous suicide attempt, the individual was placed in a punishment cell[171] which was found likely to aggravate any existing risk of suicide.[172] All these aspects were considered in finding a violation of the substantive obligation to protect life.[173]

England and Wales Jurisprudence

UK case law enshrines a specific duty to prevent self-inflicted deaths in custody, partly as detention can increase vulnerability and therefore result in a heightened risk of suicide as a consequence of the State detaining someone.[174] In 1989, the Court of Appeal identified an obligation on prisons to prevent someone who was mentally ill from committing suicide.[175] In 2000, the decision given in *Reeves* was followed to find in *Orange* that the authorities had a duty to take reasonable steps to prevent those

[168] *Renolde v France*
[169] Ibid, paras 86, 88 & 89
[170] Ibid, paras 95 & 105
[171] Although distinct from a solitary confinement cell in the same block; association with other prisoners, access to activities and visits are restricted completely while in the punishment cell; See ibid, para 61
[172] Ibid, paras 106-7
[173] Ibid, para 110
[174] *R. (on the application of JL) v Secretary of State for the Home Department* [2008] UKHL 68 (House of Lords); *R. (on the application of Bloggs 61) v Secretary of State for the Home Department* [2003] EWCA Civ 686 (Court of Appeal (Civil Division))
[175] *Kirkham v. Chief Constable of the Greater Manchester Police* [1990] 2 QB 283 (Court of Appeal (Civil Division))

in their custody taking their own life, whether or not they were diagnosed as mentally ill.[176] A judgement in 2002 found the State had an enhanced duty of care to take steps to prevent the suicide of those in detention because detention could be a causal factor in prisoner vulnerability.[177]

Since the enactment of the HRA, domestic courts have also referred to established ECtHR case law in respect to the duty on States to protect life; with the *Osman* case only being partially affirmed by domestic judgements. In July 2008, a Chief Constable of Police appealed a finding of negligence against him; and the defensive principle set out in *Hill* was re-affirmed,[178] contrary to the judgement of the ECtHR in *Osman* which found relying on this principle could breach Article 6 (1).[179] The Court did, however, refer to standards set out in *Osman* to find there was no duty of care in this case, stating the standard as to whether the State had a duty to protect life under Article 2 of the ECHR was invariable, not dependant on circumstances. Recently, the *Savage* case involved the death of a woman who committed suicide shortly after escaping from a hospital where she was being detained under the Mental Health Act; the House of Lords judged that in this case the substantive Article 2 duty was engaged.[180] The *Osman* test of whether authorities should have been aware of the imminent threat to her life was found in this case to have been passed. The recent Policing and Crime Act 2017 amended the Coroners and Justice Act 2009 so that the definition of "state detention" no longer includes an individual held under "section 4A(3) or (5) or 4B of the Mental Capacity Act 2005".[181] It is unclear what, if any, impact this will have on the understanding of State duties under Article 2 for people held under the Mental Capacity Act.

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[176] *Reeves v Commissioner Of Police For Metropolis* [2000] 1 AC 360 (House of Lords); *Orange v West Yorkshire Police* [2001] EWCA Civ 611 (Court of Appeal (Civil Division))

[177] *R. (on the application of DF) v Chief Constable of Norfolk* [2002] EWHC 1738 (Admin) (Queen's Bench Division (Administrative Court))

[178] This principle states that fear of liability might lead police officers to act very cautiously and therefore prevent them carrying out their duties; *Hill v Chief Constable of West Yorkshire*; See also Claire McIvor, 'Getting defensive about police negligence: the Hill principle, the Human Rights Act 1998 and the House of Lords' (2010) 69 Cambridge Law Journal 133

[179] *Van Colle v Chief Constable of Hertfordshire* [2008] UKHL 50 (House of Lords)

[180] *Savage v South Essex Partnership NHS Foundation Trust* [2010] EWHC 865 (QB) (Queen's Bench Division)

[181] Policing and Crime Act 2017, Section 178

3.2.2. Procedural aspect

European Court of Human Rights Jurisprudence

The protective aspect of Article 2 imposes a procedural duty on States to provide effective systems to investigate deaths for three reasons: firstly, to provide deterrence to the taking of life, secondly, to ensure those culpable for a death are held accountable, and, thirdly, to ensure victims have access to a remedy.[182] This corresponds to the administrative duty discussed previously: frameworks must be in place to protect life through deterring actions that might violate Article 2. The procedural duty relates to the ability of frameworks to determine the cause of a death and hold those responsible for the death to account.[183] The effectiveness of the systems in place to discharge this procedural duty will therefore interrelate to the effectiveness of the system to deter violations of Article 2 and therefore discharge the administrative duty. This wider procedural obligation can be discharged through ensuring an effective, independent judicial system which allows the investigation of the cause of death and identifies any actions that might have resulted in a violation in Article 2. This duty may be discharged through the availability of civil remedies or disciplinary proceedings.[184] In *Banel v Lithuania,*[185] the ECtHR distinguished between deaths caused intentionally and those where negligence was a possible causal factor: stating that in the latter situations, "a civil or disciplinary remedy may suffice".[186]

[182] *Dodov v Bulgaria,* para 83; *Byrzykowski v. Poland* (2008) 46 EHRR 32 (European Court of Human Rights), paras 104-118

[183] *Vo v France* (2005) 40 EHRR 12 (European Court of Human Rights (Grand Chamber)), paras 90-1

[184] *Calvelli and Ciglio v Italy, para 51*; *Byrzykowski v. Poland,* para 105; *Vo v France,* paras 90-1 & 94; *Dodov v Bulgaria,* para 87

[185] *Banel v Lithuania*

[186] Ibid, para 48; See also *Calvelli and Ciglio v Italy & Mastromatteo v. Italy* [2002] ECHR 694 (European Court of Human Rights)

The ECtHR has identified certain situations where there is a more onerous procedural duty which requires investigations to be initiated by the State.[187] This duty has been defined by some as the enhanced procedural or investigative duty, which links with the substantive duty discussed previously.[188] This duty has evolved over time to ensure effective investigations are carried out where the substantive obligations on the State in relation to Article 2 may be engaged. The key difference between the general procedural duty to ensure systems are in place to investigate deaths and this second "enhanced" duty is that any investigations must be State-initiated: so civil cases brought by a family would not be adequate. The distinction between an investigation devolving the general rather than the enhanced procedural duty rather is not always clear; for example, in cases involving criminal activity, any State-initiated criminal charges would be in line with general procedural requirements as well as discharging the enhanced duty. It is also not clear when the enhanced duty is engaged; cases where there has been a violation of the State's substantive duty under Article 2 would require a State-initiated investigation but cases where it is not clear whether the State had a positive obligation to safeguard life may not. The evolution of the enhanced procedural duty will be summarised below.

The enhanced procedural duty has developed from the initial obligation to investigate deaths caused by State agents. In 1995, the ECtHR found in *McCann* that in order to protect life, a State was required to ensure there was a proper investigation of any deaths which resulted from the use of force by State agents.[189] The judgement stated any investigation must be "independent, prompt, contain a sufficient element of public scrutiny, and be capable of leading to a determination of whether State agents are liable".[190] The investigation must also consider not just the actions of State agents but also the planning and organisation of the operation governing those actions. In 2001, four cases from Northern Ireland where death resulted from the use of force by State agents all came before the ECtHR which

[187] As referenced in *R. (on the application of Humberstone) v Legal Services Commission* [2010] EWHC 760 (Admin) (Queen's Bench Division (Administrative Court)), para 67

[188] https://ukhumanrightsblog.com/2012/11/14/no-article-2-inquest-over-14-year-old-overdose-death-despite-failings/

[189] *McCann v United Kingdom,* para 161

[190] Ibid

further developed this duty to include involvement of bereaved families in order "to protect their interests".[191] The criteria of an Article 2 compliant investigation devolving the enhanced procedural duty as they relate to the participation of bereaved families and other issues relevant to this thesis will be discussed in the Section 3.4.

A number of key judgements reaffirmed and contextualised the procedural duty to come into force whenever there was the possibility of a substantive breach of the operational duty under Article 2.[192] This included situations where a State failed to protect life as well as those in which State agents were directly responsible for causing death. If an unexpected death occurs in custody, the State is seen to have assumed responsibility for the individual so the enhanced procedural duty must be engaged, as the possibility of an infringement of the operational obligation to protect life must be considered. The duty to investigative deaths that occur in custody requires not just the circumstances of the death to be considered but also any potential failings of regulatory systems.[193] A further stated purpose of the enhanced procedural duty, which links to the duty to deter any State actions that might infringe the right to life, is to identify those culpable for a death and ensure they are held to account.[194] This will be considered further in Chapter 6.

The ECtHR has not always clearly distinguished between situations when the general or the enhanced procedural duty might be engaged. As the ECtHR continued to evolve the procedural duty over the last decade, it became a distinct obligation on States, not necessarily connected to the possibility of substantive breaches. In 2003, the ECtHR decided that just because there was no State responsibility for the death, it did not preclude the same "basic procedural requirements apply[ing]".[195] Three years later in *Slimani*, the ECtHR judged the procedural element of Article 2 was not dependent on a

[191] *McKerr v United Kingdom*; *Shanaghan v United Kingdom* [2001] ECHR 330 (European Court of Human Rights); *Kelly and others v United Kingdom* [2001] ECHR 328 (European Court of Human Rights); *Jordan v United Kingdom* (2003) 37 EHRR 2 (European Court of Human Rights)
[192] *Keenan v United Kingdom*; *Tarariyeva v Russia*
[193] *Trubnikov v Russia,* para 88
[194] *Oneryildiz v Turkey (No.2),* para 57
[195] *Menson v United Kingdom (Admissibility)* [2003] Inquest LR 146 (European Court of Human Rights)

substantive breach.[196] Following this, there were two cases where the State was found to breach Article 2 for not completing effective investigations, even though there was no direct State involvement in the deaths. The first judgement noted the lack of avenues for the family to achieve answers, suggesting the State has a duty to initiate investigations in cases where no other processes are available.[197] The second judgement acknowledged that although the case differed from those where State agents were possibly culpable, the same "basic procedural requirements apply".[198] This could be interpreted as there being no difference between the basic procedural duty which requires systems to be in place to investigate any suspicious deaths and the enhanced procedural duty which requires State-initiated investigations in cases where there is the potential of substantive violations by the State.[199]

It is clear that if any investigation identifies criminal actions, there must be an effective criminal justice system in place which allows the prosecution and punishment of those responsible.[200] This must be State-initiated as an effective criminal justice system is necessary to maintain "public confidence that there is no tolerance of or collusion in unlawful acts".[201] The ECtHR clarified that in the case of any suspicious death, the enhanced investigative obligation obliged the State to "act of their own motion" to effectively investigate the death and ensure those responsible were held to account, even where there was no allegation of State culpability.[202] The distinction between the general and the enhanced procedural duty is therefore not as clearly established through European case-law as is sometimes argued. However, in cases where the State may have failed in its duty to protect life (including systemic aspects), an investigation must be able to identify State liability. A criminal investigation may not cover all systemic aspects so further inquiry may be required to ensure all circumstances are considered. In

[196] *Slimani v France* (2006) 43 EHRR 49 (European Court of Human Rights)
[197] *Pereira Henriques v. Luxembourg*
[198] *Angelova and Iliev v Bulgaria* (2008) 47 EHRR 7 (European Court of Human Rights), para 98
[199] Although the racial motivation behind the killing in *Angelova* was noted, which might be why the higher requirements were considered necessary in this case.
[200] *Oneryildiz v Turkey (No.2),* para 93; *Angelova and Iliev v Bulgaria*
[201] *Oneryildiz v Turkey (No.2),* para 96
[202] *Rantsev v Cyprus* (2010) 51 EHRR 1 (European Court of Human Rights), paras 232-3

England and Wales, if these circumstances have not been dealt with elsewhere, an inquest would be expected to investigate fully to discharge Article 2 requirements.

The procedural aspect originally set out in *McCann* related to ensuring there were effective investigations in place following deaths that could be attributed to State agents in order to ensure a State was complying with the obligation not to take life unless absolutely necessary. The duty evolved to require an effective investigation process for all deaths where there was a possibility of State culpability, in order to assess whether the State could have prevented the death. The further requirement that the State ensures systems are in place to deter any infringements on the right to life by other parties has led to the procedural duty encompassing any suspicious deaths.[203] The "suspicious" deaths relates to any death that is not established as natural but as yet there is no clear criteria as to how a State should assess whether deaths can be considered natural or not. It is clear that for all deaths within State custody, there is a chance the State might be culpable (either in terms of causing or failing to prevent the death) so would require an effective investigation. However outside of detention, it is not clearly defined for which deaths the State is required to initiate an investigation or what form the investigation should take.

England and Wales Jurisprudence

It was described above that ECtHR case law did not clearly set out criteria for which deaths require an effective investigation beyond the fact that suspicious or unnatural deaths should be investigated, regardless of who might be culpable. Domestic law similarly requires all suspicious or unnatural deaths to be investigated.[204] The domestic courts have clarified two different procedural aspects relating to

[203] *Nikolova v Bulgaria* (2009) 48 EHRR 40 (European Court of Human Rights), para 57
[204] The Coroners Act 1988 required "sudden" deaths to be investigated (s.8(1)(c)) and the Coroners and Justice Act require investigations where the deceased "died a violent or unnatural death," or "the cause of death is unknown" (S.1)

Article 2: one a general duty to investigate all deaths and the second a duty related to the substantive obligation. So in cases where there is no possibility of a substantive Article 2 breach by a State, the procedural obligation may be considered to be less onerous. The protective duty of a State under Article 2(1) includes ensuring an effective system is in place to investigate the facts surrounding any sudden or unexplained death which may be by providing access to civil proceedings or ensuring there are adequate disciplinary proceedings in place. This was set out in *Jamieson:* where the court found that Article 2 set out a general investigative or procedural duty to provide a legal system capable of finding accountability.[205] The second duty, sometimes referred to as the enhanced procedural duty, stems directly from the possibility of a substantive breach and therefore relates to deaths in which State agents either caused or failed to prevent the death. Domestic courts relied on ECtHR judgements to define the enhanced procedural duty as requiring States "to initiate an effective public investigation by an independent official body" following deaths in which State agents may be implicated.[206] The Courts reaffirmed this definition in two cases involving the possibility of negligence by NHS staff where it was judged that although the State had the duty to ensure effective investigations into these cases, they could be considered as distinct from those situations where deaths occurred in State detention.[207]

In respect of deaths that occur in custody, domestic courts have considered the enhanced procedural obligation as invoked even where there was no evidence the State had breached its substantive duties under Article 2.[208] This was consequential of the enhanced duty of care the State owed to those detained involuntarily by the authorities.[209] It was also acknowledged that when someone died in the custody of the State, the authorities were in a unique position to possess the information concerning

[205] *R. v HM Coroner for North Humberside and Scunthorpe Ex p. Jamieson* [1995] QB 1; [1994] 3 WLR 82 (Court of Appeal (Civil Division))
[206] *R. (on the application of Middleton) v HM Coroner for Western Somerset,* para 3
[207] *Goodson v HM Coroner for Bedfordshire and Luton* [2004] EWHC 2931 (Admin) (Queen's Bench Division (Administrative Court)); *R. (on the application of Takoushis) v HM Coroner for Inner North London* [2005] EWCA Civ 1440; [2006] 1 WLR 461 (Court of Appeal (Civil Division))
[208] *R. (on the application of JL) v Secretary of State for the Home Department*
[209] *R. (on the application of Amin (Imtiaz)) v Secretary of State for the Home Department, para 30*

the death (including any causal factors), which puts the onus on the State to provide an explanation as to how death occurred.[210] In 2008, the judgement in the *JL* case stated that a suicide attempt in prison which resulted in serious injury may well instigate an obligation to carry out an Article 2 compliant investigation.[211] The court noted not all suicide attempts not resulting in death would require an Article 2 compliant investigation but the enhanced procedural obligation to investigate was extended to include some cases of serious self-harm in custody.

So even though England and Wales jurisprudence is not completely clear when an enhanced procedural duty is engaged, it has clarified that deaths in custody would require a State initiated investigation complying with *Jordan* requirements; to be prompt, independent, allow family involvement and adequate public scrutiny.

3.3. Inquest system

In England and Wales, Article 2 investigations are often carried out within the inquest system, which is an anachronistic part of the legal system that has continued and evolved into the modern day. As described above, Article 2 procedural obligations can be discharged in a number of ways, with some clear margin of appreciation being allowed by the ECtHR. In England and Wales, an inquest is the catch-all process that can discharge procedural obligations if they have not been dealt with in other proceedings.[212] The basic requirements of an inquest are to determine the name of the deceased, where and how death occurred. However, in order to discharge Article 2 requirements, a *Middleton*

[210] *R. (on the application of JL) v Secretary of State for the Home Department*
[211] Ibid; In this case, the prisoner had long-term brain damage as a result of his suicide attempt.
[212] Home Office, *Death Certification and Investigation in England, Wales and Northern Ireland (The Luce Report)* (2003), Chapter 10

inquest can take place which considers wider circumstances related to State substantive duties which might have been causally linked to the death (to be discussed further in Section 3.4.1).[213]

3.3.1. Main reforms of inquest system

The coronial system has evolved immensely in both its role and its nature over the last nine hundred years, responding to society as well as to changes within the legal framework (especially the criminal justice system). The responsibility of a coroner to register any sudden deaths within their geographical area of responsibility and establish basic facts such as the name of the deceased and cause of death was mentioned throughout the middle ages.[214] It was understood that in order to investigate the circumstances of a suspicious death, the coroner could call a jury to hear the evidence, decide the facts of the case and bring a verdict as to cause of death. Although the manner in which an inquest into a sudden death was carried out did not alter much from the 1500s to the middle of the twentieth century, other duties of the coroner were transferred to alternative bodies or officials.[215]

The coroner has always had a wide discretion as how their duties are best discharged. Although an inquest has many similarities to a criminal trial, frameworks established to ensure a fair trial in adversarial courts have not necessarily been put in place within the coronial system. For example, evidence given to the Home Affairs Committee (HAC) in 1980 during the investigation into deaths in custody illustrated that coroner's officers had extensive and largely unchecked influence over how an investigation was undertaken.[216]

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[213] This thesis will discuss "complex" inquests as those that relate to deaths in custody: generally distinction is not as clear as "normal" and "complex" inquests. Some inquests that do not engage Article 2 can be very complex in nature and vice versa.

[214] M. Levine and J. Pyke, *Levine on Coroners' Court* (Sweet & Maxwell 1999)

[215] Thomas and others

[216] Reported in C. Greer and E. McLaughlin, ''This is not Justice' Ian Tomlinson, Institutional Failure and the Press Politics of Outrage' (2012) 52 British Journal of Criminology 274

In 1971, the first modern extensive review of the coronial system resulted in the Broderick Committee publishing a number of recommendations.[217] This clarified the role of the coroner and inquests within the criminal justice system. One of the main issues raised by the Committee was the power of an inquest to apportion guilt for suspicious deaths. An inquest is inquisitorial in nature and therefore distinct from an adversarial criminal process which has certain protections in place for the defendant, including the opportunity for them to put a defence to the court. The incongruity of an inquest declaring an individual guilty without offering them an opportunity to defend themselves was seen to prejudice any subsequent criminal processes. This recommendation was acted upon in 1977, when the Criminal Law Act abolished the power of inquests to apportion blame to any named individual or body.[218][219]

The Coroners Act 1988 set out the legislative framework within which Coroners exercised their powers to investigate controversial deaths.[220] Read together with the 1984 Coroner's Rules,[221] it established the law in relation to the inquest system; stating that for a death in custody, a jury must be present (although other inquests could be held with just a coroner). The importance of public scrutiny was laid out, although restrictions were allowed where there were national security concerns. The Home Office produced a "Model Coroners' Charter" which set out the duties of a coroner: "It is the duty of coroners to investigate deaths which are reported to them and which appear to be due to violence, or are

[217] Broderick et al, *Report of the Committee on Death, Certification and Coroners* (London, HM Stationery Office, 1971)
[218] Criminal Law Act 1977
[219] The key case which instigated this reform was the murder of Sandra Rivett in 1975 as at the inquest into her death, her employer (Lord Lucan) was named as the person responsible for her death in absentia. Questions were asked in parliament about whether the coronial system was the appropriate place for finding guilt. This is a good example of how one case caught the public imagination and became the impetus for change that had already been proposed by the Broderick Committee but not acted on. See Clare Beckett, 'Deaths in Custody and the Inquest System ' (1999) 19 Critical Social Policy 271, p 274
[220] Coroner's Act 1988
[221] Coroner's Rules 1984. No 552

unnatural, or are sudden and of unknown cause, or which occur in legal custody, and to carry out certain related responsibilities."[222]

In 2001, the Home Office set up a fundamental review of the coronial system.[223] The Luce report was published in April 2003, making a number of recommendations on necessary qualifications and training for coroners; a Council to oversee the coronial system; limiting juries to Article 2 cases and encouraging detailed (narrative) verdicts in those cases.[224] At the same time an inquiry led by Dame Smith looked at issues which had arisen due to the Shipman case.[225] Aspects relating to inquests were published in the 3rd Report from the inquiry in July 2003.[226] It called on the coronial service to be reformed so every death could be investigated independently, as well as an overhaul of the way in which death certification occurred. The Government responded with a position paper setting out reforms of the coronial system, including a number of the recommendations from both the Luce and Dame Smith reports, which resulted in the Coroners and Justice Act 2009.[227]

The Coroners and Justice Act collated the existing law relating to inquests into primary legislation with the aim of ensuring greater consistency in practice, as well as amending some aspects of the law.[228] The largest change established a Chief Coroner, to take responsibility for ensuring greater consistency through the system via training for coroners as well as collating reports identifying failings so there

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[222] Home Office, *Model Coroner's Charter* (1999): http://webarchive.nationalarchives.gov.uk/+/http://www.homeoffice.gov.uk/justice/legalprocess/coroners/charter.html

[223] In response to cases including the Bowbelle/Marchioness disaster, deaths of children following paediatric surgery in Bristol and the retention of deceased children's organs at Alder Hey hospital.

[224] Office, *Death Certification and Investigation in England, Wales and Northern Ireland (The Luce Report):* http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf

[225] Dr Shipman was convicted of murdering a number of his elderly patients. One area the inquiry considered was the role of the coroner in certification of death as most of the deaths resulting from Dr Shipman's actions were registered as natural and not referred to the coroner so no inquest occurred.

[226] Home Office, *Death Certification and the Investigation of Deaths by Coroners: The Third Report (The Shipman Inquiry)* (2003): http://www.official-documents.gov.uk/document/cm58/5854/5854.pdf

[227] Coroners and Justice Act 2009

[228] For detailed discussion about the changes via the Coroners and Justice Act 2009 see Chief Coroner's Office, *The Chief Coroner's Guide to the Coroners and Justice Act 2009* (2013), Annexes B & C

could be greater national or systemic learning from deaths.[229] Although the Chief Coroner has initiated a number of positive changes to the system, it is important to remember that participants interviewed for this thesis were discussing inquests before the Coroners and Justice Act 2009 was fully enabled; reference will be made to where positive changes may have changed the situation discussed in the main body of this thesis. Other important changes to the law were made via secondary legislation, including the Inquest Rules 2013 and the Coroners Investigations Regulations 2013.[230] A policy Charter was also introduced setting out expectations for interested parties involved in an inquest.[231]

3.3.2. Inquests as Article 2 investigations

ECtHR jurisprudence allows discretion as to the appropriate forum for ensuring Article 2 investigations are carried out as long the relevant criteria for an investigation are in place. These criteria include ensuring any investigation is State-initiated, effective, independent, prompt, there is opportunity for family involvement and some element of public scrutiny.[232] The enhanced procedural obligation can be discharged through several different but complementary avenues which, when taken together, ensure all criteria have been met. In many situations, criminal proceedings, when associated with subsequent compensation orders, might be sufficient in satisfying a State's procedural obligations.[233] Other proceedings include health and safety tribunals, institutional or ombudsman investigations, disciplinary hearings, civil cases or inquiries. In England and Wales, an inquest usually only proceeds

[229] https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/. Due to the Government introducing proposals to remove the post of Chief Coroner via the Public Bodies Bill in 2010, the post was not fully established until September 2012 and the Coroners and Justice Act not fully implemented until July 2013 via the Coroners (Investigations) Regulations 2013.
[230] The Coroners (Inquests) Rules 2013; No. 1616
[231] UK Government Ministry of Justice, *Guide to Coroner Services* (2014)
[232] For example see *McKerr v United Kingdom*
[233] J.J. Long, 'Compliance in small claims court: Exploring the factors associated with defendants' level of compliance with mediated and adjudicated outcomes' (2003) 21 Conflict Resolution Quarterly 139; See *Mastromatteo v. Italy*

where no other legal proceedings have established the relevant facts about a death. In *Middleton,*[234] it was noted that in some circumstances, a State's procedural obligation may be discharged through criminal proceedings. However, there are other cases where a defendant pleaded guilty (as in *Edwards*[235]) or was not considered mentally fit to stand trial (as in *Amin*[236]) and wider issues related to systemic flaws contributing to a death would still have to be investigated through an inquest.[237] An inquest can be adjourned where there is a public inquiry into the death and resumption in these cases must only occur if the coroner believes there is "exceptional reason".[238] So when there is no on-going criminal prosecution or public inquiry, "an inquest is the means by which the State ordinarily discharges that [procedural] obligation".[239]

In *Takoushis,* the Court of Appeal found that for certain cases (in this instance the death involved medical negligence) the availability of civil proceedings may not be considered adequate to satisfy enhanced procedural obligations but a traditional, non-*Middleton* inquest might ensure States' obligations were met.[240] (A *Middleton* inquest must consider wider aspects which may have contribute to a death and will be discussed in Section 3.4.1). However, a failure of an inquest to fulfil the procedural requirements cannot always be taken as an Article 2 violation as it is only one way the duty can be absolved.[241] An inquest need only satisfy the procedural duty where the coroner was aware no other investigation (criminal, civil or otherwise) had provided an adequate investigation.[242] Although generally a *Middleton* inquest is relied upon to discharge the enhanced procedural Article 2 duty, any inquest may be considered as discharging the wider procedural duty where other processes have not occurred.

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[234] *R. (on the application of Middleton) v HM Coroner for Western Somerset*
[235] *Edwards v United Kingdom* (2002) 35 EHRR 19 (European Court of Human Rights)
[236] *R. (on the application of Amin (Imtiaz)) v Secretary of State for the Home Department*
[237] *R. (on the application of Middleton) v HM Coroner for Western Somerset,* para 30
[238] Jeremy Hyam, *Where Inquests Raise A Question of Human Rights* (1 Crown Office Row 2010), p 4
[239] *R. (on the application of Amin (Imtiaz)) v Secretary of State for the Home Department,* para 20
[240] *R. (on the application of Takoushis) v HM Coroner for Inner North London, para 106*
[241] *Goodson v HM Coroner for Bedfordshire and Luton*
[242] *R. (on the application of Jones) v Legal Services Commission* [2007] EWHC 2106 (Admin); (Queen's Bench Division (Administrative Court))

Current domestic law provides a duty for a coroner to investigate following any death in "custody or otherwise state detention".[243] Previously, the Coroners Act 1988 had stated all sudden deaths which occurred in either police or prison custody required a coroner to hold an inquest with a jury, unless there are criminal justice proceedings pending.[244] The Coroners and Justice Act now states a jury need not be called for any death in custody that is thought to be natural, even if sudden.[245] It is recognised that any death in custody occurs effectively 'behind closed doors' and it is therefore likely that the public and next of kin will have questions about the death.[246] The purpose of the inquest to answer such questions and consequently ensure public confidence in the authorities has been affirmed.[247] In 2003, in *Hurst,*[248] the Divisional Court set the precedence that to ensure compliance with Article 2, there must be an effective investigation into possible systemic police failings even where there had been a criminal trial. In 2015, *Letts* found the enhanced procedural or investigative element of Article 2 was triggered whenever there was a possibility State actions might have been complicit in a death but there did not need to be any evidence of a substantive violation.[249] The judgement stated cases which would automatically trigger the enhanced procedural duty include suicides in prison and of voluntary psychiatric patients.[250] In *Rabone*, the enhanced procedural obligation arose in cases of "any death for which the State might bear some degree of responsibility".[251] It is left to the discretion of the coroner to identify whether a case involves possibly substantive breaches, and therefore what investigation is required under Article 2. Throughout this thesis, the phrase Article 2 inquest is used to describe proceedings following deaths in custody where enhanced procedural duties are engaged.

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[243] Coroners and Justice Act 2009, Section 1
[244] Coroner's Act 1988, Section 8(1)(c)
[245] Coroners and Justice Act 2009, Section 7
[246] *R. (on the application of Coker) v HM Coroner for Inner South London* [2006] EWHC 614 (Admin) (Queen's Bench Division (Administrative Court)), *para 23*; *R. (on the application of Amin (Imtiaz)) v Secretary of State for the Home Department,* para 31
[247] *R. (on the application of Gentle) v Prime Minister* [2008] UKHL 20 (House of Lords), para 195
[248] *R. (on the application of Hurst) v HM Coroner for Northern District London* [2007] UKHL 13 (House of Lords) 2007
[249] *Letts v Lord Chancellor (2015),* para 74
[250] Ibid, paras 76-7 & 84
[251] *Rabone v Pennine Care NHS Trust* [2010] EWCA Civ 698 (Court of Appeal (Civil Division)), para 93

3.4. Requirements of Article 2 investigation

A coroner has wide discretion to carry out an inquest as they consider is appropriate to each case.[252] However, when an inquest is satisfying a State's obligation under Article 2, this discretion is limited in deference to the fundamental nature of the right to life.[253] As described earlier, the procedural obligation requires a State to ensure there is an investigative process that is capable of ensuring accountability for any death but the ECtHR has judged that if there is a possibility of a substantive breach, the State must ensure an enhanced, State-initiated investigation occurs.[254]

It was acknowledged in *Amin* that the ECtHR allow a degree of flexibility in how States can carry out investigations that satisfy the procedural obligation of Article 2.[255] However *Jordan* sets out certain aspects which are considered to be the minimum requirement necessary to ensure an investigation complies with the enhanced procedural duty under Article 2. An investigation must be State-initiated, independent, effective and reasonably prompt; there must be sufficient public scrutiny and appropriate involvement of the next of kin.[256][257] This means it should not rely on the next of kin to bring a case before a court; civil cases would not discharge State obligations as they are not State-initiated. The ECtHR has judged an inquest as capable of devolving a State's enhanced procedural duty where they are held in public, independently adjudicated, allow family involvement as well as investigating wider aspects related to a death such as planning of operations.[258]

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[252] Hyam; *R. (on the application of LePage) v HM Assistant Deputy Coroner for Inner South London* [2012] EWHC 1485 (Admin) (Divisional Court); *McDonnell v HM Assistant Coroner for West London* [2016] EWHC 3078 (Admin)
[253] Thomas and others
[254] Hyam, p 5-6
[255] *R. (on the application of Amin (Imtiaz)) v Secretary of State for the Home Department,* para 32
[256] *Jordan v United Kingdom*
[257] For a discussion on further relevant case law relating to minimum requirements for an Article 2 compliant investigation see Caroline Cross and Neil Garnham (eds), *The Inquest Book: The Law of Coroners and Inquests* (Hart Publishing 2016), Chapter 7
[258] *Bubbins v United Kingdom* (2005) 41 EHRR 24 (European Court of Human Rights), para 153

3.4.1. Wider aspects linked to cause of death

In 1994, the Court of Appeal in *Jamieson* judged that in reference to the remit of a coroner being limited by Section 11(5)(b)(ii) of the Coroners Act 1998 and rule 36(1)(b) to consider "how" someone died, this should be interpreted to mean "by what means" and not "in what broad circumstances".[259] However after the incorporation of the ECHR into domestic law through the HRA, this issue was reconsidered. In 2004, the cases of *Middleton*[260] and *Sacker*[261] involving deaths in prison came before the House of Lords where it was decided the relevant sections of the Coroners Rules 1984 and the Coroners Act 1988 must be interpreted in order to be compliant with Article 2. The *Middleton* ruling stated there were instances (for example where the central issue for the inquest was whether the deceased had committed suicide) where a traditional short form verdict (as described in *Jamieson*) would be adequate for a jury to describe their findings. However, it found that in some cases, this form of verdict would not discharge the enhanced procedural duty fully by limiting the ability of the jury to make conclusions on major issues highlighted during the inquest that did not directly cause death. The judgement referred to *Keenan*, *Edwards* and *Amin* to illustrate that a short form verdict would probably not have met Article 2 procedural requirements; concluding that in such instances, the coroner had a duty to interpret "how" to mean not only "by what means" but more broadly as "by what means and in what circumstances".[262] The coroner must still ensure any findings by the jury do not determine any civil or criminal liability on the part of a named person in order to comply with legislation (to be discussed in Section 3.4.2). *Middleton* was clarified in 2009, in *Lewis,* when the High Court took a narrow interpretation of what "circumstances" might be considered relevant in an Article

[259] *R. v HM Coroner for North Humberside and Scunthorpe Ex p. Jamieson,* p 24
[260] *R. (on the application of Middleton) v HM Coroner for Western Somerset*
[261] *R. (on the application of Sacker) v HM Coroner for West Yorkshire* [2004] UKHL 11 (House of Lords)
[262] *R. (on the application of Middleton) v HM Coroner for Western Somerset*

2 case and therefore investigated by an inquest.[263] The Court decided that to comply with Article 2 requirements, only issues which either caused or were contributory to the death need be considered. The coroner's discretion to decide whether issues might arguably have been contributory to a death was affirmed in *Speck,* but it was found that once an issues had been judged not to have made any real contribution to the death, the coroner had no discretion to investigate said issue.[264] In making a clear distinction between *Jamieson* and *Middleton* inquests, UK courts arguably went beyond the ECtHR, where the distinction between different procedural obligations is not as clear cut. In practice, however, in England and Wales, the distinction is not as clear as case law would suggest;[265] some coroners will treat a case where it is not clear what has contributed to a death as a *Middleton* case (therefore considering wider aspects) until it becomes apparent aspects are not linked to the death, at which point the jury will be directed to not consider those aspects. Other coroners will identify at the start of the inquest aspects which are clearly linked to a death and only allow examination of other issues if new evidence is presented to link them to the death. The Coroners and Justice Act allows coroners discretion to decide what aspects are investigated by an inquest, although it is stated investigations must be widened if necessary to comply with Article 2.[266] In 2016, the law was further clarified through *Tainton,* where it was judged that in order to comply with Article 2 requirements, an inquest verdict should reference failures which formed part of the circumstances of a death, even if they were not found to be causative.[267]

[263] *R. (on the application of Lewis) v HM Coroner for the Mid and North Division of Shropshire* [2009] EWCA Civ 1403 (Court of Appeal (Civil Division))
[264] *R. (on the application of Speck) v HM Coroner for District of York* [2016] EWHC 6 (Admin) (Queen's Bench Division (Administrative Court))
[265] Cross and Garnham, Introduction
[266] Coroners and Justice Act 2009, Section 5
[267] *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin)

3.4.2. Holding the State to account

Lord Bingham stated the procedural Article 2 obligations should be a high priority for "a modern democratic State governed by the rule of law".[268] One element to this is to ensure facts about a death are clearly investigated, including any systemic failings which may have contributed to the death. These failings should then be addressed, thus preventing further deaths as well as maintaining confidence in the State. Also, to discharge the enhanced procedural duty, an investigation must "be capable of leading to a determination of whether State agents are liable".[269] One of the purposes of an Article 2 investigation has been stated as maintaining public confidence in the State's compliance of the rule of law, including ensuring State agencies are held to account for any deaths.[270] The ECtHR referred to the Turkish justice system as having defects as it failed to provide accountability of the actions of the States' security forces.[271]

In 2005, the ECtHR judged an investigatory system that did not allow for the identification and punishment of anyone responsible for a death as a possible outcome could result in a violation of Article 2 obligations.[272] In order to fulfil its Article 2 obligations, a State must ensure accountability of those responsible for a death is possible in practise, not just theory.[273] Specifically the ECtHR has recognised the importance of prosecuting any individuals believed culpable for a death. The State was found to have violated the procedural duty in *Jordan* as they "did not allow any verdict or findings which could play an effective role in securing a prosecution in respect of any criminal offence which may have been disclosed".[274] The purpose of an Article 2 investigation was clarified in *Menezes*, where the ECtHR referenced the fact that more recent cases had refined the purpose: "the investigation

[268] *R. (on the application of Middleton) v HM Coroner for Western Somerset,* para 5
[269] *McCann v United Kingdom,* para 201
[270] *Enukidze and Girgvliani v. Georgia* [2011] ECHR 735 (European Court of Human Rights), para 243; *Da Silva v United Kingdom* [2016] ECHR 314 (30 March 2016) (European Court of Human Rights), para 232
[271] *Mahmut Kaya v Turkey,* para 101
[272] *Aydin v Turkey* (2006) 42 EHRR 44 (European Court of Human Rights); *Calvelli and Ciglio v Italy, para 53*
[273] *Jordan v United Kingdom; Dodov v Bulgaria*
[274] *Jordan v United Kingdom,* para 142

should be capable of leading to the identification and punishment of those responsible" as ""capable of leading to a determination of whether the force used was or was not justified in the circumstances ... and of identifying and - if appropriate - punishing those responsible".[275] This clarified the purpose as less restrictive than previously stated, with the requirement being to ensure careful scrutiny of State actions and that if an investigation was otherwise compliant to Article 2, a lack of prosecution itself would not be enough to lead to a violation. [276]

When an inquest is the primary procedure for discharging the Article 2 obligation to hold the State accountable, this requirement could be argued to be in conflict with domestic law which states no civil or criminal liability can be determined in relation to a named person.[277] In *Keenan,* the ECtHR referred to the procedural duty required by Article 2, stating that due to the restricted scope an inquest could not determine liability for a death, which limited the availability of an effective remedy to the next of kin.[278]

The ECtHR has found the opportunity for an inquest to result in an appropriate verdict as a vital step in ensuring accountability following a death where State agents may possibly be held responsible. However, the State response to any identified failings is also important; it would be expected that prosecutions would follow such a verdict. The ECtHR in *Jordan* stated in cases where there was controversial use of force by State agents, decisions not to prosecute should be made by someone independent and reasons should be given in order to satisfy public confidence and ensure the bereaved family can judge whether to challenge the decision.[279]

In domestic courts, the right for family participation during an Article 2 inquest has been linked to the scrutiny required to ensure accountability.[280] The Court argued that it followed family participation

[275] *Giuliani and Gaggio v Italy* [2011] ECHR 513 (European Court of Human Rights), para 301
[276] *Da Silva v United Kingdom, paras 257 & 259*
[277] Coroners and Justice Act 2009, Section 10; Coroner's Rules 1984. No 552, Rule 42; the same language is used in both pieces of legislation.
[278] *Keenan v United Kingdom,* para H20
[279] *Jordan v United Kingdom,* para 123
[280] *Letts v Lord Chancellor (2015),* para 59

was an "integral part of the Article 2 duty" linked to the "need to maintain public confidence in the adherence of the State to the rule of law".[281]

3.4.3. Family involvement in the investigation

In 1990, the UN published Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, which set out the minimum requirements for an investigation into a controversial death in custody; including the requirement that the family of the deceased should have access to an independent process.[282] The ECtHR enshrined the right of families to be involved in an Article 2 investigation via *Jordan,* where the right of the family to participate in an inquest was stated as necessary to "ensure the requisite protection of their interests".[283] The State was found to have violated its procedural obligation in six ways, one of which was in prejudicing the ability of the bereaved family to "participate in the inquest".[284] The restriction of the families' ability to participate was linked to long delays in the process, relating to problems accessing legal aid; access to legal representation will be considered in Sections 3.4.5.1 and 3.4.5.2. In the case of *Edwards*,[285] the ECtHR judged a closed inquiry in which the parents of the deceased could only attend on the days they were giving evidence failed to fulfil the UK's duty under Article 2.[286]The judgement found Edwards' parents were not able to participate in the inquiry sufficiently to safeguard their interests "given their close and personal concern with the subject matter".[287] The ECtHR reiterated that the next of kin must be allowed effective access to any investigation into deaths involving State agents in *Aydin v Turkey*.[288]

[281] Ibid
[282] United Nations, *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials* (1990)
[283] *Jordan v United Kingdom,* para 134
[284] Ibid, para 142
[285] *Edwards v United Kingdom*
[286] The lack of power to compel witnesses was also cited.
[287] *Edwards v United Kingdom*
[288] *Aydin v Turkey*

The Coroner's Rules 1984 set out rights for bereaved families, including the right to be notified about "the date, hour and place" of the inquest;[289] to be notified when the post-mortem would take place, if they have given the coroner advance notice to attend or be represented[290] and to examine witnesses.[291] Although the Rules did not explicitly set out what further rights a bereaved family may expect, the importance of respecting their "best interests" has been referenced in justifying the broad discretionary powers of coroners in a number of well-publicised inquests.[292] These rights have been retained through the Coroners (Inquests) Rules 2013 and Coroners (Investigations) Regulations 2013;[293] the only slight amendment being families now have the right to be informed the coroner has opened an investigation and also to be represented at a post-mortem, if they have previously notified the coroner of their wish to be so represented.[294] Although the coroner need not give such notification if it would be impractical or unreasonably delay the post-mortem.

UK courts also referred to ECtHR case law in establishing a legal right for bereaved families to be assured of an effective investigation. Lord Slynn in *Amin*, indicated the procedural duty was "partly one owed" to the bereaved family, who, as the representatives of the deceased had a right under Article 2 to an independent and public investigation following a death in State custody.[295] *Jordan* requirements were followed to find the "next of kin of the victim must be involved in the procedure to the extent necessary to safeguard" their interests.[296] In *Letts* it was judged that the legitimate interests of a bereaved family included knowing that any State culpability in the death of their loved one was identified, learning the truth and being confident similar deaths in the future would be prevented.[297] The rights of bereaved families to participate in an inquest are linked to Article 2

[289] Coroner's Rules 1984. No 552, r.19
[290] Ibid, r.7
[291] Ibid, r.20
[292] Including those into Helen Smith's death, the Marchioness disaster and the Hillsborough tragedy; See Beckett, p 278
[293] The Coroners (Inquests) Rules 2013; The Coroners (Investigations) Regulations 2013; No. 1629
[294] The Coroners (Investigations) Regulations 2013; No. 1629, Section 13
[295] *R. (on the application of Amin (Imtiaz)) v Secretary of State for the Home Department,* para 41
[296] Ibid, para 20
[297] *Letts v Lord Chancellor (2015)*

obligations; in an unreported case from 2005, which did not involve State actions, it was found the coroner did not have a duty to adjourn an inquest to ensure the partner of the deceased could attend.[298] Similarly, a more recent case found an administrative error which resulted in an ex-wife not being informed about when an inquest would take place, therefore preventing the deceased's young daughter being represented as an interested party, did not require a new inquest to be called.[299]

Violations of Article 2 will most commonly involve a deceased victim. It therefore falls to the family of the deceased to bring cases to the ECtHR in reference to possible Article 2 violations.[300] Applications have been accepted from the partner, parents or siblings of a deceased.[301] Applications from family members can either be with them representing the deceased or in relation to their own victim status; these are not mutually exclusive as one applicant can be considered by the ECtHR in terms of both.[302] The ECtHR has found "close family members, such as parents, of a person whose death is alleged to engage the responsibility of the State can themselves claim to be indirect victims of the alleged violation of Article 2".[303] They do not necessarily have to be identified as next of kin or legal heirs: the ECtHR has stated the applicant does not have to be the closest relative but "if a relative wished to complain about a question as serious as the murder of one of his close relations, that ought to suffice to show that he felt personally concerned by the incident".[304] It should be noted that for those circumstances when the right to life is engaged even if the victim survives, this will only be when the injuries are very severe; in the case of JL, the victim was left "incompetent to conduct his own affairs".[305]

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[298] Doyle's Application reported in Thomas and others
[299] *Chambers v HM Coroner for Preston and West Lancashire & Ors* [2015] EWHC 31 (Admin)
[300] *Kats and Others v Ukraine* (2010) 51 EHRR 44 (European Court of Human Rights), para 94
[301] *Aytekin v Turkey* (2001) 32 EHRR 22 (European Court of Human Rights); *Ergi v Turkey*; *Cicek v Turkey* (2003) 37 EHRR 20 (European Court of Human Rights); *Jordan v United Kingdom*
[302] *Keenan v United Kingdom*
[303] *Van Colle v United Kingdom* (2013) 56 EHRR 23 (European Court of Human Rights), para 86
[304] *Yasa v Turkey* (1999) 28 EHRR 408 (European Court of Human Rights), para 63
[305] *R. (on the application of JL) v Secretary of State for the Home Department,* para 2

In terms of the inquest process, the family may be involved in two different ways: either as the nominated next of kin or as an interested person. In situations where deaths occur in custody, the individual will normally have completed a form identifying their next of kin: if this has not happened (or the death occurs before the individual has done this), the coroner's officer will be responsible for identifying the next of kin.[306] The next of kin will be the person notified of the death, the need for an inquest and the time and place of any post-mortem or autopsy that is taking place.[307] The coroner has the discretion to identify anyone as an "interested person" and under normal circumstances, the next of kin will be so identified; however other family members may also be given "interested person" status. Interested parties should be involved in all aspects of the process (this will be discussed more below).

In 1993, the sister of a deceased successfully judicially reviewed a coroner's decision not to recognise her as an interested party and it was held that close blood relations who were in contact prior to the death should be allowed interested person status.[308] In 2005, the Coroners Rules were amended to acknowledge the legal standing of single sex unions under Article 8 of the ECHR by including civil partners and the rights described above are accessible to "a parent, child, spouse, civil partner, partner and any person representative of the deceased".[309] Although this does not specifically include relatives such as siblings, Rule 20(2)(h) does allow rights to be conveyed on anyone the coroner decides is "a properly interested person".[310] In 2008, the High Court judged that Rule 20(2)(h) should be interpreted broadly to ensure all interested parties were accommodated, in this case stating the girlfriend of the deceased should not be disqualified from being recognised as an interested person just because they had split up shortly before the death.[311] Although coroners still have the discretion to decide who is

[306] The Coroners (Investigations) Regulations 2013; No. 1629
[307] Ibid; The Coroners (Inquests) Rules 2013
[308] *R. v HM Coroner for Greater London Southern District Ex p. Driscoll* (1995) 159 JP 45; [1994] COD 91 (Divisional Court)
[309] The Coroners (Amendment) Rules 2005, r.2
[310] Ibid, r.20
[311] *R. (on the application of Platts) v HM Coroner for South Yorkshire (East District)* [2008] EWHC 2502 (Admin) (Queen's Bench Division (Administrative Court))

named as an interested party, the Coroners and Justice Act provides guidance stating that "a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister" might be an interested party.[312]

3.4.4. Purpose of family participation

Jordan clarifies that the next of kin should be involved in an Article 2 investigation to ensure their "legitimate interests" are safeguarded.[313] "Legitimate interests" are not clearly defined but the judgement stated part of the procedural duty imposed by Article 2 was to provide the family an opportunity to participate as a remedy beyond a financial or civil judgement.[314] In considering the issue of families being given reasons for non-prosecution of State agents, the ECtHR distinguished between the intrinsic and instrumental value of giving reasons. It stated decisions not to prosecute should be explained to the family as otherwise they would be denied "information about a matter of crucial importance to them" as well as restricting "any legal challenge" they may wish to make in relation to the decision.[315] This infers that ensuring the family is informed of reasons behind such decisions would have an important value even if it was not necessary for any legal challenge or civil case.

Although the ECtHR does not set out in detail what constitutes "legitimate interests", it does distinguish between the outcome and the process in relation to family access to the investigation. The Broderick Committee was quoted in iterating the necessity of being able to "judge an issue" through access to the process as opposed to being presented with the verdict once the issues have been judged.[316] There is therefore arguably value in ensuring family access to an inquest beyond ensuring a

[312] Coroners and Justice Act 2009; Section 47 (2)(a)
[313] *Jordan v United Kingdom,* para H10
[314] Ibid, para H43
[315] Ibid, para H21
[316] Ibid, para H70

fair outcome; the importance being allowing them to judge the issue and therefore the verdict themselves. Although the scrutiny of the public and family is not always distinguished, the ECtHR does allow that public scrutiny during an Article 2 investigation may be limited if necessary, whereas family involvement may not be.[317]

However, family participation is argued to be important beyond an opportunity to scrutinise the process, it also ensures their interests are protected.[318] One consequence of findings of State culpability might be for a family to receive compensation. Participation during the process is key to ensuring families have access to information that might help them decide whether to bring a civil case against either an individual or organisation as well as possible legal challenges to the process itself. The opportunity to challenge the process has been recognised as an important element of an Article 2 compliant investigation by the ECtHR.[319]

The psychological impact an investigation can have on a grieving family is also an important aspect.[320] The ECtHR has found the violation of the Article 2 procedural duty did not merely result in pecuniary damage on the family but also resulted in "frustration, distress and anxiety".[321] In cases of enforced disappearance, the ECtHR has found the impact on the family can result in a violation of Article 3 due to the anguish and distress caused if the State fails to respond to their queries adequately.[322] The ECtHR consider any obvious effort made by the family to investigate the situation as a key factor in determining their distress; for example repeated requests for information to which the State do not respond.[323]

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[317] This distinction between public scrutiny and family participation is not always made: in relation to State officials remaining anonymous during inquests, families are often treated the same as the press in not being allowed to see those giving evidence. See *R (Hicks) v Inner North London Senior Coroner* [2016] EWHC 1726 (Admin)

[318] *Jordan v United Kingdom,* para 109

[319] *Bubbins v United Kingdom,* para 153

[320] Traumatic bereavement was referenced during the interviews and will discussed in more detail in Chapter 4.

[321] *Jordan v United Kingdom,* para H48

[322] *Kurt v Turkey* (1999) 27 EHRR 373 (European Court of Human Rights)

[323] *Tanis v Turkey* (2008) 46 EHRR 14 (European Court of Human Rights), para 221

Australian courts have recognised that an inquest procedure[324] can impact on the grief process of the bereaved, therefore possibly interfering with private life.[325] European case law also links interference with grief, as an "intimate part of an individual's private life", with possible violations of the Article 8 right to a private life of the bereaved.[326] ECtHR judgements have recognised Article 8 rights can impose positive obligations on a State, and State actions that are shown to directly link to a restriction on a person's private life are likely to be considered as a violation of Article 8.[327] In one case, the ECtHR noted lack of legal proceedings which might lead to sanctions intended to remedy an injury might breach the Article 8 rights of the injured.[328]

Families' active participation in the process can have a positive benefit on the outcome by effectively scrutinising the evidence. The ECtHR has stated the importance of testing the evidence during an Article 2 investigation through examination or cross-examination.[329] The ECtHR judged that unless evidence relating to a witnesses account of events was examined, "satisfactory assessment [.....] of reliability or credibility" of the account cannot be made.[330] It further found untested accounts could be potentially misleading.[331] In the inquest system, families or their representatives are often the ones examining the State's account of a death in custody. Although if the family are not willing or able to perform this role, the inquest system allows the Coroner and the jury to ask pertinent questions of the witnesses; arguably an advantage to bereaved families being responsible for the cross-examination is that they are more predisposed to challenge the State's account. The ECtHR identified

[324] The Australian coronial system was based on the same framework as the system in England and Wales but has evolved as a distinct system.
[325] Thomas and others, p 397
[326] Ibid, p 396-7
[327] *Botta v Italy* (1998) 26 EHRR 241 (European Court of Human Rights); J. Thibaut and others, 'Procedural justice as fairness' (1973) 26 Stanford Law Review 1271
[328] *Stubbings and Others v United Kingdom* (1996) 23 EHRR 213 (European Court of Human Rights); Alexandra Dobson, 'Shifting Sands: Multiple Counts in Prosecutions for Corporate Manslaughter' [2012] Criminal Law Review 200
[329] *Jordan v United Kingdom,* H14
[330] Ibid, para 127
[331] Ibid, para 113

that often the families "best interests" will be in direct conflict with any State agencies implicated in the death.[332]

UK courts have recognised that the purpose of ensuring the involvement of bereaved families in inquests following deaths in custody may go beyond protecting their own interests. In *Scholes*, family involvement was argued to be more relevant in relation to the investigation of facts than when policy issues were being questioned.[333] In *Main v Minister for Legal Aid*, the court referred to family involvement in an investigation performing a number of duties including assisting the coroner in investigating the death properly as well as safeguarding the interests of the family and giving them the satisfaction of knowing that lessons would be learnt from the death.[334]

3.4.5. Aspects of effective participation

If families carry out the scrutinising role described in the previous section, family participation can ensure questions are asked in a public forum that ensures transparency and accountability. It is therefore vital to ensure effective participation for families. Legal representation and access to documents are complementary aspects to ensuring participation for bereaved families. Without prior access to documents, legal representatives cannot prepare fully for an inquest; Michael Mansfield[335] has been quoted as saying that acting for a family at a complex Article 2 inquest without prior access to documents was like working with one hand tied behind your back.[336] Conversely, it is argued that

[332] Ibid, para 134
[333] *R. (on the application of Scholes) v Secretary of State for the Home Department* [2006] EWCA Civ 1343 (Court of Appeal (Civil Division))
[334] *R. (on the application of Main) v Minister for Legal Aid* [2007] EWCA Civ 1147 (Court of Appeal (Civil Division))
[335] Senior barrister in the UK who has represented families in complex inquests such as the de Menezes case.
[336] P Scraton and K Chadwick, *In the arms of the law: coroners' inquests and deaths in custody* (Pluto Press 1987), p 85

legal representation is key to ensuring families have access to evidence, as well as providing assistance in analysing what are often a large amount of complex documents.[337]

3.4.5.1. Legal representation

An inquest process is officially an inquisitorial process which does not involve opposing parties.[338] However, there are arguments why legal representation for bereaved families attending an Article 2 inquest might be important. Firstly, the formality of proceedings; for the uninitiated, the process may be indistinguishable from other court proceedings with the coroner sitting as a judge in a courtroom before a jury and witnesses being questioned by legal representatives of interested parties such as the police or prison service. Secondly, the fact that any State agencies involved in an inquest are legally represented; a team of barristers each represent a different facet of the State institutions and State officials. Thirdly, bereaved families have the right to ask questions themselves but the formality of the process, the complexity of the law as well as their vulnerability through grief (which may well be complicated due to the circumstances of a death in custody), all limit the effective expression of this right. Also, issues that are considered within scope of the inquest are limited by law (they must have a causal or contributory relationship with the cause of death); as is the need to ensure the process does not attribute blame to a named person. These legal aspects restrict allowed questions, often to the confusion of family members. The ECtHR has judged a lack of funding for legal representation for the bereaved family was a contributory factor in finding an Article 2 violation, with the lack of equity of participants also being mentioned.[339]

[337] INQUEST, *The Inquest Handbook; A Guide for the Bereaved Families, Friends and their Advisors* (2011)
[338] Home Office, *Legal aid for representation at inquests* (Standard Note: SN/HA/4358 2014), p 1
[339] *Jordan v United Kingdom,* para H29

3.4.5.2. Funding for representation

One of the key ECtHR judgements relating to States obligations to fund representation for individuals during legal proceedings was *Airey* in 1979.[340] The ECtHR found that in order for rights to be practically accessible, funding should be available if an individual's ability to present their case would be ineffective without legal representation. The judgement stated criteria that should be taken into account included the equity of parties and the complexity of the issues involved. The difficulty in relating this and subsequent judgements to coronial law is the fact that, in principle, inquests are inquisitorial not adversarial; even though in practise this may not be the case.

One of the aspects mentioned in *Jordan* as key to ensuring effective participation for bereaved families was legal representation. In this case, the family faced problems trying to obtain funding for legal representation, which was one reason why it was found Article 2 had been violated. The lack of equity of participants was also specifically mentioned with a comparison being made between the families' position and that of the Royal Ulster Constabulary which "had the resources to provide for representation".[341]

UK courts in *Humberstone* decided that, in certain circumstances, a family should have funding for legal representation in order to ensure they could effectively participate in an inquest.[342] Funding for bereaved families is through the exceptional funding system of legal aid and decided on a case by case basis. This remained the case following the enactment of legislation put in place to reform legal aid in 2012.[343] Although criteria governing eligibility became more restrictive, the residence test[344] was

[340] *Airey v Ireland (A/32)*
[341] *Jordan v United Kingdom,* para H29
[342] *R. (on the application of Humberstone) v Legal Services Commission*
[343] Legal Aid, Sentencing and Punishment of Offenders Act 2012
[344] INQUEST, *Briefing: 10 Reasons to vote against the Legal Aid Residence Test* (2014); http://www.publiclawproject.org.uk/news/41/press-release-plp-wins-residence-test-case.-proposals-to-introduce-legal-aid-residence-test-are-unla

successfully challenged in 2016.[345] The guidance used in relation to inquests was amended following a judicial review by a bereaved family in 2015: the case will be discussed in more detail in Section 6.3.3.[346]

3.4.5.3. Access to documents

The ECtHR has stated if a death occurs in State custody, the burden is on the State to provide a satisfactory explanation as to the circumstances of the death.[347] It has held that in some situations a State has a duty to disclose all relevant information, as Article 2 cases "do not in all cases lend themselves for rigorous application of the principle of *affirmanti incumbit probatio* [he who alleges something must prove that allegation]".[348] In fact if a State fails, without good reason, to disclose all relevant information this would illustrate a reluctance to fully comply and may also be taken as an indication of the validity of any allegations against the State.[349]

The coroner has wide discretion in relation to many aspects of inquest procedure; including what access to documents and evidence interested parties are given before the proceedings commence. In 1979, *Peach* stated that unless an interested party was at risk of facing criminal charges in connection with the subject matter of an inquest, there was no necessity for coroners to guarantee pre-disclosure of the evidence to them.[350] Following that decision, pre-disclosure to bereaved families varied considerably depending on the coroner and the case. Some coroners have always ensured families are sent information about what to expect at the inquest, including a list of witnesses likely to be providing

[345] *R (on the application of The Public Law Project) (Appellant) v Lord Chancellor (Respondent)* [2016] UKSC 39
[346] *Letts v Lord Chancellor (2015)*
[347] *Selmouni v France* (2000) 29 EHRR 403 (European Court of Human Rights); *Salman v Turkey*
[348] *Timurtas v Turkey* (2001) 33 EHRR 6 (European Court of Human Rights), para 66
[349] Ibid
[350] *R. v HM Coroner for Hammersmith Ex p. Peach* [1980] QB 211; [1980] 2 WLR 496 (Court of Appeal (Civil Division))

evidence.[351] The law now states, if an interested party requests a document held by a coroner, they must either provide them with a copy of the document or make it available to them "as soon as reasonably practical".[352] However, the coroner still has wide discretion to redact part of documents, or not disclose at all if they decide the request is unreasonable or the document is not relevant.[353] Crucially if consent of the author of any documents "cannot reasonably be obtained" the coroner can refuse to disclose to other parties.[354] As mentioned above, legal support is sometimes necessary to ensure families not only have access to documents, but also are able to analyse them fully.[355] For example, in the *O'Brien* case rare pre-disclosure led to family's solicitor noticing vital forensic evidence the coroner had missed.[356]

The Coroner's Act 1988 set out the statutory power for coroners to examine witnesses on oath at an inquest but not compel witnesses to provide a statement prior to the inquest.[357] In 2007, the High Court decided the coroner could request disclosure of certain documents from a witness who was required to appear at an inquest and if they did not comply, the coroner could apply to the High Court to issue a summons.[358] In fact, a coroner who failed to make such a request for disclosure could be failing to investigate and therefore their decision subject to judicial review.[359] The Coroners and Justice Act 2009 now provides coroners with powers to require disclosure;[360] however this only allows the coroner to have access to the documents and pre-disclosure of the evidence to families is a separate

[351] J. Braithwaite, *Restorative justice and responsive regulation* (Oxford University Press, USA 2002), p 10
[352] The Coroners (Inquests) Rules 2013, Sections 14 & 15; disclosure may also be refused for legal or statutory reasons.
[353] Ibid, Section 13
[354] Ibid, Section 15
[355] Braithwaite, p 24
[356] T. Ward and D. Coles, *Investigating Suspicious Deaths in Police Custody* (Waterside Press 1997), p 114
[357] Coroner's Act 1988, sec. 11(2)
[358] *Assistant Deputy Coroner for Inner West London v Channel 4 Television Corp* [2007] EWHC 2513 (QB); [2008] 1 WLR 945 (Queen's Bench Division)
[359] Thomas and others, p 149
[360] Coroners and Justice Act 2009, Schedule 5

step. This was confirmed in 2013, when the High Court judged that the statutory duty only relates to disclosure to the coroner, but not to other parties, including the public.[361]

A 2001 High Court decision recognised that common practise had moved on since *Peach* and that effective participation may be restricted if advanced disclosure to interested parties was not guaranteed.[362] The judgement agreed pre-disclosure to families was not mandatory but that in some cases, fairness decried it should be assured. This was affirmed by *Smith* in 2008, when the High Court judged there should be "a presumption in favour of as full disclosure as possible"; [363] although the Supreme Court reversed this judgement in part two years later by deciding this case did not come under Article 2.[364] A judgement in 2009 acceded disclosure prior to inquest proceedings was generally advisable but that unless it could be shown it altered the outcome of the inquest, a coroner would not be judged to have acted unreasonably to have failed to ensure disclosure to all parties.[365] In 2010, it was re-affirmed that there was no common law duty on a coroner to ensure full-disclosure of evidence to bereaved families prior to the inquest unless it was shown that lack of disclosure prevented the ascertaining of cause of death.[366]

It can be argued that all interested parties should have access to the same evidence in the interest of natural justice; suggesting families should get pre-disclosure of documents produced by State parties.[367] It has also been noted that issues families want looked at, may fail to be developed and

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[361] *Worcester County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcester* (2013) EWHC 1711 (QB)

[362] *R. (on the application of Bentley) v HM Coroner for Avon* [2001] EWHC Admin 170 (Queen's Bench Division (Administrative Court))

[363] *R. (on the application of Smith) v Oxfordshire Assistant Deputy Coroner* [2008] EWHC 694 (Admin) (Queen's Bench Division (Administrative Court))

[364] *R. (on the application of Smith) v Oxfordshire Assistant Deputy Coroner* [2010] UKSC 29 (Supreme Court)

[365] *R. (on the application of Ahmed) v HM Coroner South East and Cumbria* [2009] EWHC 1653 (Admin) (Queen's Bench Division (Administrative Court))

[366] *R. (on the application of McLeish) v HM Coroner for the Northern District of Greater London* [2010] EWHC 3624 (Admin) (Queen's Bench Division (Administrative Court)); This case was brought by a bereaved mother whose son had died and although the post-mortem did not clearly establish a cause of death, since the mother had not received the report (despite repeated requests) she was not in a position to appreciate the importance of asking for a second autopsy or further blood tests before cremation.

[367] *Maksovich v Attorney General* 4 NSWLR 318 (Court of Appeal of New South Wales); J. Braithwaite, 'Setting standards for restorative justice' (2002) 42 British Journal of Criminology 563

consequently inquiries may be delayed if prior disclosure of the evidence to all parties is not guaranteed.[368] In relation to non-Article 2 cases, the coroner still has wide discretion on whether to disclose evidence to bereaved families prior to an inquest via Sections 14 and 15 of the Coroners (Inquests) Rules 2013; however following deaths in custody, the bereaved families can rely on ECtHR case law and Government guidelines to argue for full pre-disclosure.[369]

The Macpherson report looked into the killing of Stephen Lawrence and the subsequent investigation into his death; one of the recommendations was that evidence and documents to be presented at an inquest should be disclosed in advance to anyone classified as an interested person by a coroner.[370] Following the Macpherson report, the Home Office encouraged pre-inquest disclosure of relevant documents to interested parties in cases of deaths in police custody as a matter of "normal practise" unless there were "compelling reasons why certain documents, or parts of documents, may not be disclosed".[371] It was noted the rationale behind pre-disclosure to next of kin where possible was to reduce friction in controversial cases and allay suspicions. In 2005, this entitlement to pre-inquest disclosure was extended to other custodial deaths when the PPO developed their policy; referring to the necessity of complying with procedural obligations under Article 2.[372]

Both the police and prison services have now published guidelines suggesting that a policy of pre-disclosure to families should be followed but this is not a statutory requirement. The Coroners (Investigations) Regulations 2013 empowers a coroner to provide documents to any person they deem appropriate,[373] but does not give coroners the power to force disclosure by other bodies (such as the police service) as their consent is required for documents to be shared with other parties.[374] The only domestic legislation that families could rely on to force disclosure would be the HRA, allowing ECtHR

[368] Thomas and others, p 146
[369] Ibid, p 148
[370] E.A. Lind and others, 'Individual and corporate dispute resolution: Using procedural fairness as a decision heuristic' [1993] Administrative Science Quarterly 224
[371] Home Office, *Deaths in Police Custody: Guidance to the Police on Pre-Inquest Disclosure* (1999)
[372] Prisons and Probation Ombudsman, *Disclosing Policy* (2009)
[373] The Coroners (Investigations) Regulations 2013 , Section 27
[374] The Coroners (Inquests) Rules 2013, Section 14

case law referencing pre-disclosure. Although in *McCann*, the ECtHR found access of documents for families was not an automatic requirement;[375] in *Jordan*, the ECtHR noted that "more emphasis of involving next of kin in procedure and providing them with information" had been made by judgements since *McCann*.[376] The importance of the change in policy relating to the disclosure of police witness statements prior to an inquest following the publishing of the Macpherson report was recognised in the judgement. It was affirmed that the next of kin's interests were unlikely to be "fairly or adequately protected" without pre-disclosure; especially as it placed them at a disadvantage to effectively question witnesses.[377]

The ECtHR found access to documents for families was important for three reasons. Firstly, as it was a "positive contribution in the openness and fairness of the inquest".[378] Secondly, it could benefit the family in preparing for and then participating in the questioning of witnesses.[379] Thirdly, it was important in maintaining equity between all the parties; so if the State had access to documents then it was important for the next of kin to have similar access.[380] The ECtHR has closely identified the benefit of pre-disclosure with ensuring the fair participation of families during a process.[381] Also, in *Jordan,* one of the six ways the State was found to have failed in respect to its Article 2 procedural duty was because "the absence of legal aid for the representation of the victim's family and non-disclosure of witness statements prior to their appearance at the inquest" restricted their ability to participate.[382] The ECtHR has judged families do not have an absolute right to access all documents at

[375] *McCann v United Kingdom,* para 163
[376] *Jordan v United Kingdom,* para 133
[377] Ibid, para 134
[378] Ibid
[379] Ibid
[380] Ibid, para H29
[381] Although in *McCann*, the ECtHR stated non-access of documents for families had not hampered their participation in the process, it was noted the families had been represented and their representatives had been able to participate in the proceedings. See *McCann v United Kingdom,* para 162
[382] *Jordan v United Kingdom,* para 142

all stages of the investigation, the requirement being that they had sufficient access to participate effectively.[383]

The lack of legislative protection enshrining the right for families to be given access to evidence in a timely manner leaves them at the discretion of the coroner. In situations where pre-disclosure is not offered by State agencies involved or ensured by the coroner, families have to rely on legal arguments to access the documents. This can lead to delays in families being given the evidence, in some circumstances only receiving disclosure on the day of the inquest. It is also a concern that all the protections that are in place for families getting disclosure rely on families proactively requesting documents; which pre-supposes an understanding or knowledge that families may not have without specialist legal support.

3.5. Conclusion

This chapter sets out the legal rights relating to family participation in Article 2 investigations and illustrates that, although bereaved families do have a right to participate in any investigation, there is still considerable discretion left to decision-makers which can impact on participation. This mainly relates to coroners who can determine whether an Article 2 investigation is required, which influences opportunities to participate as well as legal protections in place. State officials including senior police or prison officers and senior individuals in the legal aid office can also influence participation via decisions about disclosure and funding for legal representation. The importance of case law in establishing the legal rights relating to Article 2 investigations has also been shown, and family involvement is a vital part of cases being brought before both domestic and European courts. It is clear

[383] *Ramsahai v The Netherlands,* para 199

that without family participation in all the cases referenced throughout this chapter, the detailed legal rights would not have been clarified.

ECtHR judgements affirm that in implementing provision, an "outcome-orientated approach" should be taken, so this thesis will now look at how perceptions influence important aspects for family participation.[384] Within criminal justice procedures, the importance of maintaining the rule of law can be used to argue for procedural fairness in principle, even if it does not alter the outcome. This thesis will argue this approach can be taken in respect to inquests where the actions of State agents are under scrutiny. This relies heavily on Tyler's work linking procedural fairness within the criminal justice system with the legitimacy of the State agencies.[385] The next chapter will look at aspects of bereaved family participation within this theoretical framework.

[384] Jaka Kukavica and Veronika Fikfak, 'Strasbourg's U-Turn on Independence as Part of an Effective Investigation Under Article 2' (2015) 74 The Cambridge Law Journal 415
[385] Tyler (1990); Tyler and Huo

Chapter 4: THEORETICAL FRAMEWORKS RELEVANT TO EFFECTIVE AND FAIR PARTICIPATION IN A LEGAL PROCESS

4.1. Introduction

The coroner has been empowered to conduct an inquest into any deaths where there was a suspicion of violence or the cause of death was unknown since the 19th Century.[386] However the purpose behind holding an inquest is argued to be distinct from the purpose of a criminal investigation.[387] An inquest must identify who the deceased was, and how, when and where they died;[388] but the coroner should only hold an inquest into a death in situations where there is no ongoing prosecution involving the death.[389] Finding the truth about the circumstances of a sudden or suspicious death where no criminal behaviour is suspected can be linked to a number of aims. Firstly, ensuring bereaved families understand what happened, which can be important in helping them come to terms with the death. Secondly, identifying the causes of death can also prevent future deaths and allay any public concerns.[390] When looking to reform the coronial system, the Government aimed to create a system which ensured public confidence.[391] The legitimacy of the system is therefore fundamentally important. The legitimacy of the inquest system can be affected by participation of bereaved families in two ways. Firstly, the right to participate ensures the right to influence the outcome; and family participation can assist in ensuring a fair and accurate outcome is achieved. Secondly, procedural

[386] F. Moskof and J. Young, 'The Roles of Coroner and Counsel in Coroner's Court' (1987) 30 Criminal Law Quarterly 190, p 196; Levine and Pyke
[387] Cooper
[388] Coroners and Justice Act 2009, Section 5
[389] Ibid, Schedule 1
[390] Cooper
[391] Home Office, *Reforming the Coroner and Death Certification Service: Position Paper*

justice theory argues that perceptions of a fair process can impact positively on perceptions of the legitimacy of the process.

Chapter 3 looked at the legal frameworks which govern complex inquests for deaths in custody but it is important to go beyond the rules and study relevant theoretical norms to understand what benefits from participation might be achieved in real life situations. Societal acceptance of rules can be consequential on various elements including consistency, foreseeability and fairness. A positivist argument would be that universal norms would be used as standards against which to consider the actions of institutions and the behaviour of citizens within the framework of rules or law.[392] It is therefore important to both consider the rules or laws governing a legal process and the theoretical norms that might be relevant in real situations.

Real life is context driven and abstract norms can be impractical as standards; therefore, it is important that any identified norm must be practically achievable in principle. This is especially true for justice which must be relevant to society in order to respond to real situations.[393] Justice is sometimes argued to be subjective and open to interpretation therefore a universal norm or definition is not easily constructed. Liebling argues it is easier to find agreement in terms of identifying injustice rather than defining what justice should be.[394] So instead of considering one overarching norm, this thesis will consider three theories which relate to the participation of families and the likely impacts of that participation; grief theory, right to participate and procedural justice theory. Grief theory explains how access to the truth can impact positively on the grief process following a sudden or unexpected death. The right to participate is linked to both the instrumental value of being able to affect the outcome of a process and also the intrinsic value of a fair process, regardless of whether it affects the outcome. Procedural justice theory illustrates that perceptions about a process impact on perceptions of legitimacy as well as confidence in and compliance with the outcome. These three norms can all be

[392] Herbert LA Hart, *The concept of law. Clarendon law series* (Oxford University Press (Clarendon), London 1961), p 76-107; I.M. Young, *Justice and the Politics of Difference* (Princeton University Press 1990)
[393] Young, p 5
[394] A. Liebling, 'Prisons in transition' (2006) 29 International Journal of Law and Psychiatry, p 423

linked to the purpose of an inquest to find the facts surrounding a death; and consequential impacts on grief, and legitimacy.

Section 4.2 looks at grief theory and the benefit of bereaved families being able to make sense of a death, especially when it was unexpected. Section 4.3 looks at the potential benefits of participation in different processes, and what likely benefits have been established in theoretical norms. Section 4.4 introduces possible instrumental and intrinsic values of a fair process, including reference to procedural justice theory. Tyler argues that in relation to criminal justice, citizens are more concerned with perceived fairness of procedure leading to a fair outcome (normative justice) than whether an outcome alone is perceived as fair (instrumental justice).[395] Procedural justice theory has been predominantly used within criminal justice interactions; including police and prison situations so it is particularly pertinent for this project. Section 4.5 considers the relevance of procedural fairness in complex inquests; including establishing the inquest system as a hybrid process (including both adversarial and inquisitorial aspects). The first section will discuss aspects of grief theory which relate to a sudden or unexpected death, as well as the importance of knowing the truth so a narrative can be formulated which makes sense of bereavement.

4.2. Grief Theory

The specific vulnerability of families who are grieving has already been referenced in Chapter 3. State responses which impact on grief have to take account of possible interferences in an individual's right to a family life. In respect of an inquest process, one reason for ensuring families are able to participate is to allow them to know the truth about the circumstances of a death. In setting out their reasons for

[395] Kevin Buckler and others, 'Racial and Ethnic Perceptions of Injustice; Does prior personal and vicarious incarceration experience alter the racial/ethnic gap in perceptions of injustice?' (2011) 35 Criminal Justice Review 269

reforming the inquest system in 2004, the Government said they would be "putting the needs of the bereaved at the centre of the new system."[396] This recognised the particular vulnerability of people who have been bereaved and the role that an inquest plays during the grief process.

Grief is a natural process following the death of a loved one and, although the process is hugely variable, situations where the response to bereavement is considered to be excessive (either by the time taken to cope or by the extent of the emotional or physical responses) have been defined as complicated grief.[397] The grief process usually includes phases of numbness, distress, despair and acceptance; although it is unusual for people to experience them in logical order.[398] There is no such thing as normal bereavement, everyone has to find acceptance in their own time and in their own way before they can move on. A close bereavement can have negative effects on a person's physical and psychological well-being; including increased medication intake and depression.[399] Academic studies have identified factors which can have a negative impact on the outcome of the grief process.[400] Factors such as the relationship between the deceased and the bereaved; the support available to the bereaved; the context prior to the death as well as the circumstances of the death can all have a significant impact on bereavement.[401] Snow and McHugh argue that in cases involving deaths in custody, the bereavement process can be adversely affected.[402] The bereavement process may be affected by the stigma that is attached to a death in custody that can result in a lack of support from

[396] Home Office, *Reforming the Coroner and Death Certification Service: Position Paper*
[397] M. Stroebe, H. Schut and W. Stroebe, 'Health outcomes of bereavement' 370 The Lancet 1960, p 1965
[398] A.W. Love, 'Progress in understanding grief, complicated grief, and caring for the bereaved' (2007) 27 Contemporary Nurse 73, p 75-6
[399] Stroebe, Schut and Stroebe, p 1962-3
[400] H.G. Prigerson and others, 'Traumatic grief as a risk factor for mental and physical morbidity' (1997) 154 American Journal of Psychiatry 616; Y. Neria and B.T. Litz, 'Bereavement by traumatic means: The complex synergy of trauma and grief' (2004) 9 Journal of Loss and Trauma 73
[401] Love
[402] Louisa Snow and Martin McHugh, 'The aftermath of a death in prison custody' in Towl, Snow and McHugh (eds), *Suicide in prisons* (BPS Blackwell 2000)

friends, family and society in general.[403] Lack of support or sympathy from a bereaved person's social network is a relevant factor identified as increasing the likelihood of complicated grief.[404]

Bereavement following sudden or traumatic deaths has been shown to have distinct psycho-social reactions to bereavement following non-traumatic deaths.[405] When someone is bereaved through a traumatic death, there is an increased risk of them developing long-term problems such as post-traumatic stress disorder.[406] It has been suggested that grief is complicated following a traumatic death (murder or suicide) due to the images that will be associated with the death; trying to avoid these painful thoughts can inhibit the healthy expression of grief.[407] Bereavement following suicide can be complicated for additional reasons involving possible dissatisfaction with external support offered prior to the death;[408] and guilt among family and friends who feel responsible in not being able to help the deceased.[409] Conversely, it has been shown that, as suicide may occur not as an isolated event but after a long series of unhappy events, some families report feelings of relief following a suicide; especially if the person who died was in pain or struggling with life.[410] However, in these cases, families indicated they felt ashamed and guilty because of feeling relief, therefore unable to express their emotions.[411] Even where deaths in custody are not sudden or traumatic, factors likely to be present can increase the likelihood of complicated grief.[412]

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[403] Ibid, p 137
[404] S. & Milne Aranda, D., 'Guidelines for the assessment for complicated bereavement risk in family members of people receiving palliative care.' [2000] Centre for Palliative Care Melbourne, Australia
[405] Kari Dyregrov, Dag Nordanger and Atle Dyregrov, 'Predictors of psychosocial distress after suicide, SIDS and accidents' (2003) 27 Death Studies 143
[406] Beverley Raphael and Nada Martinek, 'Assessing traumatic bereavement and posttraumatic stress disorder' in Wilson JP and Keane TM (eds), *Assessing psychological trauma and PTSD* (Guilford 1997); Prigerson and others; Stacey Kaltman and George A Bonanno, 'Trauma and bereavement: Examining the impact of sudden and violent deaths' (2003) 17 Journal of Anxiety Disorders 131; Neria and Litz
[407] Linda Dowdney, 'Annotation: Childhood bereavement following parental death' (2000) 41 Journal of Child Psychology and Psychiatry 819, p 823
[408] Love
[409] Snow and McHugh
[410] DM Shepherd and BM Barraclough, 'The aftermath of parental suicide for children' 129 The British Journal of Psychiatry 267, p 272; Snow and McHugh
[411] Snow and McHugh
[412] Love, p 78

Families may feel shame where a death occurs in custody; particularly if there is negative reporting about the deceased and their lifestyle which leaves families feeling unable to express grief for the death. Studies suggest that how the deceased is defined in memory may affect how well the bereaved copes in the future.[413] So where there is a perception of stigma attached to a death, this has a negative impact on bereavement.[414] Studies have shown the opportunity to express emotion, communicate concerns or problems and remember the deceased in a supportive environment can encourage a healthy grieving process.[415] Perceived stigma can impact negatively on the grief process for a number of reasons; by preventing the bereaved from seeking help, reducing positive communication and memories about the deceased, and limiting engagement with rituals that assist the grief process.

It has been shown that interventions are significantly more helpful to the bereaved where they have proactively sought help.[416] However, if there is stigma surrounding the death, then the bereaved are less likely to seek help, even informally.[417] Also, a healthy grief process requires effective communication so the death can be "accepted, assimilated and accommodated".[418] Positive communication about the deceased and the circumstances surrounding their death results in positive outcomes in cases of complicated grief.[419] However, if there is stigma surrounding a death, it can impact negatively on communication in two ways. Firstly, by restricting opportunities for grief to be

[413] Frank R Campbell, 'Changing the legacy of suicide' (1997) 27 Suicide and Life-Threatening Behavior 329; TL Dorpat, 'Psychological effects of parental suicide on surviving children' [1972] Survivors of Suicide 121; Max Warren, 'Some psychological sequelae of parental suicide in surviving children' [1972] Survivors of Suicide 112
[414] Natalie C Hung and Laura A Rabin, 'Comprehending childhood bereavement by parental suicide: a critical review of research on outcomes, grief processes, and interventions' (2009) 33 Death Studies 781
[415] Stroebe, Schut and Stroebe, p 1966
[416] Ibid, p 1968
[417] Hung and Rabin; Maureen M Moore and Stephen J Freeman, 'Counseling survivors of suicide: Implications for group postvention' (1995) 20 Journal for Specialists in Group Work 40; Jessica R. Everett Provini, Cynthia R. Pfeffer, Celine, 'Adults mourning suicide: Self-reported concerns about bereavement, needs for assistance, and help-seeking behavior' (2000) 24 Death Studies 1
[418] Love, p 80
[419] Steven L Nickman, Phyllis R Silverman and Claude Normand, 'Children's construction of a deceased parent: The surviving parent's contribution' (1998) 68 American Journal of Orthopsychiatry 126

expressed;[420] and inhibiting communication within the bereaved family.[421] Secondly, stigma can prevent positive memories and result in the creation of negative perceptions about the deceased.[422] Studies suggest if the deceased is remembered positively, it can be beneficial to a healthy grief process.[423] Research indicates that where children have negative outcomes following bereavement, they were most likely to have had negative perceptions about the deceased.[424] In addition, if a family feels shame about the circumstances of the death, they may isolate themselves and avoid carrying out mourning rituals such as public funerals.[425] Rituals such as funerals or memorial services have been shown to have a positive effect on helping the bereaved come to terms with the death: this can include any hearings or meetings that bring to light the circumstances of a death.[426] However any such activities must allow the bereaved to remember the deceased in a positive way in order to be beneficial to a healthy grief process.[427] There are a number of factors that can be present following a death in custody which make complicated grief likely; including stigma, negative perceptions about the deceased, limited opportunities for positive remembrance and delays in finding out the truth about how death occurred.

One successful intervention for complicated grief is "meaning making", which involves the bereaved creating a narrative about what happened to the deceased which is coherent to them.[428] Research has

[420] Alice Sterner Demi and Carol Howell, 'Hiding and healing: Resolving the suicide of a parent or sibling' (1991) 5 Archives of Psychiatric Nursing 350; Karen Dunne-Maxim, Edward J Dunne and Marilyn J Hauser, 'When children are suicide survivors' [1987] Suicide and Its Aftermath, WW Norton, New York 234; Ann M Mitchell and others, 'Effective communication with bereaved child survivors of suicide' (2006) 19 Journal of Child and Adolescent Psychiatric Nursing 130

[421] Dowdney

[422] Hung and Rabin

[423] Campbell; Dorpat; Warren; Dennis Ed Klass, Phyllis R Silverman and Steven L Nickman, *Continuing bonds: New understandings of grief* (1st edn, Taylor & Francis 1996); Nickman, Silverman and Normand

[424] Phyllis R Silverman and others, 'The effects of negative legacies on the adjustment of parentally bereaved children and adolescents' (2003) 46 Journal of Death and Dying 335

[425] Snow and McHugh, p 142

[426] Stroebe, Schut and Stroebe; p 1966

[427] Nickman, Silverman and Normand

[428] Robert A Neimeyer, 'Reauthoring life narratives: Grief therapy as meaning reconstruction' (2001) 38 The Israel Journal of Psychiatry and Related Sciences 171; Crystal L Park and Susan Folkman, 'Meaning in the context of stress and coping' (1997) 1 Review of General Psychology 115; Marilyn Armour, 'Violent death: Understanding the context of traumatic and stigmatized grief' (2007) 14 Journal of Human Behavior in the Social Environment 53

indicated that re-telling the narrative of a death can be a beneficial part of treatment for complicated grief.[429] Identifying the facts surrounding a death promptly can help bereaved families to create a true narrative which explains the death to their satisfaction. This can be very difficult for bereaved families if they do not know the circumstances surrounding a death because it occurred in a closed institution. It is also why it is important for bereaved families to be given accurate information straight away, as access to the truth early on in the grief process is vital to ensuring the bereaved do not create a false narrative. Research has shown that changing the narrative later is confusing and tends to increase suspicion among bereaved families.[430] Snow and McHugh highlighted that the inquest is an important factor in providing the bereaved with the facts surrounding a death so they can begin to accept it.[431] This does mean, however, that if bereaved families do not know the truth about what happened until the inquest hearing, they will be unable to successfully re-tell the narrative of the death in a therapeutic environment at an earlier stage. In addition, if the inquest fails to assign culpability for any sudden or unexpected death, it can leave bereaved families feeling frustrated. It has been shown if the bereaved cannot hold someone responsible for a traumatic death, they find it more difficult to appropriately express anger and resolve their grief.[432] This is exacerbated by normal feelings of anger following any bereavement, which may be expressed towards officials or authority figures.[433]

4.3. Fair and Effective Participation

The theory supporting the right to participation states that for participation to be effective, it must allow an opportunity to be heard and influence the process.[434] Participation does not just require an

[429] Katherine Shear and others, 'Treatment of complicated grief: a randomized controlled trial' (2005) 293 The Journal of the American Medical Association 2601; Robert A Neimeyer and others, 'Grief therapy and the reconstruction of meaning: From principles to practice' (2010) 40 Journal of Contemporary Psychotherapy 73
[430] M. McHugh and L. Snow, 'Suicide prevention: policy and practice' [2002] Suicide in Prisons 1, p 148
[431] Snow and McHugh, p 148
[432] Armour, p 62
[433] Snow and McHugh, p 149
[434] M. FitzGerald and others, *Policing for London* (Willan, UK 2002)

opportunity to be heard but parties must be confident that their viewpoint was considered and incorporated into any final decision.[435] Processes that allow parties the opportunity to be heard before any decision-maker are perceived as fairer, even when the outcome is seen as negative.[436] Initial theories proposed parties perceived a process as more fair if they had the opportunity to be heard as they believed their voice would have an instrumental effect of achieving a better outcome.[437] However, it has now been argued there is an intrinsic value in parties being heard, as it ensures they feel valued regardless of whether their voice changes the outcome.[438] An empirical study illustrated there was procedural fairness value in parties being heard, even when the decision had been made but positive impacts are maximised when parties have an opportunity to influence the outcome of decisions.[439] In a process where there are important decisions made at different stages which all have an impact on the outcome, it is very important for perceptions of fairness for parties to have the opportunity to be heard at all the stages.[440]

Thibaut and Walker first put forward the model of procedural justice which argued people were not just concerned about the outcome of dispute resolution but equally invested in the process which resolved the dispute.[441] The importance of process was linked to the opportunity to influence the outcome; therefore suggesting the most relevant aspect as to whether a process was considered fair

[435] TRS Allan, 'Procedural Fairness and the Duty of Respect' (1998) 18 Oxford Journal of Legal Studies 497, p 500
[436] Stephen LaTour, 'Determinations of participant and observer satisfaction with adversary and inquisitorial modes of adjudication' (1978) 36 Journal of Personality and Social Psychology 1531; E Allan Lind and others, 'Procedure and outcome effects on reactions to adjudicated resolution of conflicts of interest' (1980) 39 Journal of Personality and Social Psychology 643; Jerald Greenberg and Robert Folger, *Procedural justice, participation, and the fair process effect in groups and organizations* (Springer 1983); Robert J Bies and Debra L Shapiro, 'Voice and justification: Their influence on procedural fairness judgments' (1988) 31 Academy of Management Journal 676
[437] J. Thibaut and L. Walker, 'A Theory of Procedure' (1978) 66 California Law Review 541; Gerald S Leventhal, 'What should be done with equity theory?' in M. S. Greenberg K. J. Gergen, & R. H. Willis (ed), *Social exchange: Advances in theory and research* (Springer 1980)
[438] Lind and Tyler; Robert E Lane, 'Procedural goods in a democracy: How one is treated versus what one gets' 2 Social Justice Research 177
[439] Lind and Tyler; E Allan Lind, Ruth Kanfer and P Christopher Earley, 'Voice, control, and procedural justice: Instrumental and noninstrumental concerns in fairness judgments' (1990) 59 Journal of Personality and Social Psychology 952
[440] Kenneth H Price and others, 'Judging the fairness of voice-based participation across multiple and interrelated stages of decision making' (2006) 99 Organizational Behavior and Human Decision Processes 212
[441] J. Thibaut and L. Walker, *Procedural justice: A psychological analysis* (L. Erlbaum Associates 1975)

was the participation of those affected. If people are allowed sufficient input in the process, and feel they have had a fair chance to influence the result, they perceive the process as fair. It is also argued that what criteria individuals might see as the most important to assess whether a process is fair are relational and therefore context-driven.[442] So an individual's perception about their standing within society, as well as the fact that people have inherently different points of reference, will alter how they judge whether a process is fair or just. This argues that criteria such as trust in the authorities, pre-conceived beliefs relating to status and perceived neutrality of the process influence whether a procedure is seen as fair.[443]

It is self-evident that in order to be of instrumental value, participation in a process must allow the participant to influence the outcome. It is argued that where participation is vital to a perception of justice, it is the opportunity to affect the outcome, not the outcome itself that is important.[444] Professor Adams has asserted that it is the participation offered by an adversarial system, with parties being able to bring evidence before the court, which "heightens the rationality and acceptability of the result".[445] So if participation is seen as effective in allowing the opportunity to influence the outcome, it will be perceived as fair. The effect that participation has on the perception of fairness is also evident in inquisitorial settings. In restorative justice processes which utilise inquisitorial procedures, there is usually a high perception among parties relating to the fairness of the process partly due to the participatory nature of the process.[446] Participation increases understanding and

[442] T. Tyler and others, 'Conflict with outsiders: Disputing within and across cultural boundaries' (1998) 24 Personality and Social Psychology Bulletin 137
[443] Tom Tyler, Peter Degoey and Heather Smith, 'Understanding why the justice of group procedures matters: A test of the psychological dynamics of the group-value model' (1996) 70 Journal of Personality and Social Psychology 913
[444] FitzGerald and others
[445] GW Adams, 'The small claims court and the adversary process: More problems of function and form' (1973) 51 Canadian Bar Review 583
[446] Joanna Shapland and others, *Restorative justice: the views of victims and offenders* (Ministry of Justice Research Series, 2007)

therefore acceptance of a decision; as well as the fact that allowing an individual to be heard increases the likelihood they feel ownership of the decision and therefore accept it.[447]

Thibault and Walker suggested people are more likely to perceive a decision-making process as fair if they have had the opportunity to participate fully.[448] They argued this is due to the instrumental value of being able to affect the outcome by being allowed to participate. However effective participation in a process does not solely have an instrumental benefit, there may be an intrinsic value in allowing the opportunity to influence the outcome, whatever the result. The perception from a subject must be that their participation was relevant and taken into account or fairness of procedure may be in doubt.[449] The opportunity to affect the outcome must be seen as real; even if the outcome is not altered, subjects must feel their viewpoint was considered. This can be done by acknowledging and recognising the validity of the subjects' input, even if it is then explained why it is not going to be followed.[450] Giving reasons allows a subject to feel valued and identify with the process, so even if they disagree, they are more likely to accept an adverse decision.[451] It is not clear how far full participation can counter negative perceptions about an outcome, but as long as subjects do not feel their input has been ignored, they will have positive perceptions about the process which is beneficial in of itself. However, the opportunity to participate must be in practice, not just principle.

4.4. Impact of Fair Process

Dworkin argues that achieving a fair outcome should be the priority of any process; if a biased process leads to a fair outcome, it does not injure anyone; so the law should be interpreted to maximise a

[447] Allan, p 499
[448] Thibaut and Walker, *Procedural justice: A psychological analysis*
[449] Allan, p 500
[450] Eva Brems and Laurens Lavrysen, 'Procedural Justice in Human Rights Adjudication: The European Court of Human Rights' (2013) 35 Human Rights Quarterly 176, p 181
[451] Allan, p 509

moral and fair outcome.[452] A judge or adjudicators' focus should be on seeking the fair outcome, although Dworkin recognises is it impossible for a judge to always come to the right decision.[453] This argument suggests that the most important consideration in constructing normative values of justice is maximising the opportunity of a just outcome. However, what is a fair and just outcome is difficult to assess, especially as different people may have different perspectives as to what is a fair or correct outcome. In addition, authorities can only guarantee that a justice system provides fair processes and rely on that to produce a just outcome.[454] It is impractical to expect a system in which unfair or incorrect decisions are not made; it is impossible to eliminate all errors, but justice sometimes puts the value of restricting miscarriages of justice above the truth.[455] So the procedures are there to protect the innocent and it is an accepted consequence of this that, on occasion, a guilty man may walk free. The moral duty imposed on a State is to ensure that an individual experiences a fair process, not a fair outcome.[456] So it would be wrong to focus on achieving a fair outcome, rather than a fair process.

Assuming there is a moral harm in unjust decisions, a fair procedure can balance the need of authorities to minimise this moral harm with the necessity of running a criminal justice system with limited resources.[457] This definition of justice supports the argument that justice can relate more to the process than the end result; fairness requires allowing for the potential of a just outcome to be achieved and a fair process is the best way of maximising that potential. If the process is what must be evaluated against a normative definition of justice, it is for society to construct this norm by establishing what might be considered fundamental aspects to a just process. These norms may be set out as legal standards such as the principle that no one is above the law or that justice is applied

[452] Ronald Dworkin, *Law's empire* (Harvard University Press 1986), p 165
[453] Ronald Dworkin, 'Judicial Discretion' (1963) 60 The Journal of Philosophy 624
[454] Allan, p 513-4
[455] Amalia D Kessler, 'Our inquisitorial tradition: Equity procedure, due process, and the search for an alternative to the adversarial' (2004) 90 Cornell Law Review 1181, p 1215
[456] Allan, p 513-4
[457] Ibid, p 515

impartially and predictably.[458] There may also be moral values that are fundamental to a society such as dignity of all humans, which would need to be incorporated within the standards.

An instrumental approach suggests society requires a justice system which produces correct outcomes, so the rules governing the system should all be aimed towards achieving the truth. Therefore, aspects of a system are only important in respect to how they influence the outcome. It would follow that ensuring a fair process would only be important if it had the effect of producing a fair outcome. Procedures that maximise opportunities for a fair outcome therefore provide an instrumental benefit.

This argument does not necessarily allow for an intrinsic value of justice beyond the minimising of conflict and discord through ensuring confidence that a fair outcome will be reached to settle a dispute. Fuller takes a different view that the trust and confidence that the public has in the authorities are damaged if the process is seen to be biased, even if the outcome is correct.[459] This follows Kant's belief that to act in a moral way has value regardless of the outcome.[460] This approach is intrinsic in that there is value in a fair process independent of any impact it has on producing an accurate result. In respect to justice, Lerner diverged from the majority of academic writing by expressing the view that there was an intrinsic value to justice.[461] This is particularly relevant if the actions of State authorities are being scrutinised. Kessler described due process as important not just because procedural rules have the benefit of providing a mechanism for ensuring the truth but because compliance with certain principles also ensures the State does not use its power arbitrarily.[462] This

[458] See M.L. Principe, 'Albert Venn Dicey and the Principles of the Rule of Law: Is Justice Blind-A Comparative Analysis of the United States and Great Britain' (1999) 22 Loyola of Los Angeles International and Comparative Law Review 357
[459] Fuller
[460] Immanuel Kant and Mary J Gregor, *Kant: the metaphysics of morals* (Cambridge University Press 1996)
[461] Melvin J Lerner, 'The justice motive in human relations and the economic model of man: A radical analysis of facts and fictions' [1982] Cooperation and helping behavior: Theories and research 249
[462] Kessler, p 1213-4

theory provides support for an intrinsic value in fair processes above and beyond whether they maximise the production of fair outcomes.

In summary, incorporating both the distributive and procedural theories of justice, a fair process can be argued to have both instrumental and intrinsic value. The instrumental value of a fair process relates to the effect on the outcome; so aspects of the quality of decision- making and the treatment of parties can influence whether a fair outcome is achieved. A fair process can also have intrinsic value, distinct from the impact on the outcome but often linked to the morality of fair treatment for all. So this chapter will consider both instrumental and intrinsic impacts of fair processes.

4.4.1. Instrumental value: Fair process produces fair outcome

It may be argued that fair process has instrumental value because such a process produces fair outcomes.[463] Following fair procedures can minimise the dangers of coming to incorrect decisions, therefore maximising the opportunity of the outcome being correct.[464] Allan argued that the fairness of procedures were important primarily in justifying the accuracy and therefore validity of outcomes.[465] However, there can be a difficulty in objectively judging the fairness or correctness of the outcome as perceptions of fairness of outcome may differ among participants. Judgements concerning factual evidence may be easily assessed as truthful but many legal situations involve comparison to established standards or norms and are therefore more abstract.[466] It can be argued that the question as to whether a decision is correct or incorrect may be "too ambiguous to be

[463] Jon O Newman, 'Rethinking fairness: Perspectives on the litigation process' (1985) 94 The Yale Law Journal 1643, p 1647; R.J. MacCoun, 'Voice, control, and belonging: The double-edged sword of procedural fairness' (2005) 1 Annual Review of Law and Social Science 171
[464] Newman, p 1648
[465] Allan, p 497
[466] M Damaška, 'Presentation of evidence and factfinding precision' (1975) 123 University of Pennsylvania Law Review 1083, p 1085-6

meaningful".[467] It is therefore important that regardless of the actual impact on outcome, participating in a fair process positively correlates to the perception that a fair outcome will be achieved.[468] Fuller has pointed out that if "the function of law is to create an orderly interaction among citizens" then the perception of how outcome is best achieved will be fundamentally important.[469] So fair procedures offer the highest opportunity for a fair outcome, which will then have a positive impact on the belief in the fairness in the system.

4.4.2. Intrinsic value: Fair process linked to legitimacy

The intrinsic value of fair processes has been grounded in varied theories including social contract theory, natural justice and maintenance of the inherent dignity of individuals.[470] The importance of fair processes when State authorities are making decisions impacting on individuals is also linked to the legitimacy of the State. Societies require a mechanism of social control by the State to prevent and punish those who do not comply with social norms set out in law. Legitimacy can be defined as the perception by people that "an authority is entitled to be deferred to and obeyed".[471] The legitimacy of State actions therefore depends on a perception that they are fair and just. Social contract theory suggests the public will only co-operate with the criminal justice system if it is believed to be performing justly.

Beetham suggested the legitimacy of an authority which exerts powers over others comes not just from people's consent to the use of that power but also from perceptions about the authority's conformity to rules and whether those rules are justifiable in terms of societal shared beliefs.[472] He

[467] Ibid
[468] Greenberg and Folger
[469] Fuller, p 229
[470] Richardson, p 28-30
[471] J. Sunshine and T.R. Tyler, 'The role of procedural justice and legitimacy in shaping public support for policing' (2003) 37 Law & Society Review 513
[472] D. Beetham, *The legitimation of power* (Humanities Press Intl 1991)

therefore proposed there was a moral component to establishing legitimacy.[473] This has been described as empirical, as opposed to normative, legitimacy.[474] This can relate to both whether individuals perceive an authority as legitimately empowered to restrict their rights as well as whether that authority perceives itself to have a legitimate entitlement to do so. This thesis will focus on society's perception of the legitimacy of the State's authority to restrict individual rights by restraining or detaining individuals as part of a criminal justice system. The moral component to establishing legitimacy was identified in relation to policing by the research completed by Jackson et al, which concluded that people's consent to being policed was linked to whether they believed the police operated within an ethical framework similar to their own.[475] Further research suggested that both the moral alignment of police and the perception of whether they are acting legally affect perceptions of legitimacy.[476] This is particularly relevant to the inquest system which scrutinises the actions of police and prison against a legal framework.

The legitimacy of the actions of State authorities is particularly pertinent in relation to exercising control over an individual by police or the prison service as increased perceptions of a process being legitimate has been shown to correlate with an individual complying with the process.[477] Tyler's research has shown that positive perceptions about the fairness of a court process correlate with perceptions about the legitimacy of authorities, and subsequently increased likelihood of compliance to the outcome.[478] In contrast, Sunshine and Taylor showed that positive perceptions about the effectiveness of a process did not necessarily produce a corresponding correlation with compliance.[479] It is therefore important to understand what aspects of a process are likely to increase perceptions of

[473] J.R. Sparks and AE Bottoms, 'Legitimacy and order in prisons' (1995) 46 The British journal of sociology, p 48
[474] Mike Hough, Jonathan Jackson and Ben Bradford, 'Legitimacy, trust and compliance: an empirical test of procedural justice theory using the European social survey' in Alison Liebling and Justice Tankebe (eds), *Legitimacy and Criminal Justice: An International Exploration* (Yale University Press 2013), p 5
[475] Jonathan Jackson and others, 'Why do people comply with the law? Legitimacy and the influence of legal institutions' (2012) 52 British Journal of Criminology 1051, p 1052
[476] Hough, Jackson and Bradford, p 13-5
[477] Tyler (1990); Jackson and others; R. Paternoster and others, 'Do fair procedures matter? The effect of procedural justice on spouse assault' Law and Society Review 163
[478] Tyler (1990)
[479] Sunshine and Tyler

whether the process is fair, rather than whether it is effectiveness. This will be looked at in the next section.

4.5. Perceptions of Fair Process

Traditionally distributive justice models have described how people perceive whether outcomes are fair or not.[480] Some distributive theorists are now going beyond the traditional analysis of how resources are distributed to consider whether there are imbalances in the processes that control distribution.[481] This can be used to identify possible reasons for oppression or disadvantage within a group. This is why fairness in procedures is important, even if it does not change the outcome, it allows for the potential of fair distribution of resources. The same argument can be made in terms of shared values such as justice: fair processes which govern how concepts are translated into real life situations will allow for the concepts to be applied to all fairly. Procedural justice theory as set out by Tyler argues that people do not necessarily consider the outcome when perceiving fairness but evaluate the process.[482]

Transparent and accessible fair processes can be used to counter perceptions of unfairness which can exist in marginalised or disadvantaged groups.[483] It is particularly important that fair processes are in place in relation to the criminal justice system as perceptions of injustice are present especially in disadvantaged and minority groups in terms of interactions with law officials.[484]

[480] Russell Cropanzano and Maureen L Ambrose, 'Procedural and distributive justice are more similar than you think: A monistic perspective and a research agenda' (2001) 119 Advances in Organizational Justice 151, p 119
[481] Young, p 8
[482] T.R. Tyler, 'Procedural justice, legitimacy, and the effective rule of law' (2003) 30 Crime & Justice 283
[483] Buckler and others, p 370
[484] Ibid

Aspects of both outcome and process have been argued to interact to influence perceptions of fairness.[485] Perceptions of how fair the outcome is will influence how fair people consider the process to have been and conversely, perceptions about how fair the process was will influence how fair people consider the outcome.[486] Therefore the theories of equity, distributive and procedural justice can be combined to consider how perceptions of both the outcome and process will influence the perceptions of fairness.

What is perceived as fair is a subjective concept that can depend on many factors. In terms of resolving a dispute, the perception of whether the outcome is fair or not may correlate closely to whether participants receive a favourable or expected result as described by the relative deprivation theory.[487] Therefore the person who receives the most favourable outcome may perceive the outcome as fair whereas the converse will be true for the person who receives an unfavourable outcome. Trust that the process was fair (including a fair and objective arbiter or decision-maker) can lead to a belief that the outcome was fair even if not favourable (see below).

Cropanzano and Ambrose argue that both perceptions of how fair the outcome and the process are can be influenced by pre-existing expectations.[488] A study by Van den Bos et al indicated that how a process was initially framed was important in determining whether people judged fairness through the outcome or the process.[489] If the fairness of the outcome was the information an individual received first, then the outcome was likely to become the most important criteria used to judge fairness and vice-versa. This suggests that expectation is an important aspect in perceived fairness: information about a process will be used to evaluate that process so if individuals have prior

[485] Joel Brockner and Batia M Wiesenfeld, 'An integrative framework for explaining reactions to decisions: interactive effects of outcomes and procedures' (1996) 120 Psychological bulletin 189
[486] E Allan Lind and Robin I Lissak, 'Apparent impropriety and procedural fairness judgments' (1985) 21 Journal of Experimental Social Psychology 19; Kees Van den Bos, Riel Vermunt and Henk AM Wilke, 'Procedural and distributive justice: What is fair depends more on what comes first than on what comes next' (1997) 72 Journal of Personality and Social Psychology 95
[487] F Crosby, 'Model of Egotistical Relative Deprivation' (1976) 83 Psychological Review 85
[488] Cropanzano and Ambrose, p 120
[489] Van den Bos, Vermunt and Wilke

expectations, this might impact on perceived fairness. This is an important point in relation to inquests as the process is not widely understood outside of those who have personal experience of the system. It is therefore likely that established beliefs about the way courts and the justice system works in general, impact on the expectation of how an inquest should proceed.[490]

Objective criteria used to assess fairness were first proposed by Levanthal who suggested that the most important aspects were consistency, accuracy, and freedom from bias, opportunity to correct unfair decisions, compliance with moral or ethical norms and the representativeness offered to all participants.[491] These were summarised as intrinsic (as opposed to instrumental) aspects broadly established under three areas: trustworthiness of the decision-maker, neutrality of the decision-maker and how the perceptions about the process affect beliefs about participants standing.[492] Tyler and Blader put forward a model which explained how people evaluate the fairness of a process; addressing the importance of aspects which are believed to influence the outcome and those that counter different initial viewpoints.[493] Firstly, the perceived quality of the decision is decided by the neutrality of the decision-maker, how transparent the process was in coming to the decision and the potential for participation by the subject.[494] This was first identified by Leventhal who stated the importance of objective criteria to judge the quality and fairness of the decision-making.[495] Secondly, the subject's perception of the treatment they received will also affect their perception of how fair the process is.[496] Criteria such as whether an individual is treated with respect and dignity through the

[490] This will be raised later in this thesis in relation to families being provided with sufficient information about the process.
[491] Leventhal
[492] Larry Heuer and others, 'The role of resource and relational concerns for procedural justice' (2002) 28 Personality and Social Psychology Bulletin 1468, p 1469
[493] Steven L Blader and Tom R Tyler, 'A four-component model of procedural justice: Defining the meaning of a "fair" process' (2003) 29 Personality and Social Psychology Bulletin 747; T.R. Tyler and S.L. Blader, *Cooperation in groups: Procedural justice, social identity, and behavioral engagement* (Hogrefe & Huber 2000)
[494] Tyler and Blader
[495] Leventhal
[496] Tyler and Blader

process would be included and argued to influence individual's perceptions about their standing within society.

Tyler and Blader further separated each component into the general and the specific: with the general represented by the rules governing a process (the formal) and the specific represented by the specific process the individual is party to (the informal).[497] The four components are therefore described as the rules governing how decisions are made through the process, the rules governing how parties are treated, how the decision was made in a specific instance and how the parties were treated in that instance.[498] This model is useful for two reasons, firstly it combines the theories which argue the predominant reasons behind procedural justice are either that perceptions of fair processes influence perceptions of outcome (such as Thibault and Walker) or to counter relational issues such as perceptions about standing.[499] The importance of this was argued by Heuer et al, when they suggested the two theories were not mutually exclusive but that people used aspects such as trust and neutrality of the process to evaluate not just relational concerns but also the fairness of outcomes.[500]

Secondly, the four component theory recognised two criteria which other literature did not: namely the aspect of formal rules dictating quality of treatment and the influence of informal aspects (such as how individual officials translate rules in practice) on decision-making.[501] The initial studies carried out indicate that this four component theory consistently covers how people evaluate fair processes and therefore perceptions of procedural justice.[502] This allows for Fuller's assertion that in applying laws or rules to govern interactions or behaviour, the systematic structure must be respected and the social context appreciated.[503]

[497] Blader and Tyler
[498] Ibid
[499] Ibid, p 756
[500] Heuer and others, p 1470
[501] Blader and Tyler, p 756
[502] Ibid
[503] Fuller, p 229

4.6. Procedural justice in the inquest system

This section will consider how the procedural justice theory introduced above relates to the inquest system, specifically complex inquests which are looking at deaths in custody. This thesis is using the perceptions of those who have participated in such complex inquests, so it is very important to understand how those perceptions might impact on the perceived legitimacy of the system. If State failings contributed to a death, the outcome of the inquest can be important in both holding the State to account for its actions in detaining individuals and ensuring lessons are learned so future deaths can be prevented, so the legitimacy of the system is vital. This will be considered further in Chapter 6.

4.6.1. Intrinsic value of ensuring legitimacy at complex inquests

An inquest is often the primary way State actions in restraining or detaining individuals are scrutinised and therefore linked to ensuring accountability, so the legitimacy of the system is very important. This thesis is focused on the fairness of the process, and as discussed previously, a fair process can be argued to optimise the potential that a fair outcome is reached as well as impact on perceptions of legitimacy on the process itself. The legitimacy of inquests considering deaths in custody is important in two ways. Firstly, the legitimacy of the inquest system itself as a process which adjudicates whether human rights obligations are being fulfilled. Secondly, the inquest system holds the authorities to account and can provide public scrutiny of the actions of authorities.

The first aspect involves whether the inquest system itself is seen as a legitimate process. When considering deaths in custody, the inquest acts as a body adjudicating whether human rights are being respected; it is of central importance that people affected by any decisions perceive the solutions as

just and fair.[504] In reference to procedural requirements, a body performing an adjudication function must act fairly by ensuring a fair hearing (which includes right for parties to access the evidence and be heard) and unbiased decision-making.[505] In fact, some would argue that it is important that bodies that are adjudicating human rights violations should include procedural fairness as a fundamental aspect of the process simply because they are set up to protect human rights and must apply fair principles themselves.[506] Fair treatment from a human rights adjudicating body can also have a large impact on the psychological recovery of an individual who has suffered a human rights violation.[507] Section 4.2 set out the impact an inquest can have on a grieving family, and where inquests are discharging Article 2 duties to investigate a death, the lack of procedural fairness during the inquest could be considered to constitute a harm. Systemic concerns might be taken into account when the ECtHR is assessing whether a violation has occurred.[508] Research has argued that procedural justice at the ECtHR is important in part due to the authority that an ECtHR judgement has beyond the case under consideration.[509] This could also be argued to be true in relation to inquests, where one of the stated purposes is to set out any reforms needed to ensure future deaths are avoided. The legitimacy of the inquest system can therefore have a wider impact on systems and institutions in the justice system.

Second, an Article 2 inquest provides scrutiny of the authorities and therefore has a direct impact on the public understanding and trust in the police and prison systems. The public's feeling of security relies on the belief that they are protected by authorities who will treat them with consideration.[510] This is why it is so vital that authorities' actions are held to account; so people can trust those in power. The criminal justice system is based on consent; as Cooper says, "The criminal justice system works

[504] Brems and Lavrysen, p 182
[505] Richardson, p 18-9
[506] Brems and Lavrysen, p 184-5
[507] Tom R Tyler, 'Procedural justice and the courts' (2007) 44 Court Review 26; Brems and Lavrysen
[508] Brems and Lavrysen, p 185
[509] Ibid, p 186
[510] Tyler, *Why people obey the law: Procedural justice, legitimacy, and compliance*

because it is understood and respected by the people it serves".[511] Police officers enforce laws and protect the public but they are also the authority directly responsible for social control.[512] Perceptions about police legitimacy can impact on wider compliance with the law and justice system.[513] Prison officers represent the same authority within a prison society. The role of the criminal justice system is to protect the public but in order to fulfil this role; law officers are empowered to restrict the rights of some individuals (for example arresting and detaining).[514]

The rule of law requires public agencies to act "within the law" when using powers delegated by Parliament.[515] This requires police and prison officers to act fairly and consistently towards all individuals in carrying out their duties.[516] If their actions are perceived as illegitimate, their authority may be challenged and individuals are less likely to comply and co-operate with criminal justice authorities. This was illustrated in the study by Tyler and Sunshine which also showed that, as individuals' perception of police legitimacy increases, their willingness to empower officers with wider discretion also increases.[517]

The criminal justice system relies on public support, controlling behaviour through compliance to law is far more effective than requiring a permanent physical presence of authoritative officials to ensure good behaviour.[518] This is as true within a prison as in wider society as, if order is maintained through compliance, prisoners do not have to be locked in cells twenty-four hours a day but can freely associate, work and attend education programmes. Tyler's research has illustrated procedural fairness contributes to increased perceptions of legitimacy but another contributing factor is trust. Good

[511] J QC Cooper, 'Ensuring That Justice is Understood' (2011) Criminal Law and Justice Weekly 1
[512] S.E. Wolfe and A.R. Piquero, 'Organizational Justice and Police Misconduct' (2011) 38 Criminal Justice and Behavior 332, p 332
[513] Jackson and others, p 1062
[514] D.P.J. Walsh and V. Conway, 'Police governance and accountability: overview of current issues' [2011] Crime, Law and Social Change 1, p 70
[515] Richardson, p 17
[516] Walsh and Conway, p 71
[517] Sunshine and Tyler
[518] For example, the expectation is that the public do not break the law even if there are no police officers present.

governance and accountability of law officials can impact on public trust by maintaining democratic values and protecting human rights.[519] Trust relies not just on an expectation that those in the criminal justice system will act in a fair manner; it requires transparency and acknowledgement if mistakes or failures do occur.

The comprehensive work begun by Tyler on the impact of improving the legitimacy of the police force and the criminal justice system in general is arguably straightforward. The role of the police within society requires empowerment to infringe the rights of any citizen suspected of breaking the law and therefore perceptions of legitimacy are important. Police legitimacy comes from both an acceptance of the obligation to obey authority and a perception that the power given to authority is justified.[520] Cooperation and compliance with the police has been shown to be affected by the perceived risk of sanction, the obligation to obey, perceived moral alignment of the police and the lawfulness of police actions.[521]

However, the prison service involves only a minority of the public: those who have either been found guilty of a crime or who a judge has determined should be detained on remand. Within the autocratic closed system of a prison, the necessity of democratic values of legitimacy are more questionable. Although democratic systems fundamentally need legitimacy to continue, autocratic systems may find it easier to bypass legitimacy. Prisons are, by definition, autocratic systems where power is exerted in order to detain and control prisoners who are generally held against their will.[522] It has, however, been argued that the prison disturbances in the 1980s and early 1990s were related to a problem with legitimisation.[523] It may seem contrary to talk about the legitimacy of an autocratic prison system which detains people: however it is detrimental for order and security to be maintained in a prison using force and coercion alone. Controlling and maintaining safety among an unwilling population

[519] Walsh and Conway, p 63
[520] Jackson and others, p 1054
[521] Hough, Jackson and Bradford
[522] Sparks and Bottoms, p 49
[523] M. Cavadino and J. Dignan, *The Penal System; an Introduction* (Sage 1992)

without using force and coercion alone is an ongoing problem in the penal system.[524] There are not enough prison officers to have complete control over all the prisoners all the time.[525] This was recognised in the Prison Rules published in 1964, with rule 2(2) stating that prison officers should seek the "willing co-operation" of prisoners.[526] Scraton argues that prison is an expression of imposed authority that is not legitimate; with order being achieved purely through coercion and force.[527] However, there is little evidence to suggest that order is only achieved through use of coercion and force; other aspects of prison life can influence order.[528] Sykes suggested that it was precisely because authority in a prison was imposed without the consent of the prisoner that officers had to find a way of legitimising their authority in order to achieve co-operation and compliance.[529] Legitimacy is not an all or nothing concept; Beetham argues that it is created partly by comparison against social norms so there can be gradations along a scale from legitimate to illegitimate authority.[530]

It is clear that compliance with authority is a very important concept in prisons. Prison officers can gain some form of legitimacy in the eyes of the prisoners if they are treated fairly, and administrative decisions are not perceived as arbitrary. Sparks and Bottoms' research indicates Tyler's procedural justice theory translates into the prison service.[531] They showed harsh regimes could be countered by officers treating prisoners fairly and with respect, while more relaxed regimes might have little prisoner perception of legitimacy if decisions were seen as arbitrary and general security in the prison meant prisoners felt unsafe.

Giddens argues that legitimacy relies on "standards external" to the authority wanting to claim the legitimacy.[532] Following on from this, Beetham's use of shared societal beliefs to justify legitimacy

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[524] R.D. King, 'Control in prisons' in J. Vagg M. Maguire, and R. Morgan. (ed), *Accountability and Prisons* (London: Tavistock 1985), p 187
[525] Sparks and Bottoms, p 50
[526] UK Government, *Prison Rules 1964* (1964)
[527] P. Scraton, J. Sim and P. Skidmore, *Prisons under protest* (Open University Press 1991), p 63
[528] Sparks and Bottoms, p 51
[529] G.M. Sykes, *The society of captives* (Princeton University Press New Jersey Princeton 1958)
[530] Beetham
[531] Sparks and Bottoms
[532] A. Giddens, *Studies in social and political theory* (Basic Books 1977)

suggests that the legitimacy of the criminal justice system in general (as the process that put a prisoner in detention) can influence compliance and acceptance of prison officer's authority.[533] It has been shown that perceptions of treatment by State agencies does not just affect the understood legitimacy of that agency by the individual receiving the treatment but also by others watching.[534] This could be extrapolated to suggest that the perceived fairness of the inquest system (as the main investigation into deaths in custody that is open to public scrutiny) can also impact on prisoner perceptions of the legitimacy of prison authority. If there is a fair system in place that can be trusted to hold prison officers accountable, this will impact positively on legitimacy of prison officers in general. When deaths occur in prison, there will often be uncertainty among the prisoners as to the details of what happened: this should be dealt with by transparently investigating all the circumstances so questions can be answered. As Tyler has shown, it is not just about whether an outcome holds authority to account but whether the process is procedurally fair. Ensuring the dignity of the deceased is maintained as much as possible will impact on prisoner perceptions, and any investigation that disrespects either the deceased or their family will likely be perceived as procedurally unfair.

4.6.2. Achieving a fair outcome at a complex inquest

Decision-making processes are often classified as either adversarial or inquisitorial, although in reality many legal procedures are an amalgamation of the two. Kessler summarises the differences between adversarial and inquisitorial models as whether the court or parties were in control of initiating the process, gathering the evidence and setting the remit and nature of the proceedings.[535] In adversarial models, parties are seen as responsible for these aspects: with opposing sides gathering the evidence

[533] Sparks and Bottoms, p 59
[534] David M Bierie, 'Procedural justice and prison violence: Examining complaints among federal inmates (2000–2007)' (2013) 19 Psychology, Public Policy, and Law 15
[535] Kessler, p 1187

for lawyers to then take decisions on how to present and scrutinise the evidence; with the decision-maker acting in a neutral role distinct in many ways from the process.[536] Conversely, in inquisitorial procedures, the decision-maker is responsible for initiating the process, gathering and presenting the evidence.[537] The inquest system is described as inquisitorial but when complex inquests occur, the process often takes on many adversarial aspects, including having a jury and legal representatives cross-examining witnesses and the evidence.

Adversarial settings are defined as contested procedures with the adjudicator generally having no prior information of the case and taking a passive role, and with two opposing parties.[538] One party is the prosecutor who instigates the proceedings as well as provides the evidence to argue the guilt of the other, defending party: the two parties govern the presentation of the evidence.[539] An adversarial procedure is framed by rules which govern the process including what evidence is allowed to be presented and what questions can be asked of witnesses.[540] In adversarial processes, the decision-maker is unable to question any aspect of the facts unless it is brought up by either of the parties before them; their role is to provide an unbiased arbitration throughout the process. As witnesses only answer questions either side want asked, some evidence may not enter the record and the opportunity for the decision-maker to make a true judgement may be hindered.[541] If there is a jury present, then it is vested with the responsibility of determining the outcome. This is the case with complex inquests, with the law requiring juries for any death in custody.[542]

Non-adversarial procedures prioritise the process above the outcome, with the aim of repairing relationships and communities by privileging the position and the voice of the victim.[543] In an

[536] Gerard E Lynch, 'Our administrative system of criminal justice' (1997) 66 Fordham Law Review 2117
[537] Kessler
[538] Warwick Inquest Group, 'The Inquest as a Theatre for Police Tragedy: The Davey Case' (1985) 12 Journal of Law and Society 35, p 45
[539] Ibid
[540] Ibid
[541] Damaška, p 1093
[542] Coroners and Justice Act 2009, Section 7
[543] R Jamieson and K McEvoy, *Conflict, suffering and the promise of human rights* (Willan Publishing 2007)

inquisitorial setting there are officially no opposing parties and the process is governed by the decision-maker who initiates proceedings, summons witnesses and governs the evidence presented. The procedure is directed by discretionary rules allowing flexibility to ensure the truth is established.[544] The decision-maker in an inquisitorial procedure is responsible for deciding what evidence is brought before the proceedings and therefore must have prior information about all aspects of the case before them.[545] This active role of the decision-maker which necessitates prior knowledge means they will have preconceived ideas about the case which may influence the way they use their discretion to govern the process, including what evidence is relevant.[546] Also the decision-maker may be more receptive to information that confirms their preconceived hypothesis and the outcome may be influenced by confirmation bias.

An inquest is officially an inquisitorial function and certainly the coroner is responsible for initiating the procedure and requesting the collection of evidence. The coroner decides what evidence will be presented but all parties are allowed to make detailed representations as to what evidence and which witnesses should be involved in an inquest. In practice, the evidence is actually gathered by the parties following a death in custody, with the investigatory body[547] report being the central information presented before the court. In addition, the remit of complex inquests are restricted by the law which provides limitations on the evidence that can be presented, similar to adversarial processes. In an inquest, the coroner is responsible for both deciding what evidence is presented[548] and also for questioning the witnesses, as is expected of an inquisitorial process. However, in complex inquests, many coroners will leave the questioning to the different parties (or more commonly, their legal representatives). This means the process becomes adversarial with contested parties presenting

[544] Warwick Inquest Group, p 46
[545] Damaška, p 1088-9
[546] Ibid, p 1092
[547] This is mostly the IPCC and PPO.
[548] *Mack, R (on the application of) v Coroner for Birmingham and Solihull & Ors* [2011] EWCA Civ 712

different narratives. It has therefore been argued that coroners must be held to the same standard of bias as that set out for criminal procedures.[549]

Millar argues that adversarial systems are preferable in achieving fair outcomes as the contentious nature of the process, with the different parties striving to prove the other side wrong, is seen as ensuring the evidence is tested and the truth ascertained.[550] Fuller suggested that presenting the evidence through an adversarial model appeared to be "the only effective means" of compensating for the tendency of human beings to judge in line with their own preconceptions.[551] During an adversarial process, the opposing parties question the evidence provided by the other side; the scrutiny of the evidence is seen as a vital part of reaching a correct outcome.[552] Two experiments by Thibaut et al found that evidence presented via the adversarial mode created fairer outcomes, as biased decision-makers or those with preconceptions about the case were more likely to resist bias in deciding the outcome.[553] Although the independence of an arbiter is often a requirement of a fair system, it is difficult to ensure any decision-maker does not have pre-conceived ideas so the contestation of evidence allowed in an adversarial setting can be an important element of ensuring fairness.

The coroner does begin the inquest procedure with a firm understanding of the evidence to be presented (as they will have seen all documents, including witness statements), which does allow for preconceived ideas, if not the pre-existence of bias. It can therefore be argued that the adversarial presentation of the evidence is important in restricting the impact of this prior knowledge on the behalf of the arbitrator. Although inquest procedures are classified as inquisitorial and interested parties are not designated into opposing sides; in practice the process following a death in custody is

[549] Cooper, page 14
[550] Robert W Millar, 'Formative Principles of Civil Procedure' (1923) 18 Illinois Law Review 1
[551] Lon L Fuller, 'The Adversary System: Talks on American Law' Revised cd (HJ Berman Ed), Vintage, New York (1961, 1971)
[552] Damaška, p 1094-5
[553] John Thibaut, Laurens Walker and E Allan Lind, 'Adversary presentation and bias in legal decisionmaking' (1972) 86 Harvard Law Review 386

adversarial in nature with contestation of the evidence and witness statements. The importance of ensuring the different parties have the opportunity to scrutinise the evidence as in an adversarial model is fundamentally important in ensuring a fair outcome and will be discussed further in both Chapters 6 and 8. All parties are empowered to involve themselves in the process of a complex inquest by suggesting evidence to be presented and directing the questioning of witnesses. Ensuring the effective participation of parties is therefore fundamentally important in ensuring the process is fair.

4.7. Conclusion

The inquest is a process to identify facts; it could be argued that it is completely outcome driven in a way that other legal processes are not. This was an argument used by the Government during the debate on the Counter Terrorism Bill in the autumn of 2009 where provisions to hold secret inquests were put forward.[554] Jack Straw pointed out that where there was a legal requirement to hold an inquest (such as following a death in custody where no charges had been brought) it differed from criminal or civil cases that could be suspended or thrown out if procedural fairness was impossible.[555] The argument was that there may be legal necessity to the process continuing, even if full participation for families was not possible. However, this did not take account of the fact the necessity for an inquest to continue is to discharge Article 2 obligations; and without ensuring a fair process, the State's obligations would not be discharged.

The purpose of an inquest is to find the facts surrounding a death. So if the outcome drives the process, it is questionable whether there can be an intrinsic value in an inquest independent of the verdict.

[554] The issue of using intercept evidence that national security necessitates be kept out of the public domain at an inquest became an issue in the Azelle Rodney case. Schedule 5 of the Coroners and Justice Act allowed the withholding of evidence under public interest immunity (PII) but the issue remains a challenge in relation to ensuring fair and open inquests: see *Secretary of State for the Home Department v HM Senior Coroner for Surrey & Ors* [2016] EWHC 3001 (Admin)

[555] *Hansard House of Commons Debate*, 26 January 2009, column 29 available at http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090126/debtext/90126-0005.htm

However, in respect to Article 2 inquests there are certainly moral and legal norms that must be adhered to in order to ensure procedural justice. The bereaved family have rights that must be respected, as do other interested parties and the legal process must comply with certain standards. Also there is a democratic importance of holding State actors to account which is why Article 2 inquests are so important. The validity of State actions contributes to their legitimacy when using powers bestowed by the Government to restrict individuals through restraint or detention. Beyond this, the social acceptance of State actions is both morally and practically vital to the role of State actors, especially those in the criminal justice system, which relies on public trust to function effectively.

Article 2 inquests are not always wholly inquisitorial; where there is the possibility of liability in a death, there is consequently going to be a certain adversarial element evident during the process. State officers may well be suspected of wrongdoing either by acting to cause the death or by failing to prevent it. A bereaved family may want the opportunity to accuse and conversely an officer will want the chance to defend their actions. The law is very clear that the inquest is not the place for finding liability but at the same time, a stated aim is to identify failure of systems. This creates a potential conflict for the coroner, where procedural justice guides the action.[556]

So procedural fairness requires effective participation of families in order to comply with societal norms, maintain legitimacy and ensure compliance of the public. It could be argued that these principles have both instrumental and intrinsic value. Effective participation can have the instrumental value of maximising the likelihood of a fair outcome; ensuring a fair process can have an intrinsic effect of increasing legitimacy. Critics might argue that there should be a requirement on authorities to ensure fair procedures regardless of whether this reinforces legitimacy or obtains compliance.

[556] This possible contradiction will be discussed in Chapters 6 and 8.

In relation to this thesis, the theoretical framework of procedural justice sets out four important aspects relating to perceptions about family participation which can influence whether participants feel the process is fair. The first aspect reinforces the importance of perceptions about the law relevant to inquests and illustrates that ensuring families have sufficient information about the system is important in managing expectations, which influences perceptions about the process. Secondly, perceptions about the rules governing participation of families are also relevant; specifically whether they are sufficient to allow fair participation, which includes the opportunity to influence the outcome. Thirdly, perceptions about how the decision-making process is conducted are important. Lastly, perceptions about how fairly families feel they are treated during the process will be relevant.

Chapter 5: EFFECTIVE PARTICIPATION PROTECTING THE LEGITIMATE INTERESTS OF BEREAVED FAMILIES: EMPIRICAL EVIDENCE

5.1. Introduction

This is the first of three empirical chapters which examine the perceptions of participants interviewed to consider why participation of families is important in the inquest system following a death in custody and how it can be effectively ensured. This chapter focuses on how family participation can benefit families themselves. The reasons given are structured around the right to participate as set out in Chapter 4 and what are considered legitimate interests for families under Article 2 case law as set out in Chapter 3.

Section 5.2 considers the right to participate; including whether families have a representative role during an inquest process and if they do, who they consider they are representing and the requirement of the opportunity to influence the process. Section 5.3 looks at the legal protections which allow families to participate "to protect their legitimate interests". Participants mentioned a number of benefits to families participating, from civil cases to receiving redress via an apology. Also looked at is the impact participation can have on families' bereavement process.

5.2. Right to participate

Families should have the opportunity to participate in the inquest system as victims who have a right to be involved in the process which is determining what happened to their loved ones. All participants agreed families had a right to be heard and participate in the process as those most affected by the

death, and because the outcome of the inquest was likely to impact significantly on them. Two participants (FA2 and FA5) felt very let down that the system did not appear to address their role as victims. FA5 said there was no space for raising the impact of the death and the process on themselves and the rest of the family. FA2 thought they and their family were unacknowledged as victims. CO2 said "an inquest is a judicial system but also a service for the bereaved". CO4 thought it was true that in some ways the inquest was done for the family. These views argue for participation of families as victims in their own right to be a priority.

The impact of an inquest on families was raised by participants as particularly relevant in relation to deaths in custody as these deaths were argued to inherently involve practical difficulties in terms of accessing information which would normally be available to a family following a sudden death. Aspects specific to deaths in custody raised by participants were firstly that families were usually not present when a death occurred, so were unlikely to know what happened. Secondly it was pointed out that families often had little direct contact with the deceased prior to the death, so did not have an understanding of the context leading up to a death. Thirdly a lack of knowledge about the situation in custody left families not appreciating matters directly related to a death. Fourthly it was pointed out that deaths in closed institutions meant families usually could not access the location of the death.

The fact that deaths in custody meant families were unlikely to be present when death occurred and therefore not have any information about what happened was raised by a number of participants (CO3, FA1, FA2, FA3, FA5, LA1 and LA2). They all noted that participation in an inquest was often the first and only opportunity for the family to see and hear evidence about the circumstances surrounding the death. LA1 said "the family rely on the process to tell them what happened." FA2, FA3 and FA5 all said they had to see the evidence for themselves so they could understand what had happened. FA3 felt they could not trust summaries or interpretations of the facts produced by others. FA5 found seeing and hearing the evidence made it all feel real.

It was also pointed out that a family might have had limited contact with the deceased prior to the death, especially if death occurred in prison where visits are only possible a certain number of times a month and phone calls are restricted.[557] LA1 gave examples where the deceased had been in prison, so the family had little involvement in their life for a considerable period of time before the death occurred. In these cases, the family will rely on evidence at the inquest to hear about the life of the deceased leading up to the death; which is particularly important following suicides.

Another aspect raised by participants was that families were unlikely to have detailed knowledge about the custodial institutions: especially the policies and practices that govern detention. Both PPO and IPCC noted families did not understand how these institutions worked, and therefore could not contextualise decisions and appreciate their appropriateness or necessity.[558] They both believed family participation in the inquest system could benefit families by ensuring they understood the context of custody. One thing that was apparent in interviewing bereaved families was that they gained a detailed knowledge about many aspects of detention, through participating in the inquest process.

Another issue raised was that it could be challenging for families to see for themselves where a death occurred: by definition, access to custodial settings can be difficult. Although PPO said they would expect a family to be given access to the prison cell where somebody died; other participants did not think this was usual practice. CO3 noted families often struggled to visit the place death occurred.FA1 and FA4 described incredible difficulties associated with visiting the respective cells where their loved ones died.

In conclusion, all participants agreed one of the reasons families should be able to participate in an inquest is as those most affected by the death. Deaths in custody were shown to inherently mean that

[557] Prisoners can also be held hundreds of miles away from family and friend; which further limits visits.
[558] The PPO gave the example of ACCT (Assessment, Care in Custody & Teamwork) documents which are opened when a prisoner is assessed as at risk of self-harm and have to be explained to families so they can appreciate the impact of whether such a document was active at the time of death.

without participation in the inquest, families would struggle to know what happened. The importance of families having a clear narrative about what happened will be discussed further in Section 5.3.2.

5.2.1. Representing the deceased

Another reason for participation is that bereaved families have a representative role. They have a right to participate due to their position as victims (as people affected by the process) but are also there to represent the deceased. Most participants (FA1, FA2, FA3, FA4, FA5, CO2, LA2, LA4, CO3 and CO4) believed families represented the deceased during the process. CO3 noted that following a death in custody, it was always possible that the right to life may have been violated and families participated on behalf of the deceased. All the family participants saw themselves as representing the deceased in some way. FA1, FA2 and FA3 all thought the State had already let their family members down so they had to fight on their behalf with FA1 saying, "I needed to do it for [them]".

In terms of the family representing the deceased, the aspect most commonly raised was that the voice of the deceased should be heard. FA2 and FA3 both felt other parties forgot the process was about someone who had died.[559] FA1 and FA5 both thought it was very important for them to make sure everybody saw the deceased as a human being who was loved. FA1 said just because the deceased was in prison, "it does not matter how you look at it, they are still our children". FA5 felt it was vital they were allowed to read a statement about "who [the deceased] really was".

This was not just important to families but three coroners (CO2, CO3 and CO4) all noted it was important to allow space for the deceased as a person to be represented. CO2 felt the family were the only ones who could make sure the inquest heard "something about the person who died". Although half of the coroner's who were interviewed felt allowing space for the deceased to be remembered

[559] FA2 gave the example of a birthday cake being bought into the hearing during a break resulting in laughter and joy.

was important, some participants (LA2, LA4, FA3 and FA4) expressed disappointment this did not usually happen. LA2 said in their experience it was all too common for the coroner to not even acknowledge the families' grief, let alone allow space for the deceased to be remembered.

CO2 noted families representing the deceased was particularly important when the details surrounding the death might put the deceased in "a bad light". Other participants agreed; FA1, FA4, FA5, LA1 and LA6 all felt that State agencies tried to blame the deceased in some way, often by referencing their background negatively. FA5 felt straight after the death, the initial investigators focused on the background of the deceased rather than the circumstances surrounding the death. FA4 felt State parties were trying to put the blame on the deceased and it was their responsibility to set the record straight; else the process "can find [the deceased] guilty", with the behaviour of the deceased being blamed for causing the death.[560] This was particularly relevant when individuals had died in prison following a conviction, as their offending behaviour could become central to the process without referencing positive aspects of their lives (including family or hobbies). LA2 referenced inquests where prison authorities tried to focus on "some weakness in the deceased". LA1 pointed out this was not just in relation to deaths in prison but gave the example of the De Menezes shooting where the deceased was blamed and denigrated in the press. LA6 felt the involvement of the press was a specific reason why families needed an opportunity to represent the deceased so they could challenge negative and unfounded claims made in the media. Family participation ensures a more rounded picture of the deceased is presented and they are not demonised due to an over reliance on one aspect of their lives.

[560] See discussion around the Black Lives Matter movement in the United States involving police shootings of black people. For example Calvin John Smiley and David Fakunle, 'From "brute" to "thug:" The demonization and criminalization of unarmed Black male victims in America' (2016) 26 Journal of Human Behavior in the Social Environment 350; Yarimar Bonilla and Jonathan Rosa, '# Ferguson: Digital protest, hashtag ethnography, and the racial politics of social media in the United States' (2015) 42 American Ethnologist 4

5.2.2. Representing the public interest

Generally participants did not feel families had a role in representing the public interest during an inquest, even though the public nature of inquests was important. Some participants (CO2, CO3, CO4, LA1, LA2 and LA3) said it was vital Article 2 inquests were held in open court as deaths in custody were "a matter of major public concern" as people were detained "in the name of the all of us" (CO2). LA1, LA2 and LA5 all pointed out it was very rare to have the public attend an inquest; partly because details about inquests were not publically listed so non-interested parties did not know when and where an inquest was happening. CO4 and LA1 both thought the coroner should represent the public interest, even if there was no public attendance at an inquest. Other participants (FA3, LA2, LA4 and PPO) pointed out complex inquests should all require juries; who could represent the public.

As the public rarely attend inquests themselves, media reporting was introduced as important to informing the public. CO2 and CO3 said press attendance at an inquest could play an important role in informing the public. But LA1, LA5 and IPCC all said in their experience it was rare to have even local press attending an inquest. IPCC linked press interest to geography, saying contentious deaths outside of London "never get media attention". LA1, IPCC and ESP1 all noted that even if there was press interest, they were unlikely to report all the details in a complex case but only certain, headlining aspects. Equally, LA5 pointed out it was rare for inquest judgements to be made publically available.

Participants said the family do and can take on the role of disseminating the details via the press (to be discussed further in Chapter 6). LA2, LA3 and LA5 all felt families generally wanted press coverage of the process and a public record of the outcome. FA1 and FA2 were concerned that without public dissemination of inquest verdicts, the public would never know what happened. Other participants raised situations where families had concerns about public reporting without family input due to lack of accuracy. FA1, FA4, LA2 and LA4 all mentioned difficulties with the public record being via the PPO reports which were not always amended to take account of new evidence established during the

inquest. Both LA2 and LA4 said the PPO reports did not always include key failings identified during inquests: sometimes the inquest verdict "was the complete opposite" from the investigatory report (LA2).[561] FA1 said they were completely supportive of reports being published but only if "the complete and whole truth" was told.

Although most participants agreed the public nature of inquests was vital, two participants (IPCC and ESP2) raised concerns about detailed information being made publically available via media reporting without context. Generally, though, participants agreed that, although families did not necessarily represent the public interest at the inquest, they could feed into media reporting, which was vital to ensuring a transparent and open process.

5.2.3. Right to influence the outcome

The right to participate in a process goes beyond either being informed about an outcome or merely witnessing the process but involves a right to be heard and an opportunity to influence the outcome. All participants said thought this was relevant for family participation in an inquest. CO3 said families should feel their involvement was meaningful, not just a "rubber stamp". CO2 felt "very strongly" that families should be "the focus of the process". ESP2 felt "families are empowered" by being involved in the process, instead of just witnessing it. SP1 noted inquests did not always provide clear verdicts (as in criminal cases), so it made being involved in the process even more important.

Participants generally felt the right to ask questions throughout the process was very important for two reasons. Firstly the action of asking questions could help families feel involved: with LA6 saying families had "had enough of being told" and wanted to be able to ask questions. LA1, LA2 and PPO all said the ability to question officers involved in the death of their loved one was very important to

[561] LA4 gave an example where a PPO report commended staff for certain actions when it was proved at the inquest failure to carry out these actions were actually causative in the death.

families. Family participants (FA1, FA2, FA4 and FA5) explained that the opportunity to question witnesses during their respective inquests made them feel more involved in the process. CO1 and CO3 agreed that ensuring families were able to put questions to witnesses helped them feel more engaged with the process.

Secondly participants thought asking questions allowed families to really understand what had happened: FA2 felt that the further along the process, the more questions they had. ESP2 said families wanted to scrutinise the evidence and ask questions when one of their loved ones died in custody. LA6 said for families be satisfied, they had to have opportunities to clarify inconsistencies or rumours relating to how the death occurred or just about the deceased.[562]

A few State official participants highlighted difficulties with allowing families too much influence on outcomes. IPCC said sometimes families wanted things investigated which were not considered a "reasonable line of enquiry". PPO agreed families had to understand what they could and could not influence during an investigation. ESP2 said it should be remembered an investigation was not "just done for the family's benefit". SP1 supported this view, querying whether families should be given priority status over other interested parties. Three coroner participants (CO1, CO2 and CO3) agreed it was important families did not negatively impact the outcome but that it was possible to ensure their participation without affecting the judicial nature of the inquest. CO1 believed if the family wanted the inquest to go in a direction which was not helpful in reaching a correct outcome, coroners could be firm in not allowing the inquiry to be "driven by the attitude of the family". CO2 agreed as long as it did not unduly influence their decisions, family participation could be assured. CO3 said as long as the families' participation were not allowed to negatively impact on the process or influence the jury, it would be unkind not to allow it. It was unclear what might be considered "negative" impact, where it was understood families' participation must include an opportunity to influence to be valid. It may

[562] This was raised as particularly relevant if the press has reported facts about the deceased which were previously unknown to the family.

be that participants linked undue or negative influence with anything that took the inquest outside its very clear and legal remit; particularly in reference to the restriction on not identifying culpability.[563] This links to Chapter 7 which looks at the role of legal representation; which can ensure families participate fully without restricting the validity or efficacy of the process.

5.2.3.1. Right to influence the investigation

Participants pointed out that to ensure families had an opportunity to influence the outcome of an inquest, it was vital they were able to participate in investigations carried out prior to the inquest hearing, as the evidence presented at the hearing was usually decided during the investigation. CO1 said almost all investigations into custody deaths were carried out by investigatory bodies, not the coroner's staff (including gathering all the witness statements). LA3 noted most coroners "don't have the time, money or resources" to investigate fully, so had to rely on State investigators. PPO agreed that coroners relied heavily on PPO reports "to set the scope of the inquest": particularly in terms of the evidence to be presented and which witnesses would be called at the inquest.

Participants felt families should be able to influence the investigation by asking specific questions for the investigatory bodies to answer.[564] LA2, LA3 and LA5 agreed families had to be involved "before it gets to the inquest stage" (LA5) as all the decisions to do with witnesses and evidence for the inquest were made before the hearing actually started. To have an impact on the inquest, families had to be able to influence which witnesses and what evidence was to be considered. CO2 said it was important to make sure families had time to raise concerns to be addressed by investigations. LA3 agreed families had to be involved and supported early enough to suggest issues so they could be looked at by the

[563] As discussed in Section 3.4.2.
[564] Therefore subsequently influencing the evidence heard by the inquest.

inquest. FA4 found there was little opportunity to influence once their inquest had begun as the "inquest was put in place with all the questions answered".

Influencing evidence and witnesses to be heard at the inquest was argued to be important not just so families had an opportunity to influence the outcome but also because otherwise the evidence presented at the inquest could be biased by investigatory bodies. LA2, LA3 and FA3 all noted the investigation could bias the process "very, very easily by what material you do or don't make available to them [the coroner]" (FA3).[565] LA3 said that too often the IPCC did not investigate "obvious lines of enquiry".[566]

A number of participants (LA1, LA4, LA6, FA1 and FA5) raised concerns that the level of involvement offered to families during investigations carried out by bodies like the PPO or IPCC was inconsistent. LA6 said families were not able to participate fully in any investigations carried out by either the PPO or IPCC and were unlikely to get answers to questions. Other participants distinguished between different investigatory bodies. LA1 and LA4 said generally the IPCC did not answer families' questions or allow for them to be involved in the investigation but merely provided them with updates. LA4 noted the PPO system of drafting a report then "asking the family for their views" was helpful and led to more faith in the process than the IPPC, who did not take this same approach or take account of feedback from families. FA5 were able to ask questions of the PPO investigators and make suggestions, so they felt their input was important. However families are not always involved in PPO investigations with FA1 saying their first contact with the PPO was when they were given the final draft of the report.[567] CO3, LA6, ESP1 and ESP2 pointed out investigatory bodies themselves relied on police and crime scene officers to collect evidence and carry out witness interviews as they had insufficient resources to do all the necessary work themselves. These participants said police investigations were

[565] Family participation bringing balance will be discussed at Section 6.2.2.1.
[566] The example given was the Rigg case where IPCC investigators did not watch all of the CCTV and it was only because the family noticed this prior to the inquest that the additional CCTV was presented at the hearing.
[567] This can be linked to lack of access to effective legal representation, which can ensure family involvement in an investigation as FA1 did not have early support from specialist legal representatives.

not set up to allow family involvement, so the only opportunity to influence was through any liaison families had with the investigatory bodies. It was also pointed out by FA3 that investigations into deaths in hospital do not involve the family at all. Although participants generally agreed participation in the investigation prior to the inquest was important for families; in practice, this is not happening.

5.2.3.2. Right to influence the verdict

The ability to question and scrutinise the evidence during the inquest hearing itself was also introduced as important for family participation. This was partly due to the fact that families' participation in investigations could be difficult and partly because the inquest offered opportunities to scrutinise the evidence. All participants were clear families had to be able to examine evidence and question witnesses in order to be able to influence the outcome of the inquest. This will be dealt with in more detail during Chapter 6, where the opportunity for families to scrutinise and cross-examine the evidence will be shown to impact the outcome.

In addition to influencing the evidence via both the investigation and during the hearing, a few participants also discussed whether families should have the opportunity to directly influence the verdicts. In a general sense, influencing the investigation and questioning the evidence during the hearing allows families to influence the verdict but there are two practical ways families might be able to directly influence decisions taken by juries. The first relates to the fact that coroners select which verdicts (such as accident, suicide or unlawful killing) are left to the jury for consideration. The second is that it is now usual for complicated inquests (including following deaths in custody) to produce narrative verdicts in the form of questions put to the jury for them to answer, which consider circumstances of a death.

Generally families do not influence what verdicts are left to the jury, although some coroners will hear the views of interested parties before making a decision. Although one family participant felt it was

important their view was heard as to possible verdicts, other participants said family influence had to be limited. FA2 felt very strongly that misadventure should be a verdict available to the jury in their case,[568] and the coroner agreed to change the options put before the jury. LA2 and LA3 felt consideration had to be given as to how much influence families should have in terms of possible verdicts as accountability demanded a consistent framework for all inquests, regardless of what the family may want. LA2 pointed out families wanted different things from inquests; with some hating open verdicts but others finding anything other than an open verdict unsatisfactory. Patterns indicating systemic failings involving one or more institutions can only be identified if consistent verdicts are produced. LA3 supported this, saying families' right to participate in an inquest should not result in a biased outcome, particularly in cases where there might be criticisms of State agents. In order for criticisms to be seen as legitimate, they must be seen to be resulting from an independent and unbiased process, not unduly influenced by a family looking to apportion blame.

In relation to what questions are put to the jury, it is common practice for all interested parties to be able to suggest questions, and the coroner selects those (and adds any of their own) which will provide the narrative which best reflects the evidence. CO3 said they allowed families to put forward questions for the jury to answer, finding it very beneficial as different parties had different angles and therefore provide divergent questions. FA5 felt this was one way families could feel "very involved".

Participation in both the investigation and the inquest hearing itself was the predominant theme running through all responses in relation to what participants felt ensured families the opportunity to influence the outcome. Two criteria which were identified as beneficial to improving this opportunity was the support of a legal representative and access to documents relating to the death. These will be considered as aspects of effective participation in Chapter 7.

[568] With the assistance of their legal representative.

5.3. Legal right to protect legitimate interests

That the law allowed for participation for families was not a common argument by participants as to why participation was important; possibly because the legal right only establishes an opportunity for families, not an obligation on them. However one participant thought ensuring participation was possible was important because of the need to comply with legal requirements. CO4 referenced the fact decisions made by a coroner could be judicially reviewed; and that ensuring families were kept informed and involved in the process could make sure a Judicial Review was "headed off". So family participation as one aspect of a fair process minimised challenges. One family participant (FA3) thought the legal right to participate was very important, mostly because in their case, the legal right to participate was not as well established following a death in a secure hospital as for deaths in police or prison custody.

Although the fact that participation was a legal right for families was not generally given as an important reason to ensure family participation, some participants (LA2, LA3 and FA3) did note the importance of the law in framing participation. The framework allowing families to participate once they had been recognised as interested parties was referenced as vitally important by LA2, LA3 and FA3. LA3 also referred to the legal framework of the Human Rights Act as being very important in governing participation of families.[569] LA2 saw inferring interested party status on family members as ensuring their participation was protected. FA3 noted the importance of being acknowledged as an interested party, as it allowed them to ask questions.

The right for bereaved families to participate in inquests following deaths in custody is framed in both European and domestic case law by reference to their "legitimate interests".[570] Participants identified a number of varied interests that they thought should be considered, although there was some

[569] Although they noted participation was achieved before the enforcement of the Human Rights Act but only through a lot of hard work by lawyers
[570] As described in Section 3.4.4.

difference in what interests participants thought were most important to families. IPCC thought considering family's participation merely as a legal right did not take account of all possible benefits to a family, which was why participation should go beyond access to aspects set out in law. This relates to possible intrinsic values to participation, which will be discussed in Chapter 6.

Most participants acknowledged there could be difficulty in assessing what a family's legitimate interests were for a number of reasons. Firstly, it was noted the legitimate interests might be unique to each family. Secondly, one participant thought families may not know themselves what their interests were, with other participants saying their interests would change over time. Thirdly, some participants thought specialist lawyers sometimes influenced families, possibly be defining their interests for them rather than representing the family interests.

FA5 was concerned that bereaved families "all deal with things differently" and yet the State bunched them together by trying to define what "the families" want. LA3 found "different families want different things" and LA5 said families' interests "just varies from case to case". CO3 agreed saying each family and each case was unique. PPO thought one of the reasons families' legitimate interests were so variable was because "people have different grieving processes". LA6 said in their experience families generally fell into two distinct groups in terms of what they wanted from the inquest process: some wanted the truth and nothing else, others wanted people to be held to account.[571] LA1 said it was always difficult to judge what was in the best interests of families as they were all unique. It is also true that different interests are not mutually exclusive; families may have multiple interests in participating, and they may change over time.

LA3 thought one of the difficulties in identifying families' legitimate interests was because an inquest was a highly emotional time for them so often they did not know themselves what they wanted. FA2 said initially they had wanted to just understand what had happened so they could "put it to bed" but

[571] Chapter 6 will look at how the inquest process holds the State to account; it is important this purpose occurs even if the bereaved family are only interested in hearing the truth.

after going through the whole process they now felt they needed to do something to prevent further deaths happening.

IPCC felt legal representatives might have good intentions but did not always take account of the negative impacts for families in demanding regular update meetings and every bit of information available. CO2 also questioned whether legal representatives for families did not sometimes get caught up with achieving a particular outcome and potentially lost sight of what their clients really wanted. This could include wanting to change the system, where families were only focused on the individual death. In the experience of CO1, legal teams sometimes "stoked conspiracy theories in families' minds". PPO thought this was true partly due to the fact there were only a small number (6-7) of firms of solicitors who regularly represented families at inquests which meant that they were sometimes "operating with their own agendas".[572] This potential for conflict was acknowledged by two legal representative participants who said they worked hard to counter it. LA2 said "the things as a lawyer you hone in on and things [that] are the most important legally, are not really always the most important for a family". This was supported by LA5, who said sometimes families' best interests were very different than getting a particular verdict from the inquest. For example, there may be one specific point families are interested in having clarified; and once that is done, they are not concerned about the final verdict.[573]

This section established families might have different interests to protect but the next section sets out some of the most common interests identified by participants as establishing the truth, achieving redress through verdicts or outcomes and ensuring anyone culpable for a death is held to account.

[572] Difficulties associated with families finding experienced legal representatives will be raised in Chapter 7.
[573] A good example is following a suicide, a family will often be desperate to know whether the deceased intended to kill themselves or whether it was accidental. It may be that once they hear the evidence of the last person to see the deceased, they will be satisfied, regardless of any verdict.

5.3.1. Redress

One important aspect to participation is to ensure victims of human rights violations receive adequate redress which could be in the form of specific outcome, compensation, an apology or the truth.

5.3.1.1. Verdicts

The inquest verdict was seen as important to five participants but there were differing views as to what verdict most families wanted. For example, CO2 noted the official and authoritative nature of the inquest meant families listened if the verdict said "you could not have done more to help". LA1 said in some cases families "were really pleased" with non-critical verdicts and in other cases families wanted failings acknowledged.[574] LA2 and LA3 agreed that in their experience, families felt relieved and vindicated if the process gave them a detailed verdict, whatever it may be. Both FA2 and FA3 felt justice for the family and the deceased involved getting a critical verdict which highlighted failings.

Participants raised the issue of the importance of different verdicts as discussed earlier. Generally it was agreed the more detailed a verdict, the more satisfying it was for families. SP1 questioned whether narrative verdicts left families in limbo without a definitive outcome but LA2, LA2 and FA3 all said families preferred detailed narrative verdicts. LA2 said often what was seen as a "good" verdict by families was one that answered specific questions on issues "that have formed part of their narrative". The importance of families having their own narrative about the death is key to a positive grief process (See Section 5.3.2.).

[574] LA1 gave the example of a family who, during the process, were outraged at the treatment of the deceased in the prison but as these issues were not causative to the death, the verdict was not critical of the prison or its staff. LA1 thought the family would be disappointed but actually they were pleased and relieved to know nothing could have been done to prevent the death.

5.3.1.2. Civil case

Redress can also be in the form of compensation. Achieving compensation via the domestic justice system is through civil cases bought by families against State agencies found culpable for a death. Although only one family participation gave civil action as a priority, other participants thought civil cases were a key reason for why families participated in an inquest because it provides access to compensation.

CO1 said at contentious or high-profile inquests, "civil litigation is on everybody's mind". ESP2 agreed that all parties were aware of the possibility of State agencies getting sued as a result of inquest proceedings. IPCC felt inquests "usually" led to civil proceedings; with the outcome of an inquest having a big impact on any civil claim. LA5 agreed that inquests where State failings were identified were very likely to lead to a civil case.

Civil cases were not introduced as important by families, with only FA1 saying they were disappointed to be told a civil action would not be successful.[575] FA1 said they had not initially thought about compensation, but in the end they felt as State agents had failed in their duty of care to protect the deceased, the deceased's child should be due compensation. Both IPCC and ESP1 felt State parties were often more concerned with civil actions than families. ESP2 thought it was commonly the legal representatives that were more interested in taking civil cases forward.

LA6 felt even for those families who wanted a civil case, it was more to do with wanting to hold people to account and less about receiving money. LA5 said in their experience, families were not looking for a civil case to gain financially, but because (unless lawyers were working pro bono), families could only find legal representation if there was a high likelihood of successful civil action to fund the costs.

[575] This was after State failings were judged to have contributed to the death.

Not all participants agreed that civil actions were likely following inquests. CO2 said in their experience, it was only the minority of cases where civil action resulted from an inquest outcome. Both CO1 and PPO pointed out inquests were unable to ascertain blame, therefore there were limitations to outcomes assisting a civil claim.[576]

5.3.1.3. Apology

Some participants (CO1, LA1, IPCC, FA3 and FA5) mentioned the fact that an apology from the State could be a form of redress; as well as being in the best interests of both the families and the process more widely. CO1 (in their role as legal representative for State agencies) thought offering an apology early on in the process was very effective in reducing the adversarial nature of the process. LA1 agreed the State admitting any errors as early as possible was beneficial because when families felt State agencies were not sorry for failures, "that is what stops people breathing". FA3 and FA5 both felt frustrated that no one ever admitted any mistakes they might have made, let alone apologised. FA5 was dismayed that instead of apologising, years later officers were not only saying they acted correctly but even that they would do so again, which was "another slap really". FA3 felt that, at a minimum, State agents could have said they were sorry the death ever happened "under their care" without ever admitting liability. IPCC had seen a case where an officer present at the time of the death had apologised (not necessarily for their actions but for the death) and the family had found this incredibly helpful in accepting what had happened.

[576] CO1 was clear part of their role was to "not do anything that would create litigation that wasn't going to happen anyway".

5.3.1.4. Right to the truth

The primary function of any inquest is to establish the circumstances surrounding a death and all the families (FA1, FA2, FA3, FA4 and FA5) stated they wanted to participate because they wanted to find out what happened to their loved one. FA1 said what was important for families was to get "the complete and whole truth". FA3 said they "were delighted" to have a coroner who was going to have a proper, detailed inquest as they wanted the truth, whatever it was. FA5 felt satisfied that the inquest gave them "an understanding of what happened". FA2 similarly said that although they had questions that were never answered, they were satisfied that they got the basic facts. FA4 was very clear they participated in the inquest "for one thing and one thing alone, the truth": they did not care whether it was "good, bad or indifferent". FA4 and their family said the only frustration came from inconsistencies which left them questioning whether they had the truth, with FA4 Father saying, "if it falls into place, you accept it".

Other participants agreed it was important for families to hear the truth. CO2 saw the primary interest of families to be that they "want to know what happened". LA1 felt that not only should the aim of the inquest be to tell the families how someone died;[577] but "most families are pretty interested in the detail". LA2 similarly said families rarely knew what had happened before becoming involved in the inquest process and often just hearing the details was the outcome they wanted. LA6 agreed that some families just needed to hear the truth to be satisfied with the process; especially if inconsistencies were clarified. ESP2 thought families most wanted all the answers.

IPCC and PPO both acknowledged families wanted to know exactly what happened but thought as inquests had a narrowly defined scope, families might not always get answers to all their questions. CO3 pointed out the scope of the inquest did not have to limit the facts given to the family, as even if

[577] LA1 said this was particularly relevant for deaths that occurred in custody as families were unlikely to have been present when the death occurred and only found out many of the details at the inquest.

an issue could not be part of the verdict, the coroner could acknowledge it during the hearing. SP1 thought a flaw to the system was that the scope of inquests only allowed the actions of State officers to be scrutinised, when other people may be just as responsible for not preventing a death so sometimes the whole truth was not established.

All participants agreed families should be informed about the true circumstances around a death; although CO4 said there might be situations when they kept facts from the family if they would be painful to hear.[578] CO4 pointed out, though, that there were dangers to this approach, as it could be more painful for families if they learnt these facts later on.[579] This links to the importance of families hearing the facts about a death promptly, so they can form a clear narrative which benefits the grief process.

5.3.2. Bereavement

All participants referenced the role that an inquest plays in the grief process for families. IPCC felt it was important to remember that for families it was all "part of the grieving process". Participants all felt the inquest could play a part at different stages of bereavement; some saw the inquest process as just one part of the grieving process, some said the inquest verdict provided closure and others said the inquest outcome allowed the grieving process to begin. All the coroner participants saw the relevance of the inquest to the grieving process. CO1 pointed out families were the ones who were grieving so they needed particular consideration when ensuring their participation sue to their "major emotional connection" to the case.

[578] For example, CO4 said they did not necessarily ask a pathologist how quickly or painlessly someone died during the inquest, if they felt the family were not prepared for a negative response

[579] CO4 gave an example where the authorities had tried to comfort the family by telling them their child had not suffered (relating to a fatal accident) but the family had then been incredibly traumatised to hear at the inquest that the child had seared lungs, so must have been still breathing during the fire.

Participants agreed a positive impact was only possible from families participating in the process, not just being given an outcome which they had not been involved in reaching. LA2 said it was not enough for families to be told the truth, they needed "to go through the process" to accept the death. Some family participants felt participating had been beneficial in helping them work through the grieving process. FA2 and FA5 said participating in the inquest process had played a positive part of the grieving process. FA3 said the inquest allowed them to work through a lot of grief so they were able to move forward with the bereavement process "in a more settled, emotional frame".

Most participants noted it was only after the outcome of an inquest that families could find closure. CO4, CO3 and CO2 all thought participation in the inquest process could allow families to come to terms with a death and that it was clear some families "just cannot move on until after it all [….] as the inquest drags them back" (CO2). CO2 thought the inquest was undeniably part of the grieving process for families but their participation had to be managed correctly to ensure the inquest had a constructive impact on bereavement. LA5 said most families wanted to "draw a line under it" and move on once they had the inquest outcome. LA6 said families could not "move on until they've achieved" what they needed from the process. ESP2 agreed the inquest outcome was often actually "the start point" of the grieving process for families.

Two participants (LA4 and PPO) said an inquest could help families leave any guilt they felt about a death behind. LA4 thought an inquest could help families know they were not at fault over the death. PPO also referenced the unresolved guilt families sometimes felt following self-inflicted deaths and thought well-managed inquests could help resolve this.

A number of participants suggested an inquest process providing families with the truth of what happened could be an important part of a healthy grief process. IPCC, LA1, LA2 and LA6 all linked families getting the truth with them finding closure and moving on. LA6 thought families who participated in the inquest process needed to hear the truth, so they had a form of closure and then felt they could "go home to bed now".

Most families (FA2, FA3, FA4 and FA5) said constructing a truthful narrative about the circumstances surrounding the death was a fundamental and important part of the grief process. FA2 said hearing the truth was very important, as processing all the facts allowed them to settle the narrative in their own mind. FA3 felt knowing the inquest had considered everything properly before coming to a verdict provided closure. FA4 felt until they had the truth, "you are betwixt and between" and cannot assimilate a narrative that makes sense of all the facts. FA5 said the inquest gave them a sense of understanding about what happened, which led to greater acceptance about the death.

It was pointed out that potential benefits to the grief process through family participation was in practice negated by years of delays intrinsic to the system. Some participants (FA1, FA2, FA4 and LA2) made it clear the process only helped the grieving process and provided closure if details about a death were given to families in a timely manner, allowing them to integrate the facts into their narrative about the death. LA2 thought delayed access to information for families after a death could result in an extended grief process. FA2 said that while different hearings (disciplinary as well as inquest) were ongoing, it was difficult to process the grief. FA1 similarly thought the length of time and complexity of the inquest effectively stopped them moving on. FA4 felt they could not even begin grieving until the inquest process was finished.

A number of participants (LA1, LA2, FA1 and FA2) discussed the fact that if there were delays before families were given information, they were likely to have already formed a narrative to explain the death and it could be difficult for them to re-adjust the narrative to take into account new facts. FA2 said in their case some of the information they were given at the time of the death was wrong and not corrected until three or four days later; when they were told the truth it was difficult to process as they felt they had already started "going down one path" in terms of creating a narrative about the death.[580]

[580] FA2 had initially been told the deceased had killed themselves but later found out the truth was the deceased had actually been calling for help.

With families reporting they were unable to grieve until the process was completed, long delays have huge impacts. But the issue of families being given access to information in a timely manner throughout the process is also relevant; especially if it is years before families get the whole truth.

5.3.3. Preventing further deaths

One purpose of the inquest system relating to custodial deaths is to identify failings which might lead to more deaths. CO1, CO3 and CO4 all referenced the prevention of further deaths as the most important duty of a coroner. A number of participants (CO2, LA1, LA2, LA5, FA1, FA2 and FA3) believed knowing failures had been identified and further deaths therefore prevented, was a legitimate interest for families. CO2 thought most families were not interested in blaming anyone but in knowing if something had gone wrong, changes were then made as reducing the likelihood of further deaths was a positive result for families. LA1 found families were “keen to make sure that lessons are learnt”. LA2 agreed that for many families the “best outcome” was for failings to be identified and changes made. LA5 thought what most families wanted out of the process was for lessons to be learnt and if that happened, families felt it had been worthwhile participating.

FA1, FA2 and FA3 were clear that their primary desire for participating in the inquest process was to know they had made a different and ensured lessons had been learnt, so no-one else died for the same failings as their loved ones. FA1 felt strongly that their need to participate was as much about making a difference for “somebody else’s son or daughter or husband”, than it was for the deceased. FA2 felt satisfied when the coroner identified failings and notified relevant agencies but had been devastated when they realised lessons had not been learnt and the same mistakes were still being made across the country. LA2 supported this, saying they found often the most heart-breaking thing for families was to find the same issues were arising from repeated inquests, with no changes being made.

5.3.4. Punishment

A number of respondents linked redress with the punishment of those responsible in some way for the death (FA1, FA2, FA5, LA3, LA5 and LA6). FA1 and FA2 thought accountability was far more important to families than other parties. LA3 thought they would only be satisfied by ensuring accountability if someone they loved died because they would want people "paying for what they had done." LA5 thought that just because most families wanted lessons to be learnt, it did not stop them also wanting to see people who were at fault to be reprimanded publically. LA6 agreed that some families were only satisfied if holding people to account incorporated some aspect of punishment. FA5 noted that although inquests did not hold individuals to account, evidence presented during the hearing could establish the need for other proceedings (criminal or disciplinary) which resulted in individuals being punished.

Some participants (FA1, LA3, LA5 and IPCC) noted it could be very frustrating for families that the inquest system did not punish individuals; or even lead to other proceedings which meted out punishment. The IPCC acknowledged an inquest was only one place where families could get justice but that families were often frustrated when negative verdicts at inquests were not reflected in disciplinary or criminal proceedings. LA5 said it was rare for families to see accountability via criminal cases, which could be very frustrating. LA3 agreed it was very disappointing that there was no will to prosecute police officers for failings identified at inquests. FA1 said they were devastated when they realised that a critical verdict at an inquest did not automatically lead to charges or disciplinary proceedings, as it was "not a court of law".

One concern raised was that even where inquests resulted in disciplinary actions for State agents, such proceedings were not public but carried out behind closed doors so families rarely knew ultimate

outcomes. LA5 said most families preferred any disciplinary outcomes to be publically available. FA1 agreed that they were very disappointed to not know the outcome of disciplinary measures; they thought action taken against staff found to be negligent during an inquest should be publicised. FA5 felt the inquest had not held anyone to account but thought disciplinary hearings were no better as it became clear to them that "nothing is ever going to happen to them [the State officers]". IPCC thought one difficulty was that families did not understand misconduct hearings focused on someone's employment record, nothing else. This meant disciplinary hearings being run along specific rules not related to inquests as well as usually being confidential. ESP2 agreed that as disciplinary hearings related to professional standards they could not be fully publicised for good reason.[581]

Holding the State to account was raised as an important issue for families; it will be dealt with later in Chapter 6 but will be referenced here in terms of how it relates to families' legitimate interests. FA5 thought accountability meant families witnessing people admitting mistakes and taking responsibility for any actions or inactions that contributed to a death. FA1 said when the jury came back with a critical verdict, they felt "vindicated" that those at fault had been held to account. FA2 felt satisfied that the narrative verdict made clear where faults lay, even though individuals could not be named and there was no public acknowledgement of culpability.

In some instances having a public record was key to families feeling satisfied that their participation achieved something positive. LA5 said a public record could be a form of redress for families and LA3 thought families were sometimes satisfied by seeing people at fault "called to account publically".[582] LA2 believed "most families […..] want accountability in writing" and the only way this can come from an inquest is a negative verdict given in a public forum. FA1 felt alongside lessons being learnt, it was important that there was a public record reprimanding those responsible following any negative

[581] ESP2 also pointed out disciplinary matters could impact on the operationality of the police, which was one reason why they should be confidential.

[582] LA3 referenced Truth and Reconciliation processes in South Africa where people responsible for deaths were publically acknowledged but not punished and stated some families were satisfied when getting similar outcomes from the inquest system.

verdict. FA4 were mortified to find the PPO report was the only public record, as it did not reflect the failings identified during the inquest. LA2 felt an inquest verdict was more important than a PPO or IPCC report as a public record but family participants disagreed, saying PPO or IPCC reports were easily accessible to all but inquest verdicts were not.[583]

As well as PPO or IPCC reports, other public records of failings can be provided by a Rule 43[584] report which coroners produce following a critical inquest verdict. A report is made to agencies, identifying problems and recommending changes that should be made to prevent further deaths. Producing these reports and consequential actions will be discussed further in Chapter 6 but CO1, CO2 and CO3 all believed families generally saw Rule 43's as a positive outcome (as they could see steps were being taken to prevent further fatalities).

Some participants queried whether families' interests could ever be satisfied by an inquest process. SP1 thought it was inevitable inquests could not satisfy the best interests of families.[585] IPCC agreed the narrow scope of an inquest meant sometimes it was just not possible families to get what they wanted from the process. PPO agreed, stating if families were fundamentally outraged about the fact the deceased was in prison; they would not be satisfied with any outcome. However, this seemed to be disputed by almost all other participants, who all gave positive examples of how fair and effective participation for families could leave them satisfied that their legitimate interests were protected.

[583] LA2 was right that following deaths in psychiatric hospitals, an inquest would be the only public record as investigations into the death by hospitals were internal documents and not publically available at all.
[584] Coroners are empowered to produce reports aimed at State agencies identifying any failures contributing to a death and suggested changes to prevent further deaths. The Coroners and Justice Act 2009 changed the name of these reports, so they are now "Reports on Action to Prevent Future Deaths" (known as PFD reports) but previously they were known as Rule 43 reports; that is how interviewees referred to them, so that is how they are referred to in this thesis.
[585] This was based on SP1's perception that "15 out of 16 families" seemed unsatisfied after participating in inquests.

5.4. Conclusion

When looking at why families should be able to effectively participate in an inquest process, their "legitimate interests" are sometimes considered narrowly as relating solely to civil, criminal or disciplinary processes that follow an inquest. However, participants indicated the benefits to families' interests from their participation were far more varied. Families clearly saw themselves as representing the voice of the deceased during the process; as well as some participants recognising families should also be considered as victims themselves. Participants identified various outcomes such as hearing the truth, receiving an apology or knowing lessons have been learnt, that were just as important as any compensation in terms of providing families with redress. A benefit identified by most participants was the role the inquest process played in helping (or hindering) families through the bereavement process; it was clear fair and effective participation could assist in families coming to terms with a sudden death and subsequently moving on. Participants noted there could be negative impacts of families participating in an inquest, including the expense and some frustration with the system. But all acknowledged these could be minimised if families were adequately supported and prepared on what to expect: aspects which will be discussed in Chapter 7. Family participation can also benefit the process itself by improving the likelihood of a fair outcome as well as impacting on perceptions of the legitimacy of the system: this will be discussed in Chapter 6.

Chapter 6: EFFECTIVE PARTICIPATION OF BEREAVED FAMILIES BENEFITING THE PROCESS: EMPIRICAL EVIDENCE

6.1. Introduction

The previous chapter set out analysis of participants' views on how family participation can ensure families' legitimate interests are protected. This chapter will look at how family participation can benefit the process itself both in terms of ensuring a fair outcome and improving perceptions about the legitimacy of the process. Article 2 case law requires any investigation into a death in custody to be capable of identifying and punishing anyone responsible for the death; as discussed in Section 3.4.2. In situations where there are not criminal investigations, the inquest process ensures compliance with Article 2 and can play an important role in scrutinising State actions and allowing culpability to be established. This chapter will set out analysis of the interviews which relate to the important role the inquest system has in ensuring State accountability as well as how the participation of bereaved families can contribute to accountability and the legitimacy of the system.

6.2. Instrumental impact: ensuring inquests holds the State to account

6.2.1. Purpose of an inquest

The primary purpose of an inquest is to ascertain who the deceased was, how, when and where they died.[586] However, the Coroner's and Justice Act 2009 states an inquest must also ensure HRA rights

[586] Coroner's Rules 1984. No 552, Section 36; Coroners and Justice Act 2009, Section 5

are not breached by ascertaining how the death occurred.[587] Where the inquest system in England and Wales is the primary way Article 2 requirements are met, this should include ensuring any State agents culpable for a death are identified.[588] All participants linked the purpose of the inquest system with the aim of ensuring State agents were held to account for their actions. Although participants interviewed understood there were limitations as to what accountability could be achieved by the inquest process, as punishment is not a possible outcome; it was felt that ensuring failings were identified and publicised was still an important purpose of the process. Both PPO and IPCC were clear the purpose of their investigations was to identify failings by State bodies which might have contributed to a death with inquests playing an important role in ensuring accountability. LA6 said there was recognition that the inquest system was "one of the few ways in which you can begin to bring about a modicum of accountability for a system".

All participants thought accountability via the inquest system went beyond identifying failures or culpability but learning lessons from any deaths. CO1 and CO3 agreed it was "terribly important" (CO3) to make sure any failures were identified and therefore not repeated so the likelihood of future deaths was reduced; with CO1 saying "the only useful thing [they could do] was to stop other people dying". CO4 thought there were two aspects to accountability: the first being identifying culpability for a death (which the inquest was not able to do[589]) but the second was ensuring that lessons were learnt and future deaths prevented, which is where the inquest system had a fundamental part to play. LA2 said the law was very clear that an inquest verdict should record failings related to a death and Rule 43's[590] should be used to identify changes needed to prevent future deaths. FA1 and FA2 both thought inquests should identify such changes; with FA2 saying it was "ridiculous" for lessons not to be learnt considering the cost involved with a complex inquest.

[587] Coroners and Justice Act 2009, Section 5
[588] See Section 3.4.2.
[589] This will be discussed further in Section 8.3.
[590] See Fn 584

A number of issues were raised by participants relating to whether the inquest system worked effectively to identify culpability and ensure changes necessary to prevent further deaths. Two problems with the inquest system itself were identified; firstly, that the scope of inquests were limited so failures which were either not directly linked to a death or by agencies not party to the inquest were often not considered. Secondly, the fact an inquest cannot name any individuals who the jury might consider to be liable for a death was mentioned as restricting the opportunity for identifying culpability.

In relation to ensuring systemic failures were identified, LA6 said inquests were meant to do this. However, FA2 felt there was no opportunity for systemic issues to be identified and resolved (as you would if you held a corporation to account for any deaths). LA4 thought all systemic issues were rarely identified due to limitations related to the scope of verdicts so failings could only be mentioned if they contributed to the death. (So a failure in procedure could be identified that did not actually contribute to the death being investigated but could be a risk for the future; for example a failure to carry our regular checks). SP1 identified another problem as the remit of an inquest meant it focused on the immediate circumstances relating to a death, not what may have been organisational failings that ultimately led to a death.[591]

Some participants (IPCC, PPO, CO4, LA1, LA6 and FA2) mentioned the fact that inquests were not allowed to identify who might be culpable for a death as a challenge to ensuring accountability. Both IPCC and PPO said neither the investigation nor inquest could apportion blame and had to identify what happened without naming any individual who might be responsible for the death. CO4 said while this allowed inquests to focus on making sure lessons were learnt from a death, it also meant no individual was held to account. LA6 said inquests were meant to assess accountability but were not able to judge liability even though European jurisprudence indicated these were “almost

[591] So if a person killed themselves in police custody, the people involved in arresting and detaining the person were investigated but not the wider health service that might have failed the person previously.

synonymous". Legally inquests are not allowed to apportion blame but two participants pointed out that it was often clear which individuals were to blame, even though they could not be named by a verdict. FA2 felt the narrative verdict made it quite clear who the jury thought was to blame; "it was obvious who they meant" even though they could not name names. LA1 agreed that although an unlawful killing verdict could not name someone, often the truth was everyone who participated in the inquest could identify who was culpable.

Although participants raised concerns about the limitations which prevented the inquest system effectively holding the State to account, generally participants felt the biggest problems related to the lack of State response following negative inquest verdicts. The 1984 Coroners Rules set out the power for coroners to write a 'Rule 43' report to any agencies identifying failures that contributed to the death, as well as making suggestions for necessary changes which should happen to prevent further deaths.[592] The Coroners and Justice Act 2009 made changes to the provisions of these reports, including making it a statutory duty (instead of being discretionary) for coroners to order "Reports on Action to Prevent Future Deaths" (known as PFD reports).[593] However, the reports will be referred to as Rule 43 reports in this thesis.[594] CO1 said Rule 43's were very important "to protect other people from dying". CO2 and CO4 believed their power to ensure lessons were learnt came from the fact State agencies had to respond to Rule 43's and explain what steps had been taken to address identified failings. However, ESP1 pointed out Rule 43 only required a response; there was usually no follow-up. FA2 agreed saying agencies only reported back what steps had been taken to address failings but no one ever checked up to ensure these changes were sufficient or complete. LA2 said there should be a team following up on Rule 43's to make sure necessary changes were made.[595]

Some participants (LA2, LA3, LA4 and SP1) said even if there was no follow-up on Rule 43 reports, they could still be important in achieving change by providing a public record of identified systemic failings.

[592] Coroner's Rules 1984. No 552, Rule 43
[593] Coroners and Justice Act 2009, Schedule 5
[594] Partly because participants were referencing the old-style reports.
[595] The Chief Coroner now collates PFDs and they are published on the internet.

LA2, LA3 and LA4 all thought public Rule 43's could be used to push agencies to make necessary changes. SP1 agreed, saying publication of Rule 43's was the best way to ensure a State agency responded to the report. Although CO4 agreed it was important Rule 43's were made public, they acknowledged this made agencies fight hard to prevent them being given and the fact Rule 43's were public inhibited some coroners from making them. Two participants (CO1 and SP1) questioned whether Rule 43 reports were the most effective way to bring about change; both believed if coroners had private constructive dialogue with State agencies, there was sometimes no need for a public document. LA2 thought the most effective coroners were those who produced Rule 43's and also engaged with relevant institutions to find out what changes had occurred. Both SP1 and LA4 agreed the most important thing (regardless of whether a Rule 43 was public or not) was whether State agencies provided evidence when necessary changes had been made. It is inimical that critical Rule 43's are seen as important to change as they require resources to be directed towards correcting failings but because of this, State agencies fight harder to prevent them being ordered.

Some participants were concerned coroners took very different approaches as to ordering Rule 43's. LA1, LA2, LA5 and SP1 all said coroners ordered Rule 43's in different circumstances; with some coroners producing a lot of reports and others none at all. The main differences in approach related to whether the necessary changes had already been made by State agencies. Due to delays in the system, participants said years often passed between the death and the inquest hearing, which meant agencies often informed coroner's that changes had been made in the interim period. LA1 and LA4 said in such cases, some coroners would agree not to order a Rule 43 report whereas others would still produce a report so there was a public record. CO3 said the only reason for ordering a Rule 43 was to prevent deaths, so if the necessary changes had been made, there would be no need to order a report. Some participants (LA1, LA4 and LA5) identified a problem with only ordering a Rule 43 report if changes had not been made, as this did not allow for any national learning to occur.[596] CO4 said

[596] So one prison might have made the necessary changes to prevent a death but if a Rule 43 was not made, other institutions might not be aware of the potential problem.

before making a Rule 43, they considered not just whether the necessary changes had already been made by the institution in question but also whether similar failings might be a problem elsewhere. CO2 agreed Rule 43's could be useful in sharing concerns so others could learn lessons from a death.

Another concern raised by participants relating to inadequate State responses to inquest verdicts was where neglect or unlawfulness was identified during an inquest but no prosecutions followed. FA2 felt the lack of criminal proceedings in cases where neglect was identified limited accountability and made them feel the process was just "a huge exercise to clear the [State]". LA1 and LA3 said lack of prosecutions following negative inquest verdicts limited accountability as "the desire or the will to prosecute police officers has been poor" (LA3). LA5 agreed, saying it was very frustrating for families when there was no way of "getting accountability through the criminal law". LA3 thought prosecutions were only due to public pressure after campaigns led by bereaved families. The next section will look at this and other roles families play in enhancing accountability via the inquest system.

6.2.2. Impact of bereaved families participating in an inquest

Families could be argued to benefit the capacity of the system to hold the State to account in two ways. The first relates to the positive impact family involvement has on the outcome of an inquest. The second relates to the fact families often instigate dissemination of outcomes and push for necessary change.

6.2.2.1. Optimising fair and accurate outcome

This next section considers whether participants felt family participation had a positive impact on the outcome of an inquest. CO1 was clear an inquest was not specifically for the family so their

participation should only be allowed if it helped achieve a fair outcome. A number of ways this could happen were identified, including the fact the family play a role in scrutinising the evidence, can ensure the process is equitable and sometimes even provide additional information relating to a death.

Family provide scrutiny

Participants felt the most important impact on an outcome from family participation was through scrutinising the evidence. All participants felt that for inquests following a death in custody, cross-examination and scrutiny of the evidence was vital in ensuring a fair outcome. LA1 said whenever it was possible the State might be responsible for a death, scrutiny had to be stringent. LA2 agreed, saying without cross-examination of witnesses during the inquest, you would not get "the proper verdict". LA6 said good cross-examination could be "very effective, teasing out what really happened". SP1 agreed the "British method is that evidence is subject to scrutiny".[597] ESP2 thought somebody had "to be in a position to probe and test" the evidence, otherwise there could be no confidence that the system would reach the correct outcome.

LA5 pointed out the need for families to scrutinise the evidence depended on the quality of the investigation itself. LA3 felt the two State investigators (PPO and IPCC) were "hopeless" and that it was therefore families and their legal teams who had to examine the evidence to find the truth. Both LA2 and LA4 had experienced inquests where the verdict had been the complete opposite to the PPO report due to the scrutiny of the evidence during the inquest process. LA4 said "in a PPO report [it] is regarded as a positive, and by the time we get to the inquest it's turned into a negative."[598] Both LA4

[597] SP1 did questions whether the high costs associated with adversarial inquests was always necessary.
[598] LA4 gave an example where (even though an ACCT document had been open) very few of the consequential requirements had been put in place but the PPO had commended staff in their report. The failings were identified during the inquest and the PPO acknowledged they should never have commended people who had actually failed to do their job.

and ESP2 agreed that however thorough an investigation was, the full story could only be identified through probing the evidence and witnesses.

CO1 and CO3 pointed out that they examined all the evidence as it was gathered, so they thought the process was not as reliant on families where the coroner was effectively investigating the case. LA3 and LA5 thought coroners rarely had "the time or resources to sit down and think critically" (LA3) or scrutinise the evidence thoroughly, so it was very important families took on this role. CO1 admitted there were examples of coroners who "abdicate the questioning to the representatives". LA5 and LA6 thought, even though some coroners were very good at asking questions, there was always the danger this could affect perceptions about their independence and open them up to charges of bias. LA5 thought it was therefore inappropriate in the most contentious cases for coroners to cross-examine the evidence. ESP2 agreed somebody needed to take "the adversarial position" to scrutinise the evidence but coroners could not do this as they had to remain independent.

Participants felt where coroners did not scrutinise the evidence or cross-examine witnesses, families had to take on this role to ensure a fair outcome. But even where coroners were actively involved in questioning, participants still thought it was important for families to be able to question parties. CO2 was clear that when family members were actively involved in an inquest, it usually ensured negligence was identified. CO1 and CO3 felt the most contentious inquests should allow all parties to scrutinise and cross-examine the evidence. LA2 said often the only scrutiny came from legal representatives acting for the family and any restriction of questioning by the family limited the likelihood of reaching a fair outcome. LA5 said families provided greater scrutiny by "pushing boundaries, trying to find things out". LA4 agreed, saying families were always going to "press ahead […….] trying to find things out", which made sure everything was questioned closely.

Some family participants felt they had to take on the responsibility of scrutinising the evidence. FA3 thought the family were "there as the prosecutors", and it was very positive to have the family (with good legal support) to take the lead in scrutinising evidence, which was why inaccuracies and mistakes

not identified by the investigation were brought to light during the inquest. FA2 agreed families had to be persistent to get the truth from State agencies. FA4 felt "like I am an investigator half the time" as they had to "do the job" the investigators failed to do.

Some examples of family scrutiny identifying new evidence relating to a death were given during the interviews. LA3 talked about the Sean Rigg case where it was the family, not the IPCC, that identified the police were lying by analysing CCTV evidence. Similarly, FA2 said through scrutinising the evidence and questioning witnesses, they identified inconsistencies: "a lot more came out from the witnesses than [had been] in the statements" through cross-examination. FA5 said as a result of their legal representative questioning witnesses, stories were changed and evidence of perjury was established. FA4 said it was through questioning that it became clear mistakes had been made in the investigation.[599]

Some participants (LA2, LA3, IPCC, FA1, FA3 and FA4) thought one reason families could be so effective in scrutinising the evidence was because they wanted to know all the details. LA2 said families generally "live those cases" so were in the best position to scrutinise the evidence. IPCC agreed families sometimes knew the case in exhaustive detail. FA1, FA3 and FA4 all knew the files in great detail and scrutinised every bit of information; identifying gaps or errors. The Rigg case mentioned above by LA3 illustrated how families sometimes get so involved that they know the case better than anyone else. LA3 said it was the family (with the assistance of their lawyer) who went through all the videos; and such detailed scrutiny could not be provided by the coroner "who would not have had time to look at hundreds of hours of CCTV".

Another problem identified with the system was the fact it relied on families to scrutinise the evidence, even though this might not be a role families could or wanted to take on. LA2 said families were expected to analyse all the evidence and then examine witnesses. FA2 and FA3 acknowledged

[599] For example the time of death had been wrongly noted down, the ligature found in the cell had been lost and not all possible causes of death had been considered by the medical examiner.

not all families would be happy to go through everything in as much detail as they did or challenge State parties. FA2 said the process required them to be "like a dog with a bone" and they thought "a lot of families would have just gone along with it".[600] The role of a legal representative was raised as vital in assisting families scrutinising the evidence, this will be discussed further in Chapter 7.

CO2 said ably represented families could provide a scrutiny role but coroners needed to be aware that when family members were not actively involved, they had a "bigger burden" to scrutinise the actions of State parties. LA1 agreed a "progressive coroner" should take into account whether the family either were not involved in the inquest or not represented and ask the questions necessary to scrutinise the State.

FA3 thought some juries might help scrutinise the evidence via questioning. However, other participants (PPO, LA1 and LA3) said this was rare, with PPO saying juries had a few questions in about 50% of cases but were "not massively engaged in the process" the rest of the time. ESP2 and LA6 both thought an independent (of all parties) advocate examining all the evidence during an inquest was a better approach than leaving it to families.[601] The financial burden would have to be met by the coroner for any such legal representatives. Although some participants agreed that scrutiny could be carried out by the coroner, jury or an independent lawyer appointed by the coroner; families are often considered the ones best placed (with the support of their legal representatives) to challenge and question the evidence.

[600] FA2 challenged the verdicts to be left to the inquest jury and managed to ensure all possible verdicts were considered.

[601] A coroner can appoint an independent advocate as "Counsel to the Inquest" for certain high profile cases including the 7/7 bombings: see http://webarchive.nationalarchives.gov.uk/20120216072438/http://7julyinquests.independent.gov.uk/int_persons.htm

Family bring balance to the process

As well as scrutinising evidence and impacting on the likelihood of achieving a fair outcome, families also bring balance to the process which is linked to perceived legitimacy. Some participants (CO1, LA1, LA2, LA3, LA4, LA5, LA6, FA3 and FA5) felt the system was set up so State parties were either not actively seeking the truth, or fighting during the process to ensure all the facts were not brought to light in order to avoid possible civil cases or Rule 43 reports. CO1 (as a legal representative) said when representing a NHS trust, instructions would be "to avoid a Rule 43 report by any way you can". FA3 agreed, saying they thought State institutions would always be on the defensive as they had to "protect their image [……] to avoid at all costs to be publically criticised." LA1 found in their experience, State parties had "a bottomless pit of resources" aimed towards avoiding a critical verdict and any evidence they presented was "entirely self-serving".[602] LA2, LA3, LA4 and LA6 thought State bodies were only focused on limiting any criticism of themselves: with LA6 saying that following a death in custody, any State agency involved "does not want to admit anything if they can avoid it". LA5 agreed State agencies were sometimes more interested in "muddying the waters" than finding the truth.

Two participants (FA5 and LA5) felt that even when the State was not actively working against finding the truth, all non-family parties provided a cohesive front, which could only be balanced by family participation. FA5 experienced every other interested party sticking together during the inquest; with the doctors covering for the police and vice versa: "it was like a little club really".[603] LA5 supported this view, saying usually different State authorities "sweep up" any inconsistencies for each other. The

[602] LA1 thought this was partly as a result of the Manning cases which created a requirement for the DPP to review any case following a critical inquest verdict which had left State agencies even more concerned about receiving a negative outcome. This will be referenced in more detail later in this chapter.

[603] In fact they felt some individuals involved probably did feel remorse for what happened but could not express it as they had to stick together with the other officers. During the inquest hearing, FA5 witnessed one officer whose statement had originally disputed the others had been ostracised; which made them question their confidence in the State agencies.

possible imbalances caused by families not knowing the system or other parties will be discussed further in Chapter 7.

The scrutiny provided by families was linked by a number of participants to ensuring confidence and therefore legitimacy of the system. Both CO1 and CO3 thought because custodial inquests always had the potential to be contentious, it was important for legal representatives for all parties to be involved to provide balance. LA2 and LA3 thought in order for coroners to run an independent and balanced inquiry, they had to hear the families' perspective. FA2 agreed, saying if coroners were only hearing from State parties "then inevitably that's the side they are going to come down on".

Participants thought families provided a different viewpoint from other parties, who tended to be experts on issues arising after deaths in custody. LA3 said the family could usually identify new questions to be answered.[604] LA4 thought families provided different perspectives than other parties, so their participation brought "a new slant". CO3 agreed that families asked questions "from the heart or about things that trouble them", so it could be very constructive to have them feeding into the process.[605] FA2 said they sometimes thought of angles or questions that even their legal representative had not. IPCC and PPO agreed families were often the most likely to have interesting and "very relevant" (PPO) questions, which usually benefited the process greatly.

Family provide information about deceased

Families can also assist an inquest by providing important evidence about the background of the deceased and, in some circumstances, even details relevant to a death. Process wise, CO3 said "sometimes there are things they [the family] need to say" about the deceased. Although IPCC pointed

[604] Again the role of legal representatives assisting families with this was pointed out; which will be discussed in Chapter 7.
[605] CO3 did note, though, that legal representation was very useful in helping families frame the questions appropriately: as referenced in Chapter 7.

out whether families could provide relevant information to assist the process was heavily reliant on "what kind of contact the family had had with the person before they died". In terms of police deaths, LA3 and LA4 said the family may have vital information about circumstances before an individual came into contact with the police.[606] LA3 and FA1 said even when the deceased had been detained and therefore separated from the family, families still might have insight about their state of mind or other things linked to a death.[607]

Participants also gave examples of families gathering evidence where investigatory bodies were not effective. FA4 felt they were acting as investigators in gathering, assessing and scrutinising evidence because they "had to do the ground work". FA4 Father pointed out a photo was not taken of one key piece of evidence (the ligature), so they asked him to do it; "that is the only way we got a photograph".[608] FA3 "gathered yet even more evidence to support our case".[609] LA6 knew cases where the family "dug up some fresh material", necessitating a new inquest. LA3 mentioned when Sean Rigg's family were responsible for identifying the fact CCTV evidence was missing. So families can affect the accuracy of the outcome by scrutinising and questioning the evidence, bringing balance as well as introducing relevant facts to the process.

6.2.2.2. Families instigating change

FA2, FA3 and FA5 all felt they not only provided a different viewpoint (as mentioned above) but also that they pushed the process forward. FA5 found they had to drive the whole process to ensure it did

[606] For example, cases where the family call the police to assist them when they have concerns about the behaviour of someone.
[607] For example, if an individual is worried about an upcoming criminal hearing or having problems in prison that might lead them to take their own life.
[608] FA4 said the pathologist had to change his mind about some aspects in the report when showed the photographs at the inquest.
[609] With the support of their legal representative.

not just stop and believed it was only due to their complaint that the case was referred to the IPCC.[610] FA2 and FA3 were convinced that without them, their respective inquest processes would not have been as thorough. LA6 thought families often felt they "need[ed] to be proactive to keep people up to the mark".

As well as taking a proactive role during the process, families can also instigate positive changes once the inquest has concluded. This includes changes to rules for detaining State institutions as well as changes to the investigatory system itself. In respect of the inquest as an investigation holding the State to account, reforms have been interlinked with the evolution of Article 2 via ECtHR case law. The ECtHR identified the ECHR as a living instrument, illustrated by the manner in which Article 2 obligations have broadened since the inception of the ECHR.[611] Fundamentally, changes have been in response to societal evolution and to ensure Article 2 is interpreted in a way that ensures the protections are effective.[612] Cases are brought before the courts by those affected by a State's actions; so in relation to Article 2, cases are brought by bereaved families.[613] LA6 was clear that "families are very active [……..] they are the ones who bring about the changes". LA3 agreed, saying often decisions to prosecute officers depended on families and their lawyers "pushing for prosecutions". IPCC said there were cases where the family were the key instigators in getting an inquest outcome publicised by actively engaging with the press. FA1 said they had written countless letters, trying to ensure lessons were being learnt from the inquest.

Bereaved families[614] also play a vital role in judicially reviewing decisions relating to the inquest system, thus changing the system. LA4 and LA6 both said families were key to important legal changes increasing accountability via the inquest system.[615] Achieving "the betterment of the system" was a

[610] FA5 felt it would merely have been registered as a hospital death without them driving the process, even though the injuries that caused the death were sustained in police custody.
[611] Mowbray, 'The Creativity of the European Court of Human Rights', p 60-71
[612] *R. (on the application of Amin (Imtiaz)) v Secretary of State for the Home Department*
[613] Often with the support of campaigning organisations.
[614] With support from organisations like INQUEST or JUSTICE.
[615] LA4 gave the example that before the *Middleton* case, juries were limited to one word verdicts so it was difficult for failings that might have contributed to a death to be raised.

key aim for FA3, who challenged the investigative system for deaths in a mental health setting. The following section describes three areas where families instigated change in the inquest system via case law; the importance of what verdicts are left for the jury to consider, how the State must respond to certain verdicts and when legal aid must be available for families.

6.3. Examples of families instigating change

6.3.1. Inquest verdicts

A series of challenges by families to existing practice has clarified the law around when the verdict of unlawful killing should be left for the jury to consider. At an inquest, the criminal standard of proof is required for a jury to bring a verdict of unlawful killing (or suicide); so they must consider it proved beyond a reasonable doubt.[616]

A number of cases brought by both State parties and bereaved families have clarified the law around this issue of when an unlawful killing verdict should be left for the jury to consider. In 1999, Roger Sylvester died after being restrained by police, and an inquest jury gave a verdict of unlawful killing but the police judicially reviewed the decision, which was subsequently quashed.[617] The High Court found police actions could not be proved to have caused the death,[618] so no jury would have been likely to find the officers guilty of manslaughter in a criminal case, and therefore unlawful killing should not have been left to the inquest jury. In 2005, the police involved in the shooting of Harry Stanley successfully judicially reviewed the decision of the coroner to leave the verdict of unlawful killing to

[616] Note in all other inquests, the standard of proof is on the balance of probabilities as in civil courts; *R. (on the application of Cash) v HM Coroner for Northamptonshire* [2007] EWHC 1354 (Admin) (Queen's Bench Division (Administrative Court))
[617] *R. (on the application of Anderson) v HM Coroner for Inner North Greater London* [2004] EWHC 2729 (Admin) (Queen's Bench Division (Administrative Court))
[618] It was proved the restraint may have contributed to hypoxia but a causal link to the death was not proved.

the inquest jury.[619] The judgement found a jury could not have concluded beyond a reasonable doubt that the shooting did not occur under an honest belief of self-defence and therefore an unlawful killing verdict should not have been left to them.[620] The law restricting a coroner to only leave unlawful killing to an inquest jury when the evidence would support a criminal conviction was affirmed in the *Bennett* case; where the application by the bereaved family to judicially review the coroner's decision was refused, as the *Galbraith*[621] test had been correctly applied in deciding which verdicts to leave to the inquest jury.[622]

The importance of allowing a jury to return an unlawful killing verdict if appropriate has since been recognised. In 2007, a bereaved family took a case to the High Court, which found the coroner was wrong to not leave unlawful killing as a possible verdict at the inquest into the death of Darren Cash (who died after being restrained by police).[623] The judgement said if there was evidence on which an inquest jury might decide a verdict of unlawful killing to a criminal standard; this option should be left open to them. This was affirmed in *Tainton*, but it was judged that issues which could not safely be left to the jury as possibly causative to a death (as it would be unsafe for the jury to make such a decision), should still be referenced in a narrative verdict if considered as wider circumstances linked to the death.[624]

Generally, coroner's decisions on what verdicts are open to a jury can only be challenged on Wednesbury[625] grounds (action established legally as fully unreasonable or irrational).[626] However, it

[619] *R. (on the application of Sharman) v HM Coroner for Inner North London* [2005] EWHC 857 (Admin) (Queen's Bench Division (Administrative Court))
[620] Even though Mr Stanley was unarmed and walking away from the officers at the time of the shooting and the forensic evidence did not support the police description of what happened.
[621] *R. v Galbraith (George Charles)* [1981] 1 WLR 1039; [1981] 2 All ER 1060; (Court of Appeal (Criminal Division))
[622] *R. (on the application of Bennett) v HM Coroner for Inner South London* [2007] EWCA Civ 617 (Court of Appeal (Civil Division)), para 4
[623] *R. (on the application of Cash) v HM Coroner for Northamptonshire*
[624] *R (Tainton) v HM Senior Coroner for Preston and West Lancashire*
[625] *Associated Provincial Picture Houses Ltd v Wednesbury Corp* [1948] 1 KB 223; [1947] 2 All ER 680 (Court of Appeal)
[626] *R. (on the application of D) v Inner South London Assistant Deputy Coroner* [2008] EWHC 3356 (Admin) (Queen's Bench Division (Administrative Court)), para 25

has been clarified that coroner's have greater discretion than a judge in a criminal case, in deciding what to leave to a jury. In 2008, in refusing a family the right to judicially review a coroner's decision, the Court stated the coroner had a duty to ensure the jury was not left any verdicts that might risk determining liability which would be illegal as set out in the Coroners Rules 1984.[627] Previous judgements decided coroners were able to consider the interests of justice in deciding what verdicts to leave to an inquest jury.[628] It was clarified in *Menezes* that this distinguished coroners from criminal judges, as they were unable to "act as a filter for unmeritorious cases".[629] Although wide discretion is still with coroners as to which verdicts should be left to juries, the detailed case law resulting from families challenging decisions has helped clarify the law, and therefore improve consistency.

6.3.2. State response to an inquest verdict

One aspect of achieving accountability is to leave the verdict of unlawful killing for the jury to consider but it is then vital that the State responds appropriately to such a verdict (including the prosecution of officers if necessary). As inquests only proceed once any criminal proceedings are completed, if an inquest hearing is being held it is likely either a prosecution failed or the decision was taken not to prosecute the case. If an inquest results in an unlawful killing verdict, it might be expected prosecutions would follow, given the fact unlawful killing can only be found using the criminal standard of proof. This leads to questions as to why unlawful killing verdicts do not automatically lead to prosecutions; let alone convictions.[630]

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[627] *Da Silva v United Kingdom,* paras 122-3

[628] *R v HM Coroner for Exeter and East Devon ex parte Palmer* [2000] Inquest LR 78 (Court of Appeal); *R. v HM Coroner for Inner London South District Ex p. Douglas-Williams* [1999] 1 All ER 344; (1998) 162 JP 751 (Court of Appeal (Civil Division)); *R. (on the application of Bennett) v HM Coroner for Inner South London,* para 30

[629] *Da Silva v United Kingdom,* para 219

[630] There have been eleven unlawful killing verdicts at inquests where State actions resulted in a death but only three unsuccessful prosecutions: see INQUEST, *Learning from Death in Custody Inquests: A New Framework for Action and Accountability* (2012)

Although there are still questions as to how effectively the process is working, families challenging decisions were key in requiring the State to officially respond to unlawful killing verdicts. In 1997, the decision by the Director of Public Prosecutions (DPP) not to prosecute police officers involved in the deaths of Shiji Lapite and Richard O'Brien (after both inquests concluded with unlawful killing verdicts) was judicially reviewed by the bereaved families.[631] During the judicial review, the DPP conceded the decisions not to prosecute in these cases were flawed.[632] A Government inquiry was initiated following these cases; the subsequent report influenced the changes in guidance explained below.[633]

In 1998, the inquest into the death of Alton Manning[634] in HMP Blakenhurst returned a verdict of unlawful killing. The CPS decided not to prosecute anyone in relation to his death but in 2000 his family judicially reviewed this decision.[635] The Court concluded that when there was a death in custody and the inquest returned a verdict of unlawful killing, the family was entitled (unless compelling reasons existed) to hear the reasons behind CPS decisions not to prosecute any officers involved.

In 2001, the ECtHR in *Jordan v UK* commented on the need for the State to reassess any decisions regarding prosecutions if inquest verdicts indicated it was necessary.[636] The ECtHR also referenced the importance of the DPP giving families reasons explaining any decision not to prosecute following a controversial death, so they could "challenge the decision legally if they should wish."[637]

Subsequent to these judgements, in 2001, the Attorney General announced a review of the role and practices of the CPS in cases of a death in custody. The report published in April 2003 recommended "A new package of measures to increase the transparency of the decision-making process and to

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[631] In conjunction with the case of Derek Treadaway, who was found to have been tortured in police custody; *R. v DPP Ex p. Treadaway* Times, October 31, 1997 (Divisional Court)

[632] In relation to the second death, it transpired the decision not to prosecute the officers had relied on their evidence alone and had not taken into account statements by other witnesses.

[633] In response to these cases, the Government set up the Butler Inquiry to look into the Crown Prosecution Service (CPS) decision-making process relating to deaths in custody and other serious cases; Gerald Butler, *Inquiry into Crown Prosecution Service decision-making in relation to deaths in custody and related matters (Butler Report)* (1999)

[634] Mr Manning had died in 1995 after prison officers had used a neck hold to restrain him.

[635] *R. v DPP Ex p. Manning* [2001] QB 330; [2000] 3 WLR 463 (Queen's Bench Division (Administrative Court))

[636] *Jordan v United Kingdom,* para 142

[637] Ibid, para 123

involve families more."[638] Current guidelines for the CPS now state that on completion of an inquest, all the evidence will be considered (including any new evidence exposed through the inquest process) before a decision on whether to prosecute is taken.[639] If there will still be no prosecution, families will be informed and given reasons for the decision.[640] The CPS also offers to meet with families so the "decision can be explained to you in more detail".[641] Domestic courts affirmed this process is necessary for an inquest to satisfy Article 2 procedural obligations following a death in which State agents may be implicated.[642] Similarly, the ECtHR has stated that the fact any verdict of "unlawful death" now meant the DPP must reconsider any decision not to prosecute is a key aspect of the inquest system's compliance with Article 2.[643] The High Court decided in 2006 that the review process as set out in *Manning* was compatible with Article 2 obligations as described in *Oneryildiz*.[644] Families have played an important part in ensuring that the State must respond to any unlawful killing verdict; and now, if a prosecution is not taken forward, reasons must be given to families to explain this decision.

6.3.3. Legal aid for families participating in an inquest

A recent example of a bereaved family driving change within the inquest system itself related to the guidance for Legal Aid Agency (LAA) officers deciding whether to provide families with legal aid funding to pay for legal representation during an inquest process via the exceptional fund system. In 2013, Christopher Letts committed suicide, shortly after being released from a mental health clinic; his sister, Joanna Letts, applied to the LAA for legal aid funding for a lawyer to represent her during the inquest process. Initially she was refused legal aid; although after she started to judicially review

[638] The Rt Hon The Lord Goldsmith, *A Review of the Role and Practices of The Crown Prosecution Service in Cases Arising from a Death in Custody* (2003), para 6.8
[639] Crown Prosecution Service, *Prosecution Policy and Guidance: Deaths in Custody* (2004)
[640] Ibid; available at http://www.cps.gov.uk/publications/prosecution/death_custody.html#a10
[641] Ibid
[642] *R. (on the application of Middleton) v HM Coroner for Western Somerset,* para 16
[643] *Bubbins v United Kingdom,* para 153
[644] *R. (on the application of Da Silva) v DPP* [2006] EWHC 3204 (Admin) (Divisional Court), para 43

the decision, the LAA reversed its decision. Mrs Letts continued with the judicial review, however, to ask whether the criteria used by the LAA on granting legal aid for inquests were fair and legal.

Under Section 4 of LASPO 2012, the Lord Chancellor was empowered to produce guidance for the LAA, governing how applications for legal aid should be dealt with; including applications for funding for legal representation during an inquest.[645] The guidance gave two criteria which had to be met before granting legal aid; firstly the case should come under the remit of Article 2 and secondly legal representation must be deemed necessary for a family member to be able to participate in the inquest.[646] It was the first criterion that was questioned by Joanna Letts, as the guidance suggested that in deciding whether a case was within the remit of Article 2, the LAA should judge whether the State had arguably breached substantive Article 2 obligations. Joanna Letts argued that in some cases, the procedural or investigative duty under Article 2 was automatically engaged; regardless of whether the State could be shown to have been responsible for the death. The Lord Chancellor acknowledged there were some deaths where Article 2 was automatically engaged but disagreed as to which cases came within this category. The Court found the procedural duty went beyond cases where there was State culpability for a death; [647] and stated the guidance did not allow for the fact families should be involved for the purposes listed[648] in cases where there was no State culpability.[649] The Court therefore judged the existing guidance contained an "error of law" that was likely to lead to wrongful decisions.[650]

Following the *Letts* judgement, the Lord Chancellor published updated guidance which gave new criteria for the LAA dealing with an application for exceptional legal aid funding for an inquest process.[651] The first criterion now states that cases should engage the procedural obligation of Article

[645] Legal Aid, Sentencing and Punishment of Offenders Act 2012
[646] Lord Chancellor, 'Lord Chancellor's Exceptional Funding Guidance (Inquests)', 2013
[647] *Letts v Lord Chancellor (2015)*
[648] To discover the truth, to be comforted by the fact the state was shown not to be at fault or to know lessons would be learnt to prevent future death (ibid, para 64)
[649] Ibid
[650] Ibid, paras 100-1
[651] Lord Chancellor, *Lord Chancellor's Exceptional Funding Guidance (Inquests)* (2015)

2; the second criteria remaining the same.[652] Clear guidelines are provided as to when the procedural obligation would be engaged, including the fact it can be triggered automatically in such cases as "intentional killings by State agents, violent deaths and suicides in police or prison custody or during the course of arrest or search, and all violent deaths and suicides of persons detained in mental hospitals".[653] The guidance still includes reference to cases where the procedural obligation might not be automatically triggered but where there is evidence showing the State might have arguably breached either of the substantive Article 2 obligations.[654]

Without the Letts family bringing the challenge,[655] the first criterion would have remained unlawful.[656] The second criterion is still in place, requiring the LAA to judge whether legal aid would be required to ensure family involvement in order to protect their legitimate interests. The guidance suggests considerations which might indicate legal aid funding was required would be "the nature and seriousness of any allegations" likely to be made against any State agencies; any particular vulnerability of the next of kin; and whether the family had already played "an active role" in an investigation into the death.[657] So the test to receive exceptional legal aid funding is still a high one for families to reach, which is likely to continue to make it difficult to get the legal support they need (as referenced in the Chapter 7).

[652] Ibid, para 7
[653] Ibid, para 11
[654] Ibid, para 14
[655] Particularly without them continuing with it once they had been awarded legal aid themselves.
[656] It should be noted this change was only possible because Joanna Letts was legally represented by a specialist solicitor and two barristers as well as being supported by INQUEST.
[657] Lord Chancellor, *Lord Chancellor's Exceptional Funding Guidance (Inquests), paras 21-3*

6.4. Intrinsic impact: family participation impacts on perceived legitimacy of system

Participants acknowledged that participation of families did not necessarily lead to perceived legitimacy or an increased confidence in the process. Family experiences of how independent, fair and transparent the process was impacted heavily on their perceived legitimacy and confidence in the process. Aspects identified by participants which constitute fair and effective participation will be looked at more closely in Chapter 7 but certain aspects are highlighted here in relation to whether they improved family perceptions about the process. Family experiences of how independent, fair and transparent the process was correlated to increased trust and confidence in the process.

6.4.1. Independence of system

Independence was identified as a key issue relating to both confidence in the inquest system and its legitimacy. LA2 and LA6 both thought family confidence in the system relied in part on their perception of whether the process was completely independent and not biased to "the other side" (LA2). IPCC noted they had to be very careful to be sure they were not perceived by any parties to be biased.

Concerns were raised about a lack of independence in relation to both investigations and coroners themselves. One issue mentioned was the fact IPCC investigations were not perceived as independent of the police for two reasons; firstly, because they relied on police to carry out investigations and secondly because a high proportion of IPCC staff were ex-police officers. LA1 thought although there were high hopes when the IPCC came in, lack of independence (as exemplified by almost all officers being recruited from the police) and transparency had led to "a fundamental lack of trust" and "fairly wide acceptance [that the IPCC] is just not fit for purpose". LA6 gave the example of the Duggan case

where a witness went to the BBC instead of the IPCC because they did not trust either the police or IPCC.

ESP2 and LA6 pointed out the IPCC had a lack of resources, so often had to rely on the police to carry out parts of the investigation; in particular securing and searching the scene of death. FA5 were dismayed to find the IPCC relied on the police (who were not independent of those involved in the death) to carry out the investigation and consequently lost confidence in the system. ESP1 and LA6 said "some people don't have much confidence" (ESP1) in the independence of the IPCC as they often have ex-police working on investigations. FA5 said once they realised how the IPCC was made-up, they did not consider it to be properly independent leaving them with "absolutely no faith in the IPCC, whatsoever". FA2 agreed, saying that when they realised IPCC investigators were predominantly ex-police it left them questioning the independence of their investigation.

However some participants (ESP1, CO2, CO3, CO4 and FA3) thought a lack of confidence in investigating bodies only reinforced how important perceptions about coroners were to maintain confidence in the whole system. ESP1 thought the inquest process could provide independent scrutiny and transparency which "adds a layer of legitimacy"; they believed the public had more confidence in the inquest system than the IPCC and therefore saw it as more legitimate. CO2, CO3 and CO4 all said families' perceptions of whether the inquest process was independent was very important; with CO4 saying they were careful to do nothing that "could be said to [be] compromising your judicial independence". FA3 was very concerned about the lack of independence of the hospital investigation but was satisfied as the coroner instructed independent expert witnesses.[658]

Problems were still identified which limited the perceived independence of coroners; the first being that they were sometimes seen to be biased to the State. CO1 suggested an "open channel of communication" between coroner and State parties could ensure a good working relationship but

[658] This was even though the jury actually agreed with the hospital expert, not the independent witness.

acknowledged this might be perceived to impact on the independent decision-making of the coroner. LA2 thought families lost confidence in the system if the coroner appeared to be biased and sympathetic towards State parties. LA3 said coroners sometimes treated families (especially unrepresented ones) as a nuisance, but were more positive towards State parties. FA1 felt "the coroner was on the prison side" in their inquest. FA4 felt the same, saying it was obvious the coroner was biased to the State party as "he accepted the police thing word for word". Two participants (CO1 and SP1) were concerned coroners could be biased towards families. This might impact on perceptions of other parties, but this thesis is focusing primarily on the possible relevant of procedural justice theory on perceptions of families.[659]

Another concern raised was links between coronial staff and local police: regardless of whether that police force was involved in the death. CO4 acknowledged both their coroner's officers were retired police officers. ESP2 explained their local coroner's officers were serving police officers:[660] and noted this had a large impact on the process as, in practice, a lot of initial decisions were made by coroner's officers.[661] FA5 made a distinction between the two coroner's officers, one of whom was a police officer: saying they felt more comfortable with the non-police officer. FA2 were concerned when they realised the coroner's officer was not just ex-police but friends with one of the officers whose actions were under scrutiny.[662]

A closely related issue raised was the fact coroners relied heavily on police or other investigating bodies to gather evidence and investigate the death which restricted their independence. FA3, FA4 and LA6 all thought this limited the capacity of the coroner to oversee an independent process. Both FA3 and LA6 were clear this decreased the legitimacy of the inquest. FA3 thought this was particularly

[659] SP1 thought coroners tended to be biased towards families as "aggrieved families" were the only ones likely to appeal coroner's decisions, however this is not accurate, as appeals are also often on behalf of State parties.
[660] Detached to the coronial staff but still actually police employees.
[661] For example, coroner's officers will often decide who to ask to carry out the post-mortem as well as being the point of contact for families.
[662] In fact, they felt the officer in question was given preferential treatment: for the example the officer was able to sit through the whole hearing before giving evidence whereas other witnesses were unable to sit in the hearing until they had been questioned.

relevant in relation to deaths in secure hospitals, where investigations carried out before the inquest were not independent at all.

Participants suggested a perceived lack of independence in the system led to families having little confidence in either the process or the outcome. PPO, LA1 and LA2 all linked perceptions about the independence of the process with how confident families were that the correct outcome was reached. FA2 found their confidence in the inquest was questioned when they felt the coroner's staff were biased to the police. The discretion left to the coroner and their staff means their impact on the process is huge, therefore their perceived independence will always be important.

6.4.2. Fair process

The perceived fairness of the process was also very important to families and could lead to increased satisfaction and acceptance of the outcome. LA4 said in their experience, families were always satisfied if the coroner had been fair throughout the process. LA5 thought there were intrinsic complexities involved with most custody deaths which meant fairness during the inquest process was incredibly important. CO1 and CO2 said, regardless of the outcome, the most important thing was for all parties to feel the process had been fair.

Family participation was suggested to allow families to assess the fairness of the process and ensure they perceived the inquest as distinct from other agencies which could help their acceptance of the outcome. CO3 said the bereaved family could start by feeling antagonistic to the coroner but by allowing them to engage fairly, by the end of the process they could be satisfied and even grateful to the coroner.

FA2 were concerned when the process appeared unfair, even when it was other parties who were being treated unfairly.[663] FA4 agreed saying they were convinced the correct processes should be followed, not because it might have changed the outcome but because "that is only fair and proper". Perceived unfairness left the family with no confidence in the outcome or in the inquest system. FA3 also thought the most important thing was to have a fair process with balanced evidence, regardless of whether it changed the final outcome. LA2 thought families did not mind other parties protecting themselves as long as ultimately the process was fair. Perceptions about fairness were linked with both legitimacy and confidence in the outcome.

6.4.3. Transparent process

Another aspect identified as important to influencing perceptions of legitimacy was the transparency of the process: in particular whether families perceived State parties as being honest and upfront with them. Negative examples were given where families felt State parties were not being honest so they lost confidence in the system or struggled to accept the outcome. FA4 said they lost confidence in the prison when they lied to them about details (such as which cell the deceased had been in)[664] and gave them inconsistent information about important facts[665] so the family felt the prison were not being honest with them.

CO1 (in their role as legal representative for State agencies) thought that if State agencies were open with families from the start, then families had greater trust and confidence in the State as they perceived them as being transparent. FA3 also thought State parties acknowledging mistakes not only

[663] They gave the example that the press had reported two police officers had lied about what happened, which the coroner said the jury were not to be informed about, but then a barrister for another party "accidentally" showed the jury the press report. Although FA2 thought the jury should have been told about this, they were unhappy with the way it had happened as "things like that shouldn't really be going on".
[664] FA4 Father was taken to one cell to pay respects following the death but when he went back to the prison to take photographs, they took him to a different cell and pretended it was him that was confused.
[665] Such as who was present when the deceased was found and what time they were found.

increased families' confidence in the authorities but also improved public confidence in, and therefore the legitimacy of, the State agency. FA5 said immediately following the death, they implicitly trusted State officials but when they started being evasive, FA5 lost confidence in them. FA4 felt the same, saying they started by wanting to trust the State officials but in the end concluded they could not as they seemed them to be hiding things from them.

Most concerns mentioned related to the State agencies involved in the deaths, but as with the previous section, a transparent investigation or inquest process could also impact positively on perceptions. FA5 made a distinction between the State officers involved in the death and those investigating the death: their confidence in the investigation remained strong as they thought the two officers were thorough and kept the family well-informed, as well as responding promptly to questions; so they felt they were being open with them. Similarly, FA3 made a distinction between the State agencies and the coroner; they lost confidence in the former when they became aware the State were only providing them access to the evidence "under duress" but were confident the coroner wanted a transparent process. It is therefore clear a transparent inquest process could lead to families accepting the outcome and feeling the system was legitimate although this would not necessarily change perceptions of State officials involved. Similarly, participants thought where families were supported to effectively participate in the inquest process, this left them feeling the whole process was transparent. Both IPCC and LA1 thought effective participation for families had a big impact on whether they found the system transparent and therefore accepted the outcome and could be confident in the legitimacy of the system.

6.4.4. Legitimacy of process

Family participation impacting on the legitimacy of the inquest system was seen as key by participants, partly due to the purpose of the system of investigating deaths in custody which involved

both closed (and therefore non-transparent) institutions and potentially contentious issues in terms of duty of care. CO1 explained inquests into custodial deaths were distinct as there was always an understanding, not that the deaths were necessarily controversial but potential criticisms of the State could be investigated. CO3 said one of the reasons they encouraged legal representatives (for all parties) to be involved in questioning was because it provided a perception of legitimacy for all parties to be engaging with the process. FA2 felt very strongly that as the State duty of care was under scrutiny, it would not be legitimate for State bodies to participate without ensuring equitable participation for families.

Some participants (LA6, FA1, FA3, IPCC and SP1) linked the general reform of the system and increased family participation with increasing legitimacy of the system via increased public confidence. LA6 said in their experience, the reform of the inquest system over the last 30 years ensuring greater family involvement in the process, had increased legitimacy in the eyes of the public. FA1 felt that if families could participate fully (with Government funding for legal representatives) in inquests following prison deaths, the penal system would be improved and therefore public confidence in the system would increase. FA3 thought what was "damaging to the public confidence and legitimacy" was when State parties were defensive and did not treat families fairly or respectfully. IPCC admitted inquest verdicts did have an impact on public perception of the police, although they were not sure whether awareness of family participation also had an impact. SP1 was clear that the perception of an inquest being independent, transparent and open to the public was vital to the legitimacy of the system; even if the public did not attend or know much about the process, "it's the symbolic nature".

6.4.5. Trust in the process

Participants believed a benefit of family involvement was that it allowed them to judge the process for themselves, which could result in them trusting both the system and the outcome. Two coroners

(CO3 and CO4) acknowledged that perceptions about the coronial system could be negative to start with, but engaging with the process allowed families to feel more positive. CO3 noted families sometimes saw the system and coroners in particular as "archaic, old-fashioned", but participating in a fair process could change their minds. CO4 thought if families could participate effectively they saw an inquest as a "living investigation[s] to come [……] to answers, to help people come to terms with [the] death". When FA3 realised their coroner was happy to challenge the State and stick to the law, they trusted they were going to get "a proper inquest".

FA3, FA4 and FA5 all thought they could only trust in the outcome when they had been able to assess the evidence presented themselves and understand the process. LA2 and ESP2 agreed that trust came from fair participation, and families being "able to go through the process" (LA2). It should be noted that sometimes family participation led them to challenge the legitimacy of State agencies, even if the inquest system is seen as fair and therefore legitimate. FA4 felt the inconsistencies and mistakes made after the death meant a fair inquest was unable to make up for the failings in the investigation. It should also be acknowledged that if families participated in an inquest process they did not feel was fair, independent or transparent, they would be likely to mistrust the process and see it as illegitimate.

6.5. Conclusion

This chapter set out the importance of a transparent, legitimate system to assess State actions restraining and detaining individuals, to ensure they are carried out within established legal frameworks. State actors may be called 'citizens in uniform' but they are in unique positions that separate them from a citizen.[666] They have responsibilities to prevent crime and secure peace and are consequently given powers with which to carry out their duties. It is fundamental to the rule of law

[666] P. Scraton and P. Gordon, *Causes for concern: British criminal justice on trial* (Penguin Books 1984), p 17

that when a State uses its power against a citizen, it must apply its own previously stated rules as understood by the citizen.[667] They have a duty of care to the public and it is in recognition of this that the *Hill* defensive principle of common law was established.[668] This stated if State officers were worried their actions would be too heavily scrutinised, this might lead them to take a defensive approach which could be damaging in terms of officers failing to protect individuals. It is therefore arguable that jurisprudence allows them greater benefit of the doubt in matters such as use of force compared with members of the public, who do not have a duty of care. There are very few prosecutions for use of force or other actions by police or prison officers that result in death. This means an inquest is often the only place where State officers are held to account; which is a key aspect to Article 2 procedural obligations.

Participants were clear that ensuring accountability was a key aim for the inquest system and that families played a vital role in achieving this. It was argued families' benefited accountability in a number of ways including providing scrutiny of State actions (therefore optimising a fair outcome), providing assistance and balance to the process as well as ensuring lessons are learnt following an inquest by instigating change. There are numerous examples where family campaigns have been key in changing the rules governing State action[669] and investigatory bodies[670] but this chapter focused on changes to the inquest system itself.

Wider intrinsic value to family participation was identified as improving the legitimacy of the system, not just as perceived by the family but by the public as well. Participants supported procedural justice

[667] Fuller, p 217
[668] *Hill v Chief Constable of West Yorkshire*
[669] See amendment to rules governing use of restraint in youth custody institutions: UK Government Ministry of Justice, *The government's response to coroners' recommendations following the inquests of Gareth Myatt and Adam Rickwood* (2010)
[670] See change in policy to prevent officers discussing what happened before giving evidence after a police shooting: https://www.ipcc.gov.uk/news/ipcc-calls-action-officer-note-taking & http://www.pfoa.co.uk/211/post-shooting-procedures

theory where perceptions that the process was independent, fair and transparent improved perceptions of legitimacy and resulted in families accepting the outcome and trusting the system.

Chapter 7: ASPECTS NECESSARY FOR EFFECTIVE PARTICIPATION OF BEREAVED FAMILIES: EMPIRICAL EVIDENCE

7.1. Introduction

The previous two chapters presented the reasons why it was important for bereaved families to be allowed to participate in an Article 2 inquest. This chapter summaries participant views on what is required for participation to be effective. As discussed previously, families have different reasons for wanting to participate in an inquest, so they might require different things to ensure their participation is effective in fulfilling their needs and protecting their legitimate interests. Some participants (CO1, IPCC and PPO) also pointed out that not all families wanted to participate fully in the process. Both IPCC and PPO said families all wanted to engage on different levels during investigations; some wanted to know everything and have a lot of input, while others did not want to comment or even see information. This was also said to be true during the inquest process, with CO1 pointing out that each family was unique so levels of participation during a hearing consequentially differed. IPCC felt the amount of contact the family had with the deceased prior to the death was a determining factor on family engagement; saying in their experience, families who were in close contact with the deceased were more likely to want to be involved in the process.

Family participants (FA2, FA3, FA4 and FA5) felt the biggest challenge for families who wanted to engage was that the system did not recognise families had varied needs and might want to "deal with things differently" (FA5). FA2 were initially very depressed after the death of their loved one which left them with little motivation to engage with the investigation process but other families (FA5) wanted to be involved in everything from the start.

Another factor participants noted was that family structures influenced how involved families wanted to be in the process. FA2 thought engagement without a large family was difficult as it was time consuming and emotionally draining. FA5 felt their engagement was more complicated as each member of their large family wanted to participate on different levels and at different times.[671] LA4 agreed that they often saw families whose members wanted to engage on different levels.

This chapter identifies generalities as to what can assist participation for those families that do want to engage; allowing for the fact each family is unique and therefore there will always be some aspects that are more important than others for different families. It should be acknowledged that lawyer and family participants' views relate to families that wanted to engage; and although coroners and investigatory bodies may have come into contact with families who did not want to engage, generally most of their experiences are of those families who participate actively.

7.2. Right to participate

7.2.1. Right to be heard: voice of the deceased

Chapter 5 illustrated that an important aspect to families' participation in an inquest is to ensure they are able to represent the deceased through the process. This chapter begins by considering how this can be achieved. Three coroners (CO2, CO3 and CO4) gave examples of how they allowed families to ensure the voice of the deceased was present; including putting a photograph of the deceased on the bench, asking the family how the deceased should be referred to (such as their first name etc.;) and allowing a statement about the deceased to be read out. FA5 was allowed to tell the inquest about their memories of the deceased. Although neither FA3 nor FA4 felt there was sufficient space in the process for them to represent the voice of the deceased, they did explain that small things could make

[671] It should be noted FA2 agreed that as next of kin, it was difficult as they had to not just be point of contact with official agencies but also coordinate the different needs of family members.

a difference. FA3 felt the coroner brought the focus back to the deceased by concluding all hearings by expressing condolences to the bereaved family. FA4 said that when one of the days of the inquest fell on the anniversary of [the deceased's] death, the coroner held a minute's silence, which they appreciated.

It is clear that small actions can be taken which ensure the deceased as a person is not forgotten through the process. Obviously family participation is key to this, as those most likely to be able to represent the deceased.

7.2.2. Right to Influence: access to the process

Fundamentally important to allowing effective participation is ensuring families have access to the inquest process, which includes making sure they are fully informed about the process (including their rights) as well as practical issues that can impact on attending the hearings themselves. A vital step in ensuring families are kept informed about the process is for them to be identified as interested parties.[672] One of the primary ways coroners identify who should be the interested party for families is to look to the next of kin (or their representative if they are minors).

Some participants (LA1, LA4, LA5, CO3 and IPCC) said coroners sometimes restricted interested party status to the one individual identified as the next of kin, which could cause problems. Both IPCC and CO3 had seen cases where the coroner refused to deal with more than one identified next of kin and nobody else in the family was allowed interested party status; which was technically within the rules but they thought not very helpful. LA1, LA4 and LA5 said they similarly found coroners preferred to designate one family member as an interested party which meant only this individual could access their legal rights. Participants pointed out a complication from this approach was that the individual

[672] A coroner must identify anyone who has a legitimate interest in the outcome of the inquest; which includes not just family members but other parties such as prison or police officers involved or representatives of insurance companies.

designated as interested party had to represent the needs of the whole family, which was noted as being a huge strain. FA2 said in their case they had a large family so had had to deal with a lot of people who were ringing constantly and putting their own viewpoints across.[673] This was not an uncommon situation with other participants saying they had seen participation in complicated inquests tearing families apart. IPCC said they had experienced families turning on each other. LA1, LA5 and LA6 had all worked with families who fractured under the pressure of the process. LA5 and LA6 had experienced cases where families had come to disagree with the family member initially identified as the point of contact, which made it very difficult.[674]

Another problem mentioned was that it could sometimes be difficult to identify the next of kin; particularly in large or broken families. ESP1 agreed it could sometimes be very difficult to identify one next of kin; giving the example of a deceased having been married to one person but living with somebody else. Both ESP1 and LA1 had seen coroners ask the family to identify a single point of contact even if different family members (for example parents and partners) were not on speaking terms. LA4 said where families were split, with parents having new partners, expecting them to work together as one interested party with one lawyer was unrealistic if not impossible in some cases. LA5 pointed out that designation of a single point of contact had a negative impact on funding, as even where families were split, legal aid was only available to the person identified as next of kin. Access to funding and legal representation will be discussed further later.

A number of participants pointed out that although it was within the rules to identify only one point of contact as an interested party, it was possible to give more than one family member interested party status. Both ESP1 and IPCC said if families were split the police would designate multiple Family Liaison Officers (FLOs) so different parts of a family could be dealt with separately.[675] CO4 said

[673] FA2 gave the example that at one point in the process, the press had reported family connections inaccurately, and members of the family expected them to deal with it: they were "ringing me up of a night and having a go".
[674] LA5 pointed out there were practical difficulties if families wanted to change who was their point of contact because the original person had been officially designated as the legal representative's client.
[675] Which was beneficial if different members of a family did not talk to each other.

whenever the family was split, they made sure everyone who was a properly interested person was able to participate. FA3 and FA4 both thought it was important for all family members to be involved, with FA4 Father saying there was a benefit in family members who were not grieving the most being involved in the process as they could be less emotional. FA3 said in their case, other family members were allowed to ask questions, although they were not the next of kin and not legally represented so were not able to participate fully. It is clear the system allows sufficient discretion for multiple family members to be given interested party status, and therefore participate but this flexibility is not always utilised effectively.

7.2.2.1. Information about system

One of the primary difficulties mentioned that prevented families participating in an inquest was a lack of understanding about the process. Participants pointed out that inquests were unique processes and little understood apart from those who engaged with the system regularly; which meant families needed basic information in order to understand the process. LA3 and LA5 said the inquest process was alien to most people so families generally did not "have an understanding of what it's supposed to be". LA3 and CO1 thought the title 'coroner's court' led families to believe the process would be similar to criminal hearings. LA2, LA3, LA5, PPO, ESP1, ESP2 and SP1 all thought it was very helpful for families to have the inquest process explained to them as it prevented misunderstandings and helped manage expectations. LA2 said, in their experience, if families understood from the beginning what was likely to happen during the process, they found it less frustrating. CO3 agreed that managing families' expectations from the start led to them being more satisfied with the process. ESP2 said it was only natural to be more satisfied and accepting of something you either expected to happen or at least were prepared for in advance.

CO2, CO3 and CO4 all agreed good coroners should (either themselves or through a member of staff) speak to families directly to make sure they understand the process and know what to expect. None of the family participants had experienced such a personal process and all suffered from a lack of initial information about the inquest process. FA1, FA2, FA3 and FA5 all received little information from the coroner's office and said one of their biggest worries was they had no idea about the system or what to expect. FA5 said they felt "very, very at sea" and FA1 felt like they had been "thrown in a big hole" without any advice on how they could get out of it.

All family participants wanted better information about the system from the coroner's office but also thought there should be better signposting to organisations like INQUEST, which could provide impartial advice. FA5 said they had only found support by googling 'inquests' and FA3 felt it was only through "incredible good fortune" that they were directed to INQUEST. Although IPCC said families should receive signposting information from the outset from IPCC officials, LA2 said in their experience the PPO were far better at signposting families to either INQUEST or specialist legal representatives. Family participants (FA2, FA3 and FA5) indicated signposting did not always happen, and often they struggled to find anyone to advise them on who to contact.

Another issue to consider is how information should be provided to families. As discussed earlier, families are all unique and therefore have different views on how much information they want to be given at any one point and in what format. FA1 said they wanted to have simple, straightforward hard copy information; whereas others (FA2 and FA5) said they did not understand the hard copy information they were given and wanted to have people to contact to answer questions. It should be remembered that immediately following a death, next of kin may be too distraught to retain information given to them, which is why different approaches should be available. FA5 said that when they first met with the police, they struggled to retain and understand what they were saying. One solution is to ensure families are signposted to support organisations but also provided with basic

facts about the inquest system in multiple formats (such as hard copies, websites and point of contacts).

In order for families to engage with the process, it is important they are aware of their rights. Participants explained a failure in families being informed about specific rights limited their participation. FA5 said they were not given any information about what their rights were. FA3 said they had not realised at the start that they had a right to be informed about what was happening at all.[676] FA4 said they did not know they could appoint someone to attend the post-mortem on their behalf and "were kept in the dark about things like that."[677] Unfortunately current rules do not require families to be told they have a right to be represented by a lawyer and to have access to evidence gathered during the investigation. LA2 said often families only realised they could have a solicitor by reading about other cases in the press; other families were only signposted by INQUEST. CO1 explained the current rules for disclosure to families stated "if they ask, you have to give it to them" but if families were not told about their rights, they did not know to ask. FA2 were not sent any information about the process and later realised this was because they had not asked.

Participation in an inquest process starts soon after the death has occurred, so early provision of information and support is the first step to ensuring fair participation for families.

7.2.2.2. Access to engagement during the hearing

In addition to families being given relevant information from the start of the process, participants identified issues with access to the hearing itself. One of the problems identified was the lack of details about the inquest hearing. FA2, FA4 and FA5 all said they had been given little or no information about

[676] In fact, they were told they could not be told anything about the investigation while it was "an ongoing inquiry".
[677] The rules require the next of kin to be informed about when the post-mortem will take place and allows them to nominate a representative to attend on their behalf, but families are not necessarily aware of this.

when and where the inquest would take place. FA2 said their biggest worries about participating were practical ones: "where will I go, and who'll be there and where will I sit and will I have to sit on my own?"[678]

Additional worries identified by families related to having to take time off work for weeks to attend the inquest, find childcare for the same time frame, travel the distance to the courtroom and then find convenient parking. FA2 said the practicalities of attending the first inquest "were just a nightmare"; they had to drive 60 miles every day for six and a half weeks as well as finding childcare for that period. FA5 suggested it would be incredibly helpful if coroners provided families with details of how to find the location and possible places to park.[679]

Coroners were aware of practical difficulties some families had in attending inquest hearings but CO4 and CO2 both said that in their respective areas there were a limited number of suitable locations that could be used. They pointed out complicated inquests could take weeks and it could be difficult finding courtrooms free for such a long period; which meant sometimes families had to travel considerable distances. CO4 said if they were aware there would be difficulties with the family attending a particular location, they would try to find an alternative but it was not always possible.

Participants identified further difficulties with finding suitable spaces: local halls often did not have adequate facilities but courtrooms could be intimidating for families. FA5 said their inquest was held in a Town Hall, which did not really have enough room for all the attendees. However both FA2 and FA4 said their inquests were held in criminal courtrooms which they found very formal and intimidating. LA5 said they had seen positive examples where coroners had been "very mindful of the family" and rearranged the courtroom layout so either all parties were on the same level or families were invited to sit alongside the coroner on the raised bench. Regardless of the space used, separate waiting rooms were suggested as very important. Two family participants (FA2 and FA5) were

[678] LA1 pointed out although there had been difficulties with families not being notified about where and when an inquest would be happening the new rules should address this.
[679] The only parking FA5 found was £15 a day.

approached informally during the inquest by other parties whose actions were under scrutiny, which they both described as “awful”. They suggested a space set aside for families to sit in peace and discuss things with their legal representatives “should be standard” (FA2) and “like a little bit of a refuge” (FA5).

Formality was not just due to the space used for a hearing but some participants (CO3, CO4, LA3, LA5 and SP1) felt the process was inherently formal. CO3, CO4, LA3 and SP1 said it was difficult to make the process user-friendly as it was “a court at the end of the day” (CO3). LA5 agreed that some families found the process incredibly formal, which negatively impacted on their participation. For example, the use of technical or legalistic language was seen as an impediment to families understanding what was happening. CO2 and CO3 said they tried to minimise the terminology used as it was difficult to follow and encouraged all parties to use “reasonably user-friendly language” (CO2). FA2 said this would have been helpful for their inquest as it had felt like the process was being run in “a foreign language”.

Another aspect raised as impacting on access to the process was the delays which often occurred before inquest hearings were concluded. FA2, FA5, CO2, CO3, PPO and IPCC all said delays were likely following deaths in custody, with families having to wait five or six years before the inquest hearing. Chapter 5 illustrated the negative impact delays could have on the grief process. FA5 said another problem with the whole process taking so long meant multiple meetings and hearings which were both practically difficult and traumatic for families to attend. Although PPO and LA4 acknowledged delays were a problem, they pointed out that inquests could not be held before the report by the investigatory body was complete as the evidence was not yet compiled so some delays were necessary.

It is clear that the current system poses challenges for families accessing the process; but support and advice can certainly minimise the difficulties faced by families by managing expectation and reducing worry about the unknown.

7.3. Fair and Respectful Treatment

7.3.1. Respectful treatment

Chapter 5 set out why procedural fairness towards families during an inquest system is important. One aspect of that is respectful treatment and the next section sets out what participants thought that entailed. All participants were clear that the general approach of the coroner and other decision-makers towards families should not be underestimated in how much of an affect it had on family participation. LA4, LA5, CO1, CO2 and CO3 all agreed it was very important for coroners to ensure respectful treatment of families, as it improved the families' experience of participating but could also provide a "benefit for the process".

As discussed above, participants were clear about the benefits of coroners or their staff engaging with families early on in the process to make sure they understood what was happening. FA1, FA2, LA2 and CO4 all said if coroners allowed time to meet with families before the hearing began, it helped make the process seem less daunting and encouraged families to participate more fully. FA5 said although the coroner did not meet with them, the coroner's assistant had met with them and been very welcoming. Participants pointed out if it was not possible for coroner's to meet with families, then a simple way to ensure families felt involved in the process was to welcome them at the start of the hearing. LA2, FA1, FA3, FA4 and FA5 all thought it was beneficial if coroners simply acknowledged families and referenced their grief at the start of the process: "it's such a small thing but it's just not done, incredible" (LA2). FA1 said in their case, the coroner ignored the family completely and LA2 said unfortunately they often saw coroners who did this.

As mentioned previously, participants pointed out that families were often the only parties involved in an inquest who had no experience of the system. Participants said because families were often at a disadvantage to other parties, as well as having an emotional reaction to the process, coroners had to

ensure families felt at ease. LA3, LA5, CO2 and CO3 felt families had to be given certain leeway in how they participated as they were not professionals and therefore had to be treated sensitively and compassionately. CO3 said coroners needed to have "more tolerance, more patience, just more sensitivity" to ease the process for families. LA3 and FA1 thought coroners should take the time to ensure families did not feel like a nuisance or a "lesser class" (FA1) than other parties so they felt comfortable and positive about participating in the process.

Participants identified ways in which coroners and their staff could ensure families felt they were being treated respectfully. CO1 and LA3 suggested one approach was for coroners to take into account that families might need more breaks than other parties, as inquests were physically and emotionally draining for them. CO2 said they positioned the family at the front of the court so they could "maintain eye contact with them". LA5 said they had seen positive examples of coroners doing "simple day to day things" such as ensuring there were enough seats for family members at the inquest.

It was also pointed out that it was not always in the power of coroners to ensure a respectful environment; CO1 said all parties had to act in a reasonable and measured way in order for there to be a positive collaborative approach. LA5 agreed that it was the actions of State parties that could be disrespectful to families. Three family participants (FA2, FA4 and FA5) raised concerns that they felt other parties seemed to forget the purpose of the process was to look at the circumstances of someone's death, with FA2 saying "it was so insensitive".[680]

It is clear respectful treatment for families can be provided in simple ways without conflicting with the rules and regulations governing the inquest system. The impact of simply politely welcoming families at the start of a hearing should not be understated but it should also not overstated. FA3 pointed out

[680] All of them said they had been hurt by certain behaviour of the other parties, including officials that were laughing and joking during the inquest process and on one occasion actually celebrating a State officer's birthday with a cake in the courtroom during a break.

respectful treatment only goes so far if it is not backed up by ensuring families are treated fairly as well.

7.3.2. Fair treatment

The importance of fairness and why it is relevant for parties to perceive that they were treated fairly throughout the inquest process was discussed in Chapter 6. LA1, LA2, LA4, LA5, FA1, FA2, FA4 and FA5 all thought families often felt the process was unfair and biased towards the State parties. Factors mentioned as resulting in families feeling the process was unfair included the fact other parties were better represented, funded and supported to participate in inquests. Equity as it relates to equality of arms in terms of legal representation is discussed in the next section, but other disparities between families and other parties were raised. Three family participants (FA1, FA2 and FA5) said it felt very unfair to them that State parties were supported to attend the inquest whereas families struggled to cover the costs of participating. Both FA2 and FA5 noted all the other parties attended as part of their jobs so they were effectively paid to attend whereas the family had to take unpaid leave to be there. FA2 said “it was like really rubbing salt in the wound, the fact that I knew [the officer under scrutiny] was getting paid to attend”. FA1 thought the most unfair thing was that all the other parties were “taken care of [….] it didn’t matter what it was costing”, whereas families were left “out on a limb”. Generally, concerns expressed by participants that the inquest process did not appear to be fair related to the lack of equity between the support available to different parties; with the main issue being legal representation.

7.3.3. Equity of legal representation

All participants thought equity between parties was beneficial in ensuring a fair inquest. Both CO2 and CO3 thought this was particularly important for inquests looking at deaths in custody as “there should

always be equality of arms if you are dealing with something as serious as a sudden or unexpected death" (CO3). CO1 said, in their experience, it was rare for parties involved in inquests into custodial deaths to not all be legally represented. However, all the legal representative participants said in their experience, there was "almost exclusively in these cases a complete lack of equity" in terms of access to information and legal representation (LA1). LA2, LA3, LA4 and LA5 all identified the "inequality of arms" (LA3) in relation to legal representation, with State parties always being fully represented but families struggling to find funding to pay for one lawyer. LA4 said not just State parties but all other interested parties (such as private security or insurance companies) were always represented by legal teams. Almost all the family participants (FA1, FA2, FA4 and FA5) felt it was incredibly unfair they had to pay for their own lawyers but the legal representatives for other parties were paid for by the State. FA4 pointed out it did not seem right that State parties had experienced legal teams from the start but families were left "to fend for themselves".

An important issue raised by a number of participants (LA1, LA4, LA5, CO3, FA4 and FA5) was that because each different State party was legally represented, this resulted in "an array of lawyers" for the prison, police or hospitals (LA4). LA1 and CO3 said in most cases, State parties had multiple legal teams, as each official had their own lawyer; as did the overall police force or prison as well as the national service, senior officials and maybe the Ministry of Justice: "there can be a load of different people" (CO3). FA5 said in their case, thirteen State parties were individually represented. LA1 and LA5 said in their experience, legal representatives for different State parties usually worked together so families definitely felt "ganged up on" (LA1). Both LA2 and LA4 had similar experiences and were concerned that multiple representatives for State parties could all argue a particular view point, which might bias how the evidence was perceived. FA4 and FA5 both felt very strongly that all the State parties worked together in their respective cases. Both LA1 and LA5 pointed out multiple legal representatives for State parties were especially concerning in relation to equity as families are generally designated as one interested party (as discussed earlier).

Lack of equity was also raised in respect to the quantity and quality of legal representation available to different parties. This linked to funding (See Section 7.4.2.3.) but is also mentioned here as participants talked about differences in the number and seniority of legal representatives as an issue of equity. CO3, LA1, LA2, LA3, LA5, FA1, FA4 and FA5 all said generally families were represented by one solicitor, while other parties had large legal teams, including barristers. CO3, LA1 and LA5 said families were often not legally aided, whereas State parties appeared to have "a bottomless pit of resources to put into representation" (LA1). LA2 and LA3 said the State was always legally represented by experienced barristers. It was pointed out by SP1 that State officers needed to be well represented as it was their actions which were under scrutiny.[681] It could be argued that instead of limiting the representation for State parties, equity could be achieved by ensuring families are sufficiently funded to have similar representation in terms of quality, if not quantity.[682]

7.4. Legal Representation

All participants raised the issue of legal representation for families being linked to ensuring effective participation in an inquest process. It was mentioned in relation to fairness and equity (see previous section) but participants identified other reasons legal representation for families was vital. This section will look at the aspects which were put forward as benefits of legal representation, and what is important in ensuring families have access to legal support.

[681] It should be noted a recent case found that an individual who had been acquitted of arson (relating to a fire which resulted in a death) did not require funding for legal representation at the subsequent inquest into the death. The decision was challenged as breaching their Article 6 rights, but it was judged there was no breach as an inquest was not a criminal proceeding. *R (RJ) v Director of Legal Aid Casework* [2016] EWHC 645 (Admin)

[682] Attempts have been made in 2017 to introduce legislation that ensures parity of funding for families in cases involving scrutiny of the police. An amendment was introduced in the Police and Crime Bill: see House of Lords Debates on the Bill through 2016 and 2017 and the Public Authority (Accountability) Bill or Hillsborough Law was introduced as a Private Members Bill by Andy Slaughter on March 29th 2017.

Almost all participants (CO1, CO2, CO3, CO4, LA1, LA2, LA3, LA4, LA5, LA6, PPO, IPCC, FA2, FA3 and FA5) said in their opinion, legal representation for families during the inquest process was the most important factor affecting participation. CO2 and CO3 said families should be ably represented in all custodial death inquests "in an ideal world" (CO3); with LA1 saying it was "beyond important". Both PPO and IPCC said they always preferred families to be well represented; as unrepresented families could struggle to participate in the process which left them feeling "outside of it" (PPO). LA4 and LA5 said families could only participate effectively if they had a lawyer representing them. FA2, FA3 and FA5 all thought they would not have managed to engage with the process without legal representation.

LA2, LA2, LA4 and LA5 all thought the primary benefit in them supporting families was to ensure their legitimate interests were protected. This included ensuring families could defend themselves and the deceased during the process, with LA2 and LA3 pointing out families were often attacked or smeared through the process.

Participants generally agreed that grieving families were in a vulnerable position during the process, which made it even more important that they had support and assistance from legal representatives. LA2, LA4, LA5 and LA6 felt the fact that families were dealing with a very emotional situation meant it was too demanding to ask them to participate without having legal representatives. Both LA5 and LA2 said that even with their expertise, if one of their loved ones died in custody, they would want their own legal representative to support them through the process. Two family participants gave examples of how their emotional state affected their participation. FA4 said it was difficult to remain calm while engaging with the process (especially State officials) when you were grieving and found themselves becoming upset or angry. FA2 said immediately following the death they did not feel in a "fit state to do anything".[683]

[683] For example by making an official complaint.

Most participants (CO1, CO2, CO3, CO4, IPCC, PPO, LA1, LA2, LA3, LA4, LA5 and SP1) agreed that legal representatives were vital in supporting families, as although certain family rights were set out in law, a lot of decisions about the inquest process were left to the discretion of individual coroners. They all said the coronial system was hugely variable because so many decisions were left to the coroner, who all had "very different ways of doing things" (CO2). Both IPCC and LA1 said some coroners were not aware of the complexities of Article 2 law, which could limit the protections put in place to ensure family involvement. LA2 and LA4 both thought there was unfortunately a large disparity between the approaches taken by different coroner's in relation to engaging with families. LA4 and LA5 agreed that legal representatives could negate the disparities in the way coroners treated families. This was reflected by two family participants, with FA5 saying they felt they "would have been at the mercy of the coroner" without legal representation. FA2 also thought unrepresented families would never know they had the right to influence the process and challenge coroner's decisions. This leads on to the next section which looks at why legal representatives for families are so important in ensuring their effective participation.

7.4.1. Benefits of legal representation for families

7.4.1.1. Early access to legal representation

Participants were clear families needed to have legal representation early on in the process for full beneficial effects. CO2, CO3 and CO4 said it was very important for families to have good representation from the beginning; with CO4 saying they would "very strongly encourage" families to find representation as soon as possible in the process. CO2, CO3 and PPO all thought it was very difficult if families found legal representation late on in the process; with CO2 saying they found it "profoundly unhelpful". LA2, LA3 and LA5 all agreed it was more beneficial to represent families from an early stage, as it allowed families to be both fully involved and able to influence the process. One

participant linked early access to equality and fairness with FA1 saying they had wanted legal representation as soon as possible when they realised the State parties had representatives in place immediately following the death.

7.4.1.2. Explain inquest and custody processes

It was discussed in Section 7.2.2., that families were at a disadvantage in not understanding the inquest system and family participants mentioned finding legal representatives helpful in explaining the process to them. FA2 and FA3 said before they found lawyers, they had not known what an inquest entailed, what to ask or when to ask it. LA3, LA4 and LA5 all thought part of their role in representing families was to make sure they understood the inquest process. It was pointed out by some participants (CO2, CO3, PPO and IPCC) that if families were unrepresented, other officials had to step in and make sure they understood the process. CO2, CO3 and PPO all said it was coroners who had to explain the aim and scope of the inquest to unrepresented families during hearings. IPCC said they had been involved in cases where they had to "do a fair bit of work" explaining the process when families were not legally represented. Both PPO and CO3 said the main difficulty for coroners was to make sure families knew how they could be involved in the process.[684]

LA4, PPO, FA2 and ESP1 pointed out it was not just the inquest system that families did not understand but usually they had little knowledge about custodial systems. LA4, PPO and ESP1 said the terminology used by professionals working in custodial institutions was very hard for families to follow, if it was not explained to them. This was supported by FA2 who said, before they met their lawyer, everything had seemed to be in a foreign language. PPO was also concerned that without legal representatives

[684] An example given by CO3 was that it could be difficult to allow questions that families had as they might be outside the scope of the inquest.

providing context for families, what they heard about custody processes during an inquest might be misunderstood and appear very cold and harsh.

7.4.1.3. Legally complex

In addition to assisting families with understanding the process itself, another important factor to be considered when looking at whether legal representatives are required is whether parties need assistance understanding the law governing the process. CO3, LA1, LA2, LA4, LA5, PPO, SP1, FA1, FA2, FA3 and FA4 all said any inquests into a death in custody involved complex points of law and legal arguments were common, which required experienced legal representatives supporting families to ensure they were not excluded from participating. LA1, LA3 and LA5 all mentioned the preparation that had to be done before an inquest hearing, including legal submissions. LA5 pointed out that the level of legal preparation for a custody inquest was complex in terms of both the law and the medical or forensic evidence. SP1 agreed that inquests covered complex legal matters, so it was understandable legal representation was needed for all parties. PPO said legal complexity was one reason coroners found it difficult to involve unrepresented families. FA1, FA2 and FA3 all said they found the whole inquest process very legal, and would have struggled to understand without legal representatives.

LA1 and LA2 said they found they had to battle the State parties on issues including disclosure, the scope of the inquest, what verdicts could be left to the jury and what constituted neglect or culpability. It was pointed out by LA2 and FA4 that lack of legal representation for families could also have a negative impact on the outcome if it meant coroners only heard the legal opinions of State parties,

which could bias any decisions they made.[685] This issue also links with a point raised earlier lack of equity where State parties had large legal teams but families may only have one representative.

Another aspect raised was the issue of legal strategy which was noted by a few participants (CO1, LA4, LA5 and SP1) as being particularly relevant for custody inquests where juries were present. LA5 said even if coroners were able to assist families with the complexities of inquest law, legal strategy was still very important in building a case and bringing out the evidence you wanted. Both CO1 and SP1 pointed out inquest processes were structured differently from other legal processes which meant legal representatives had to consider very carefully how to get their message across to the jury within the limited rules. SP1 thought this involved legal representatives learning "to behave in a different way".[686] Again, the emotional state of families was an issue with LA4 and LA5 both pointing out it was very difficult for them to objectively strategise, even if they had the skill or experience.

7.4.1.4. Assist in getting access to documents

The importance of families having access to all the documents in a case will be discussed later but the role that legal representative's play in assisting families in achieving access was raised by a number of participants. LA2, LA3, LA5 and IPCC all said families having legal representation made a "significant difference" (LA2 and LA5) to the amount of documents that were disclosed to families before the inquest hearing; especially when families had to battle State parties to get full disclosure. FA2, FA3 and FA4 said this reflected their experiences, as State parties withheld evidence from them until their respective legal representatives managed to fight for full disclosure. FA2 said they were prepared "to fight tooth and nail" for disclosure but they felt very dependent on their solicitor. FA4 said their lawyer "basically had to force things out of [the State]". It was pointed out by LA4 and LA5 that, in addition

[685] The importance of families bringing balance to any decisions was discussed in Chapter 6.
[686] This links to the need for legal representatives to have specialised experience to be discussed later.

to being able to fight State bodies, experienced legal representatives also had the advantage of knowing what documents should be available, whereas families did not know what to ask for. LA6 said ultimately unrepresented families had to rely on State parties "being vaguely honest" and disclosing everything. Once families get access to all the evidence, the next step is to be able to understand it.

7.4.1.5. Assess evidence

The fact families usually lack understanding about custody processes mentioned earlier, was also referenced in relation to being able to assess any documents disclosed to families during the process. LA3, LA4, LA5, IPC and PPO all said legal representatives had to go through all the evidence on behalf of families before the inquest, as specialist knowledge was needed to be able to assess it. LA3 and LA4 pointed out that families did not know what to look for when given access to documents but expert legal representatives understood the language and practice referred to in official documents so could pick up things families might not. FA2 and FA5 agreed, saying that without knowing or understanding custody procedures they had found it impossible to piece all the evidence together, identify any gaps in documents or whether an action discussed represented correct or incorrect practice. Three participants (LA2, LA4 and PPO) said experienced legal representatives were not just useful in assessing the evidence before a hearing but being able to follow the evidence as it arose during an inquest hearing. Assessing the evidence as it was disclosed was linked as a vital step in families allowing scrutiny through questioning at the inquest.

7.4.1.6. Asking questions

The importance of families scrutinising the evidence presented at an inquest by questioning witnesses was discussed in Chapters 5 and 6 respectively in relation to the impact on families' influencing the

outcome of the process. Participants (LA1, LA2, LA3, LA4, LA5, LA6, PPO, FA2, FA3 and FA5) were clear that unrepresented families struggled to ask questions and challenge State evidence. PPO said without legal representation during the process, questioning was a very frustrating experience for families. LA6 said good cross-examination by a legal representative was the only effective way of "teasing out what really happened". FA2, FA3 and FA5 said they did not think they would have been able to question the evidence at all without the support of their legal representative. Different reasons were given as to why legal representatives were vital in assisting families in questioning the evidence, including their emotional state, the need for skilled cross-examination and their lack of knowledge about custodial practices or the inquest system.

Firstly, the emotional state of families mentioned previously was thought by some participants (LA2, LA4 and LA5) to leave them at a distinct disadvantage in being able to question witnesses. LA2, LA4 and LA5 all pointed out that attending inquests was traumatic for grieving families, and it was "simply not possible [for them to] take an objective stance and to be able to question those people" (LA2) without support from legal representation. Secondly, the fact that legal representatives were more skilled at cross-examining witnesses was mentioned as being important in finding the truth. LA2, LA4 and LA6 all said in their experience, State parties did not want to admit anything if they could avoid it, so legal representatives had to question them in a way that would bring out "all the facts" (LA4). FA4 said their barrister "basically had to force things of the witness", which ultimately introduced evidence not previously mentioned in their witness statements. Thirdly, the lack of understanding about custodial practices was raised (as discussed above in relation to identifying and assessing relevant documents). PPO, LA2 and LA3 said unrepresented families struggled to understand the evidence given at an inquest which left them unable to fully question anything presented by State parties. LA3 said this meant issues relating to fault or neglect were not always identified. Fourthly, the fact families did not understand the inquest system was raised by a number of participants, who pointed out the scope of hearings were limited by law so only certain questions were permitted. CO1, CO3, CO4 and IPCC all said families often wanted to know the answer to questions which were outside the scope of

the process and legal representatives could help explain this to families as well as advising them which questions were permitted. FA2, FA4 and FA5 all said their respective legal representatives had taken the family concerns and crafted them into questions that were allowed. They all thought this approach had been very effective in helping them participate, as it had allowed the issues they wanted to be raised during the inquest.

It was suggested by CO3 that coroners could take on the role of questioning on behalf of unrepresented families; so if families wanted to raise issues, the coroner could turn them into appropriate questions and put them to the witnesses.[687] CO3 and LA3 pointed out that some coroners could be relied upon to make sure all the necessary questions were asked to get to the truth, even if unrepresented families were not able to ask the questions themselves. LA2 and LA4 expressed concerns that most coroners did not have the necessary skills or experience to question parties but even if they did, it would prevent families' views being put forward. If coroners take on the role of questioning where families are not able to raise issues themselves, although the outcome may be the same, families' participation in this part of the process would be severely limited. One solution was proposed by LA4, who said when they were unable to represent a family during an inquest, they would always ensure the coroner was aware of any questions the family had, and ask for them to be put to witnesses by the coroner.

7.4.1.7. Support

In addition to assisting families with the legal nature of inquests, good legal representatives were also noted to perform a role akin to liaison officers by supporting families through the process. PPO, IPCC and ESP1 all referenced how important it was for families to have FLO's to assist them through the

[687] In fact, CO3 thought it was not necessarily a problem if families asked questions that were outside the scope of an inquest as the coroner could just ensure any out of scope issues are not put to the jury.

inquest process (this links to the need for families to have the system explained to them mentioned earlier). ESP1 and PPO both said FLOs should explain the scope of the inquest system to families; specifically what aspects relating to a death would be investigated. However, a number of participants (ESP1, ESP2, FA2, FA4 and FA5) pointed out that for deaths where State bodies' actions were under question, FLOs provided by the State struggled to provide independent support to families. ESP1 and ESP2 both agreed police FLOs were first and foremost police officers, who took on an investigatory role while with families. ESP2 did not think this prevented them also supporting families but acknowledged families might be concerned if they knew FLO's were there as investigators rather than to support them. This was reflected by some family participants (FA2, FA4 and FA5), who felt that when FLO's began acting like investigators, they could not trust them to support them. FA4 found their prison FLO was not independent as they worked with other prison staff in trying to intimidate the family. FA1 and FA3 felt the system did not seem to acknowledge how emotionally shattered families were and how necessary it was for them to have support from people who knew the process. Both IPCC and PPO said it was understandable families were frustrated during the process but that there was a gap in support available, as victim support did not get involved following deaths in custody as they were not usually investigated as criminal matters. FA2 thought families should have access to witness support schemes reflecting the service available in criminal courts.

A number of participants (IPCC, LA1, LA5, FA2, FA3 and FA5) said good legal representatives could fill the gap in the system, by providing families with support as well as legal advice and assistance. IPCC said they had seen good legal representatives act as case workers for families; which was beneficial for everyone involved in the process. Both LA1 and LA5 said families needed support and advice from legal representatives; someone "holding their hand through it [the process]" (LA1). FA2, FA3 and FA5 all said their legal representatives provided them with both practical and emotional support during the inquest process. FA2 said, their legal representative went "way beyond [their] role" and "wore

many hats in the process".[688] FA3 and FA5 said supportive and kind legal representatives made a wonderful difference and helped them feel at ease. If families feel well supported, the process is less stressful for them and therefore participation easier.

7.4.1.8. Benefit the process

The main points raised during this section relate to how legal representatives can assist the participation of families during the inquest process but participants also identified two ways in which families being legally supported benefited the process itself. Firstly, it was suggested legal representation for families improved the process by making the role of the coroner easier. CO2, CO3 and CO4 all noted if families had good legal representation it "makes the coroner function easier" (CO2) as well as making the process smoother, because coroners had to give more time and support to unrepresented families. Both PPO and IPCC agreed legal representation for families was positive in assisting the process; with PPO saying the whole process could be negatively affected when coroners had to work hard to involve unrepresented families. LA2 also felt they assisted coroners by making the process smoother when they represented families.

The second suggestion was that by assisting families in challenging the State narrative and putting alternative views forward, legal representatives helped ensure a fair outcome (as discussed in Chapter 6).

7.4.2. Challenges to legal representation for families

7.4.2.1. Adversarial

One argument used against the necessity of families having legal representation is that the inquest process is in principle inquisitorial rather than adversarial. Most participants who worked in the

[688] This included sitting with them every lunchtime, going over everything with them each evening and even liaising with journalists on the families' behalf.

inquest process acknowledged the system was meant to be inquisitorial but said in practice inquests looking at deaths in custody became adversarial. LA1, LA2, LA3, LA5 and LA6 all said although an inquest was fact-finding and not a court of blame, for controversial cases (such as deaths in custody) "the reality is that the Coroner's Court is adversarial" (LA3). LA6 said inquests became "remarkably like a criminal court" and LA1 thought "it is a complete anomaly that there is this fallacy that it's an inquisitorial process". LA2 noted that when you were fighting for the truth about what happened to a loved one, "it was not a nice and fluffy situation". ESP2 and PPO both agreed inquest processes following a death in controversial circumstances always became adversarial.

Two participants thought it was the presence of legal representatives themselves which caused the process to become adversarial. CO1 and CO2 both said although the inquest process was set up to be inquisitorial, it was "the rare custodial death" (CO1) inquest that did not have legal representation for all parties, which meant it was unavoidable the process became adversarial. However other participants pointed out it was not just the presence of legal representatives but the fact the process was deciding responsibility for deaths in controversial situations which meant "people were going to be defensive" (SP1). LA1, LA2, LA5 and LA6 all said State bodies were always on the defensive and trying to limit criticism, which automatically meant inquests became adversarial. CO1 said that (as a legal representative for NHS Trusts) they had to try and avoid shortcomings being identified which inevitably meant taking an adversarial position. Both FA1 and FA3 thought State parties would do anything to protect their image, which made it unrealistic to think you were not going to get opposing sides. This provided context of why participants felt legal representatives for families was important in ensuring equity, which is a vital principle for a fair adversarial process. As introduced in Section 6.2.2.1., participants generally agreed that scrutiny was an important part of holding the State to account, and the process becoming adversarial can be consequential to the need to cross-examine evidence.

Although participants acknowledged inquest processes became adversarial, they did not necessarily think this was beneficial to the process. SP1 said in their opinion, when inquests became adversarial this did not contribute to understanding why a person had died. CO1, CO2 and CO4 all raised concerns about situations where families wanted to use an inquest to put the police or prison on trial; which was not the purposed of the process. FA3 said they would have preferred a more collaborative approach but in their case it was the State party who had taken an adversarial stance. ESP2 said regardless of which parties led to an inquest becoming adversarial, once that situation had arisen it meant State parties did not engage in the process fully as they were preoccupied with fighting to protect their interests.

7.4.2.2. Specialist legal representation

Participants indicated that it could be difficult for families to find legal representatives with experience and expertise in complicated inquests. CO3, CO4, SP1 and IPCC all said inquests were a specialised process so legal representatives had to be experienced in order to assist families. CO3 thought "thank goodness for that" when they realised good legal representatives were supporting families. LA1, LA2 and LA3 all agreed that inquests were unique legal process and that non-specialist lawyers struggled to prepare families. LA3 said they needed to know custody processes and rules as well as inquest case law.[689] FA3, FA4 and FA5 all said it was obvious to them that inquests were unique proceedings requiring legal representatives with relevant experience. Both FA4 and FA5 had to change legal representatives as they struggled with inexperienced solicitors with no experience of complex inquests.[690] Two coroners (CO2 and CO4) thought it caused problems if families were represented by

[689] LA3 said that, as a barrister, they had to provide families with a lot more information and support if their solicitor was not an inquest specialist.

[690] FA4 said they experienced both specialist and non-specialist support as their first solicitor was very knowledgeable but their second solicitor struggled to help them at all as they did not know the inquest system.

non-specialist legal representatives who were not experienced in inquest law; with CO2 saying it was "worse [for them] than being unrepresented".

A number of participants (CO2, IPCC, FA1, FA2 and FA5) pointed out that geography was an important factor in finding specialist legal representation. IPCC, FA2 and FA5 all thought the legal representatives with the most experience were based in London, with IPCC pointing out State parties were usually represented by legal teams from London (wherever the inquest was being held). CO2 and FA1 said in their respective rural locations there were no specialised legal representatives; with FA1 saying it had been impossible to find any solicitor local to them who would take them on as clients.

All family participants pointed out it was not just geography which made it difficult to find legal representatives but, unless advised by either coronial staff or an organisation like INQUEST, it could be difficult to know who had the necessary expertise. FA5 said without being signposted, the most obvious way of finding a solicitor was to use Yellow Pages, which is how they initially ended up with someone who did not know anything about inquest law, let along custody deaths. SP1 pointed out it was not just families who needed specialist representation, and that the process could be negatively affected if any parties had inexperienced lawyers. FA3 agreed saying the legal representative for one of the other non-State parties involved in their inquest appeared to have no experience in complex inquest law, which made it difficult as both the coroner and the families' legal representative had to keep reminding of legal restrictions. Generally, though, as other parties do not have the same financial constraints as families, they are supported by specialist legal representatives.

7.4.2.3. Funding for legal representation

One aspect raised by most participants as incredibly important in ensuring families having adequate legal representation was funding. This was discussed above in reference to fairness and equity, with participants raising concerns that State parties were well-funded whereas families often struggled to

get funding for legal representatives. CO2, CO3 and IPCC all said families were "not likely to be legally aided" (CO2), which meant most families were either unrepresented or had to find a legal representative who would work pro bono.[691] LA1, LA3, FA1 and FA2 all mentioned the emotional impact on families if they struggled to get legal aid funding. LA1, FA1 and FA2 pointed out the cost of a single experienced legal representative for custodial inquests ran into tens of thousands of pounds. FA1 said they were so worried about how they would find this money, they contacted the Ministry of Justice and were told that they would just "have to sell something". CO2, CO3, IPCC, LA1, LA4 and FA2 all explained that trying to get Legal Aid funding was an incredibly complicated process. LA4 said the process to apply for legal aid was so noxious that some families did not see it through. This reflected the experiences of FA2, who said applying for legal aid had taken months and involved filling in "endless forms" about their wages, outgoings and bank account details.

One of the ironies pointed out by a number of participants (LA4, LA5, LA6, FA2 and FA3) was that applying for legal aid was so complicated that most families needed the assistance of legal representatives to complete the process. LA4, LA5 and LA6 all said legal expertise was needed to secure sufficient legal aid funding; with LA5 and LA6 saying solicitors had "to fight for every single hour of work" (LA5). LA4 said they probably spent "half my time writing to the Legal Aid Agency". Both LA4 and LA5 said they often had to take the case and put resources into assisting a family without knowing whether they would be recompensed by the LAA. FA2 and FA3 both said their legal representatives had been vital in helping them with the legal aid application.

In addition to the need for legal support in dealing with the LAA, other factors introduced as impacting on funding were the inquest being categorised as an Article 2 case, the next of kin being willing to engage with the process and the fact the LAA tended to challenge the adversarial nature of complicated inquests. Firstly, LA2, LA3 and LA4 all said families getting legal aid funding relied on coroners identifying the inquest as engaging Article 2; with LA3 pointing out that before the HRA,

[691] IPCC pointed out this was a particular issue for foreign nationals.

public funding was almost never available for even the most complicated custodial inquests. Secondly, LA4 said there were two issues relating to the family dynamics which impacted on legal aid funding; the first being that usually only the next of kin was considered for funding, so if they did not want to engage but someone else in the family did want to, they might not get funding. The second issue raised by LA4 was that the LAA needed financial details of all family members, so one person may be refused legal aid because they had a parent or sibling who had sufficient funds but did not want to use them to engage in the process. Thirdly, LA1 thought the biggest challenge for families trying to get legal aid funding was the fact the LAA said inquests were inquisitorial, not adversarial, which was both very unfair and "naïve".

The lack of equity between the State parties' legal representatives (in the form of well-funded, experienced teams) and families' legal representatives (in the form of one legal representative) was discussed earlier. A couple of participants (LA1, LA5, FA2 and FA5) said they thought this lack of equity was due to the legal aid funding being so poor. FA4 and FA5 only had a solicitor to represent them at their respective inquests (and no barrister) as they had no legal aid funding and had to pay the costs themselves. LA5 said they "cannot do many inquests on public funding" as LAA funding would not cover the full costs because the complexity of custody inquests was not recognised.[692] Even though both FA2 and FA3 managed to get legal aid funding, it only covered a proportion of the legal bill, not the full costs.[693]

Both CO2 and LA1 said a common effect of families struggling to get funding was that they did not have legal representation from the start of the process and both experienced cases where the inquest hearing started before families managed to get legal aid funding. LA6 pointed out that families found it almost impossible to get legal aid funding to judicially review any decisions or request an inquest to

[692] So the LAA did not approve sufficient hours of legal work needed to support families.
[693] LA5 said that sometimes, even if there was a successful civil case, families did not recover the costs incurred in participating in an inquest, let alone receive compensation.

be re-opened which impacts on the effect of family participation on holding the State to account as discussed in Chapter 6.[694]

The conclusion is that for whatever reason, complex inquests do become adversarial and although it might be preferable for families not to have to take the scrutinising position, in reality this is what happens and to ensure the process is fair and equitable, families should have experienced legal representation.

7.5. Access to documents

This section will set out the importance of a families' right to access documents, illustrate how this right is not fully enforced and look at how full implementation to the right should ensure families have access to information in a timely manner which allows them to digest material, assess and scrutinise it to prepare for the inquest.

7.5.1. Right to information

Access to documents was raised as particularly important in impacting families' participation in relation to deaths in custody, as it is only through the documents that families are able to find out the facts surrounding a death. LA1 and LA5 pointed out the State held the information about what had happened and it was unfair not to share it with families. FA1, FA3 and FA4 all said they relied on the reports from the investigatory bodies to inform them about what happened; with FA1 saying the report was "where I found out about everything". FA4 said families were at a disadvantage as they could not collect any evidence themselves but had to wait for the State to provide it. FA3, FA4 and

[694] This creates situations that without legal support families are unlikely to be successful in either of these endeavours but they cannot get funding for legal support unless they had already been successful.

FA5 said it was only through accessing the documents that they realised what they had been told originally had been incorrect. This disparity between what families were told by officials and what they later found out will be looked at later in relation to providing families access to documents in a timely manner.

The legal requirement under Article 2 for all documents to be disclosed to families was noted by a number of participants (LA3, LA6, CO1, FA3 and FA4) as vitally important. LA3 and LA6 said full disclosure to families should be automatic in Article 2 cases. Both LA3 and CO1 said some coroners "would not even contemplate" (CO1) giving families' disclosure unless it was an Article 2 inquest. FA3 and FA4 both said they had to rely on the law to get full access to documents before the inquest hearing. However, CO1 considered disclosure so important to participation that they always gave families full access, even if Article 2 was not engaged. LA3 said this was good practice as it ensured "a full and fearless enquiry".

Even with the legal right, families do not always obtain full access to documents for a number of reasons. A couple of participants (CO1, LA6, FA3 and FA4) said there was a lack of knowledge about the law, which was frustrating. Both LA6 and CO1 said there were still coroners who were not clear on the rules, which was why there were inconsistencies on families getting access to documents. IPCC said some coroners would not allow families to have a copy of the investigatory report before it was presented at the inquest. Both FA3 and FA4 experienced officials not knowing the law in relation to disclosure, with FA4 having to contact the Home Office to force the coroner to give them access to all documents. FA3 found the coroner had to use the law to demand the hospital trust provided the family with all the witness statements collected during the investigation.

LA1, LA2, LA3, LA6, FA1, FA2, FA3 and FA4 all said it was a struggle for families to get full access to documents in a timely manner. LA1, LA2, LA4, LA5 and LA6 said they were usually caught up in lengthy arguments with the authorities about material being disclosed to families. LA6 said it still happened "time after time" and LA1 said they could not "think of an inquest […] where there has not been a

battle for disclosure". FA1, FA2 and F3 all said it had been difficult to get access to the evidence (including witness statements); with FA2 saying it felt like "a real closed door policy".

Some participants (LA1, LA6, ESP1 and FA3) said that even where authorities agreed to disclose documents to families, disclosure was not full and exhaustive. ESP1 and LA1 were both concerned that unused material was not disclosed to families, even though this was normal practice in criminal cases. FA3 said in their case some witness statements were relied on at the inquest hearing which they had not seen previously. LA1 said they had been involved in situations where either the family had been given a list of documents but not the documents themselves or even where access had only been via LA1 viewing documents at the State offices but being unable to copy or take away documents. This latter approach would obviously severely limit participation of families, who would not see the documents at all but rely on their legal representatives to assess, scrutinise and feed back to them all the relevant details.

LA1, LA4, LA5, FA1, FA2, FA3 and FA5 all said that even where there was disclosure, there were often lengthy delays before families were given access to documents. LA1 and LA4 said it could take months or even years, with State parties often coming up with different excuses to delay disclosure. LA5 said sometimes families only got access to documents just before the inquest hearing started; this was the experience of all the family participants. FA5 said the IPCC kept making excuses about why they could not provide the family copies of the CCTV evidence and eventually only handed it over three or four days before the inquest.[695]

Participants summarised the importance of families having access to documents in a timely manner for three main reasons: firstly, that they needed to be able to prepare for the inquest hearing, secondly, that they needed to be able to scrutinise the documents, and, thirdly, that they had to be able to digest the information. IPCC, LA1, LA3, LA4, LA5, FA2, FA4 and FA5 all said there should be an

[695] When eventually provided with the CCTV, it was in an inaccessible format so FA5 had to rely on the police supplying a different copy the morning of the inquest.

expectation that families would have access to all the evidence gathered to help prepare fully for the inquest. LA1, LA3 and LA5 all thought families and their legal representatives were "handicapped" (LA3) or prevented from engaging, if not given access to the evidence to be considered by the inquest. LA4 said if they were only given the draft investigation report on the day of the inquest, it made it impossible to prepare properly. LA3 said the evidence had to be assessed so that lines of enquiry could be identified and fed into the investigation. FA2 felt left in the dark and unable to engage because they had not had sight of the evidence in time. FA4 said in their case, it was difficult to go through all the evidence just before the inquest and it would have been much easier if they had been given access to all the documents earlier.

FA1, FA3, FA4, FA5, PPO, LA1, LA2, LA3, LA4 and LA6 all thought families must be allowed to scrutinise and challenge the evidence presented at the inquest; and that disclosure must be made sufficiently early to allow this to happen. PPO said one of the purposes behind ensuring families had full disclosure of the evidence was to ensure they were able to ask questions during the hearing "in an informed way". FA2 and FA4 both said it was only by going through all the files that they realised "things don't tally" (FA4). If families do not get disclosure early enough to fully scrutinise the evidence, it might only be after the inquest that inconsistencies were identified or the inquest itself might have to be adjourned. FA3 said they were given an adjournment by the coroner for the inquest as "clearly it was out of order to hold an inquest" before they had had the chance to scrutinise the evidence. LA3 agreed, saying coroners had to be patient and wait to hold the inquest hearing if State parties were slow to disclose.

Another point raised by LA3 was that if full disclosure was not made in a timely manner, it meant any lawyer representing the family might waste time looking into issues that were not necessarily relevant. This links to the point raised earlier about families not being provided with accurate information at an early stage, leading them to create a narrative around misapprehensions. This has a negative impact on their grieving process, as it is difficult to reconstruct an alternative narrative after a period of time.

LA4 said when families were presented with evidence at a late stage in the process which turned "everything on its head", they struggled to adjust the narrative they had created to explain the death. This is one reason why it is so painful for families to hear new evidence or facts at the inquest hearing, years after the death happened. CO2, CO3, CO4, IPCC, LA2, LA4, FA2 and FA5 all said how important it was for families to have time to digest the information about a death. IPCC recognised "it has gone wrong if the first the family know about something is at the inquest". CO2, CO3 and CO4 all thought it was important for families to have time and space to assimilate evidence which was likely to be painful to hear. CO4 said one reason they held pre-inquest hearings was so they could go through the more complex or potentially painful evidence with families. LA2 agreed, saying allowing families' access to evidence in good time before the inquest ensured they had time to take on board potentially painful facts. FA2 and FA5 both said delayed access to information left families misunderstanding what had happened which could be very painful. FA2 said they were grateful they had seen the evidence before the inquest as it gave them "the chance to digest it a bit". Alternatively, FA5 said they were only able to watch CCTV footage of circumstances surrounding the death the morning of the inquest, which was "really, really hard" as they had not had time to digest it before the hearing started and the footage was shown.[696]

Some explanations were introduced as to why families were not always given access to documents in a timely manner. IPCC, FA2 and FA4 said a balance had to be achieved between giving families access to information as early as possible and making sure the information was correct. IPCC agreed families had a right to information but said they had been criticised for passing on information to families before it had been verified. FA2 and FA4 both agreed with this in principle, saying they wanted to be kept informed but only wanted the facts, not speculation. Both FA1 and FA4 had been provided with documents in a piecemeal way, without any context and found this was more of a problem than a

[696] In fact, when the footage was shown they had to leave the courtroom a few times because it felt horrible; "so sad and quite cruel".

benefit. It was discussed earlier that legal representatives could help families go through the evidence, but without legal representation, families can be inundated by documents they do not understand. IPCC and ESP2 said one reason disclosure might be delayed was if there were good reasons why information should not be in the public domain and there were worries families could not be trusted to keep material to themselves. CO2 was very clear that even if there were legal reasons why evidence could not be made public, families should always be provided with full access and could be trusted as long as it was carefully explained why material had to be kept confidential.

It is clear that families' rights to access all relevant information are vital to ensuring fair and effective participation; but families struggle to access this right fully, especially without the support of legal representation.

7.6. Conclusion

Access to the process for families should include access to information about the process and their rights as well as practical access to the hearings. Some of the pertinent issues raised were that inquests were not widely known about so it was particularly important families were given information about what the process entailed. A number of concerns were raised about the support offered by FLOs as they were lined to the State parties, which led to issues of independence. The role of organisations like INQUEST and good legal representatives were mentioned as useful in providing families with information as well as the support needed following a death in custody. Another big concern to families was practical access to the process, with family participants highlighting difficulties with accessing the locations for inquests. Coroners explained resources were a problem which did sometimes lead to inconvenient locations for lengthy inquests but certain easy steps were mentioned which could assist families such as providing them maps to the location, ensuring available parking spaces and a private area for them to use during breaks. Other issues such as the need for families to

take time-off to attend lengthy inquests as well as having to find child care on were mentioned but are not as easily resolved.

The need for families to be treated respectfully during the inquest process was seen as important by participants and again family participants identified simple steps which could improve their perceptions of the process. Ensuring families had reserved seating for the inquest, coroners taking the time to welcome the family at the start of each day and making sure all parties behaved in a respectful way by remembering the deceased were all seen as useful ways to ensure a respectful environment. However, respectful treatment can only go so far in ensuring families were comfortable participating; fair and effective participation requires families to be able to influence the investigation, question the evidence and influence the verdict. Two factors identified as fundamentally important in ensuring families had these opportunities were the support of experienced legal representatives from the start of the process and access to documents in a timely manner. Legal representatives were argued to be important in ensuring equity of parties as inquest processes following deaths in custody were always adversarial and legally complex processes. Legal representatives could also provide the support to families not offered by FLOs. The lack of funding for families to be legally represented was identified as a key barrier to ensuring equity and fair participation. The complexity of accessing legal aid without legal support was a common problem raised by both family and legal representative participants. Providing families with access to all the documents about the death in a timely manner was pointed out to benefit families as it ensured they could prepare for the inquest by scrutinising the evidence as well as allowing them to digest painful facts and incorporate them into a narrative that benefits the grieving process.

Chapter 8: EFFECTIVE AND FAIR PARTICIPATION OF BEREAVED FAMILIES IN THE INQUEST SYSTEM: DISCUSSION

8.1. Introduction

This last chapter will look at the key themes identified through the analysis of the interviews and discuss them in the context of legal and theoretical frameworks introduced in Chapters 3 and 4. The analysis of the interviews was set out in chapters 5, 6, and 7 which described how participation can benefit families themselves; how it can benefit the process; and what are important factors to ensure families can participate fairly and effectively. The empirical research first introduced why it is important for bereaved families to be able to effectively and fairly participate in an inquest process following a death in custody, both in relation to potential benefits to families themselves and wider benefits to the process. Second, the interviews introduced what the participants thought fair and effective participation looked like for families, and how to optimise this.

Chapter 5 explored what participants considered to be the key legitimate interests for families who participate in an inquest. The law allows family participation in order to protect their legitimate interests, so decision-makers such as coroners must interpret what is understood as legitimate interests and ensure participation is possible to protect these. Although domestic law does set out certain legal rights for families participating in inquests, coroners are given wide discretion as to how the process should be governed. It is therefore important coroners understand what the legitimate interests of families are, and ensure participation which facilitates their protection. Chapter 5 analysed what participants thought the legitimate interests of families should include: finding the truth and ensuring failings were identified, which participants linked to ensuring families were able to access compensation through civil cases, receiving apologies and knowing that future deaths had been

prevented. Two other legitimate interests were associated with the fact that participation could have a positive impact on families' grief process and that families represented the deceased through the process.

Chapter 6 considered whether there was an instrumental benefit of families participating in the inquest process. This went beyond families participating for their own "legitimate interests" and looked at wider benefits to the process. The key themes identified were: families' participation could have a positive impact on the likelihood of a fair outcome and disseminating those outcomes; and ensuring the process was procedurally fair. It was clear that scrutiny of the evidence was seen as vitally important, and although some coroners could carry out this role, difficulties with lack of time or resources as well as the need to be seen as being unbiased meant it was thought families were better placed to do so. Effective participation therefore benefits the outcome. Examples were given of engaged families driving necessary changes to prevent future deaths. It was also shown that effective and fair participation could lead to families perceiving the process as fair, independent and transparent which increased their trust and confidence in the outcome; all of which increased perceptions about the legitimacy of the system. This supports procedural justice theory established for interactions with the criminal justice system.

Chapter 7 analysed factors which participants saw as important in ensuring fair and effective participation, thus maximising the likelihood that the benefits raised in Chapters 5 and 6 were achieved. Key themes identified here were ensuring families could access the process; that they must be kept informed about the process and the evidence to be presented; that they must be supported by experienced legal representation and be treated fairly and respectfully. There are certain rights in place to support families accessing the process, getting disclosure of evidence and being allowed legal representation. However participants highlighted challenges which restricted full realisation of these rights. It was also pointed out that if families found it challenging to access their rights, this had negative impacts on how families perceived the process and the outcome.

Key themes identified within these chapters will now be discussed, referencing relevant law, theory and practice. This chapter will argue that ensuring fair and effective participation for families can protect their legitimate interests but also go further to maximise instrumental benefits for a fair outcome and have intrinsic benefits by increasing the legitimacy of the process and the wider system. The chapter concludes by setting out requirements for ensuring fair and effective participation for families, including necessary reforms.

8.2. Family participation protects their legitimate interests

Although families may have different reasons for participating in an inquest, the interviews identified that learning the truth, identifying culpability and preventing future deaths were often prominent interests. Participants understood the importance of the legal framework setting out the rights families had in relation to participation but it was felt that ensuring participation for families was still very much left to the discretion of the coroner. Although the main themes of learning the truth, identifying culpability and preventing other deaths are established in law, participants felt that the interests of families were not effectively represented for two reasons. Firstly, how the inquest process relates to a family's grief process is not recognised; for example, delays to a family learning the truth negatively impacts on how that family process their grief. Secondly, the fact families represent the deceased through the process is not acknowledged. These two aspects need to be taken into account for the effective protection of families' interests.

8.2.1. Legitimate interests of families

Participants generally felt families should be able to participate as those most affected by the death as victims in their own right; rather than solely as representatives of the deceased, who are the direct

victims of any Article 2 violation. Where families were participating in an inquest as victims, participants suggested their legitimate interests might include the right to the truth, financial compensation or receiving an apology. All of these could come under the broad definition of families accessing redress. Participants generally thought it was difficult to clearly define what might constitute the legitimate interests of a family partly because families are all unique and partly because they thought legitimate interests could be very context specific. Participants who were legal representatives said there was difficulty in defining what a family's legitimate interests might be because, firstly they might not know themselves, and secondly their interests could change during the lengthy process. It was acknowledged that a family's interests may divert from what their own lawyers might see as important, let alone what decision-makers may see as families' legitimate interests. Case law establishes assessing State culpability, learning the truth and knowing future deaths are prevented as possible legitimate interests for families.[697] It is important, if going beyond what is established in law as legitimate interests for families, that their views are considered.

Participants said they thought families all had different reasons for being involved in an inquest; although understanding what happened to their loved one was often fundamental. Deaths in custody usually occur in a closed environment; even deaths following interaction with the police can be when the individual is already in police custody. This means it is unlikely for family members to be present immediately prior to any death and therefore they rely on the police or prison staff who were present to inform them about what happened. The importance of participation in a process looking at a death which occurred in a closed environment was raised as key by participants. The likelihood that families would have no other way of finding out about the circumstance surrounding a death was central to why participants said participation in the inquest process was vital, so families could understand for themselves what happened. It was also pointed out (particularly in reference to deaths that occurred in prison) that families may have had limited contact with the deceased prior to their death; with the

[697] *Letts v Lord Chancellor (2015)*

inquest being the only opportunity for families to hear about the circumstances prior to any death (not just the circumstances causative to any death).

Participants agreed that for many families, their main aims in participating were to ensure mistakes or failings were identified and State agents were held to account for any actions which were causally linked to a death. Accountability will be considered later in this chapter but identifying issues that were causally linked to a death was thought to be important to families for two reasons. Firstly, any finding of negligence could be linked to a family receiving compensation through civil action. Secondly, participants felt it was very important for families to hear acknowledgment of any mistakes and be assured that lessons had been learnt so future deaths could be prevented.

One legitimate interest referenced by both families and their legal representatives was being able to access the civil system to be awarded compensation if an inquest verdict found that failings or negligence contributed to a death. Civil cases were referred to as important by participants, in ensuring the State compensated families fairly as well as assisting families with the costs of participating in the inquest process. Families were clear that participating in a complex inquest could be very expensive for a number of reasons and in particular because of the cost of specialist legal representation. In Chapter 7, families talked about the expense of specialist legal representation, with some legal representatives saying civil cases were the only way families and their lawyers managed to recoup some of their costs. Participants made it clear civil compensation did not always cover all the costs, especially when additional expenses included the need to take time off work, travel costs and funding child care for multiple meetings and hearings over a period of years, during a lengthy and drawn out inquest process.

Participants also thought that receiving compensation represented an acknowledgement on behalf of the State authorities that they had failed in their duty of care to the deceased. Family participants referred to the importance of some sort of apology from the State, which could take different forms, including simply stating regret for the death, acknowledging mistakes or failings, making firm

commitments that lessons had been learnt and actually apologising for any culpability in the death. All of these have distinct nuances, as State officials can regret the death occurred without acknowledging responsibility for it but it is clear that for some families, even the former can provide comfort. For some families, the most important thing to result from the State apologising for a death is an assurance that future deaths would be prevented. This form of redress for families is linked to holding the State to account but relies on the truth being established. Accountability can mean many different things but the small part an inquest may play relates to ensuring the facts of a death are understood and any State failings identified.

Participants understood the importance of the legal framework protecting the right of families to participate in the process. European case law only gives families a right to participate in order to "protect their legitimate interests", which leaves broad discretion to decision-makers on how to ensure compliance with this aspect of Article 2. Domestic case law defines legitimate interests as including being able to assess State culpability, learn the truth and be confident future deaths will be prevented.[698] Participants pointed out that domestic law provided more specific guidance to coroners as certain rights are established in statute (such as the right to be present or to send a representative to witness the post-mortem)[699] which give families, lawyers and coroners a reference point. Such clarity is beneficial to coroners if they are interpreting Article 2 protections, as participants felt that often families and their legal representatives had to remind decision-makers of the rights established in law to ensure families managed to access the process.

[698] Ibid, para 70
[699] Coroner's Rules 1984. No 552, Rule 7

8.2.2. Participation impacts on grief process of bereaved families

Learning the truth is set out as a legitimate interest for families in UK case law,[700] but participants linked learning the truth with assisting families to come to terms with their grief; with the facts established at an inquest playing a key part in families getting closure following a death. This can be linked to grief theory, as described in Chapter 4, following sudden deaths which suggests that truth can be important for a bereaved family member being able to process their grief following a death. Family participants said how important it was to know the truth; and for what they were told to make sense. FA4 Father said "If it falls into place, you accept it. Fine, if it is done properly." It is therefore very important that families have confidence in the facts as presented either by State agencies or the outcome of the inquest; so they can trust the narrative and are able to then move on through the grief process.

Participants were also clear that any delays before they were given the truth had a negative impact on their grief. Access to information as soon as possible is therefore very important in helping families create an understanding of what happened. It was also clear that mis-information at an early stage could be damaging for two reasons; firstly it could be painful for families, and secondly because it allows families to create an inaccurate narrative. Mis-information also means that if families were initially given information that was wrong, it makes it harder for them to trust what they are told by the State later on. This impacts on bereavement, as families only trust evidence they have seen and tested for themselves.

Effective participation can therefore benefit the grief process, if families can be confident of the facts about a death presented to them in a timely manner and therefore incorporate the facts into a narrative to help them understand the death. However, lack of effective participation, which leaves

[700] *Letts v Lord Chancellor (2015)*

families without access to, or trust in, the facts can decrease opportunities for families to reach a positive outcome following a death.

Any death in custody that results in a complex inquest is likely to take years before the investigation process is completed, with some families waiting ten years before an inquest hearing is held. If learning the truth is an important step in bereavement and the truth is only settled at an inquest hearing, this has obvious implications on families suffering complicated grief. Even for those families who process a death and manage to move on in some positive ways, attendance at an inquest hearing years later can open up old wounds. Also, there is the likelihood that additional details about how the death occurred only come to light during the hearing, which means families may have constructed a narrative to help them understand how the death happened; and years later, that narrative could be shown to be wrong or based on inaccurate facts. This leaves families having to re-create a new narrative to fit new facts. Consequently, the inquest process itself may prolong the grief process, if family participation does not ensure they are informed of all the facts at an early stage.[701] Participants felt participation in the inquest process could benefit a families' grief process, but only if participation was fair and effective. Where families' participation involves accessing adequate support and information about the process and the death itself, it can reduce the likelihood of complicated grief and help families come to terms with their bereavement.

8.2.3. Representing the deceased

An additional legitimate interest for families was identified by participants as the opportunity to represent the deceased throughout the inquest process. Families and coroner participants were clear that it was important for the deceased to be remembered and referenced respectfully during the inquest. Families welcomed any space during the process which allowed all parties to remember the

[701] Snow and McHugh, p 144

deceased. Families and legal representatives felt very strongly that the voice of the deceased could be lost during the process; this was thought to be particularly important where the actions of the deceased were called into question or in some way argued to be causative in their death. If people die in either police or prison custody, there is sometimes a presumption that they are in some way at fault, with the inquest often being the only place this presumption can be questioned. Even if the deceased was shown to be involved in illegal activities; as one family member (FA1) said "[the deceased] went to prison to lose [their] liberty, not [their] life." Coroner participants gave examples of how they ensured the voice of the deceased was heard; including allowing families the opportunity to read out a statement about the deceased. This was important as it allowed families to counter any negative descriptions about the deceased. Families felt it was also very important to ensure other aspects or dimensions of the deceased to be referenced during the process, so their life beyond any interaction with the criminal justice system was recognised. Families felt very strongly that part of their role in participating was to ensure an alternative and fuller account of the deceased was reflected during the process.

The more media interest there is in a case, the more important it is for families to ensure different sides of the deceased are represented. This could be for two reasons: firstly, that families want an opportunity to correct misapprehensions which have already been publically disseminated and secondly, if there has not been any media reporting before the inquest but there are press present during the hearing, the bereaved family want to ensure there is a fair and representative record of the deceased. Misapprehensions or inaccuracies in the press can either involve skewed and unfair views of the deceased or a false and misleading reporting of the facts surrounding the death. The first situation is often inevitable in relation to a death in prison where, by definition, the deceased is perceived by the public as an offender convicted of a serious crime which posed such risk that it was necessary to imprison them. Academics agree that there is a stigma to being identified as a prisoner

as they are generally demonised by the public.[702] Specifically, prisoners are often seen as having "achieved stigma" due to their own behaviour, so the public are less likely to be sympathetic towards them.[703] This ignores issues relating to whether the deceased was on remand at the time of death (and therefore not convicted of any offence)[704] or an understanding that imprisonment does not automatically mean the offender was violent.[705] Of course, regardless of what offence may have been committed, a prisoner is still a human being with inherent dignity and ensuring they are seen for more than their crime is an important point relating to families wanting the deceased to be fairly represented during an inquest. Although deaths following interactions with police involve people who have not been convicted but are merely suspected of a crime, public opinion can still be very negative about someone who the police arrest, as it has been shown that just being accused of a crime by authorities can result in stigmatisation.[706] Deaths resulting from police use of force often lead to media reports of the victim's behaviour being responsible for the police actions: including phrases like "resisting arrest" and "hostile manner".[707] Of course, a large number of police interactions are with the most vulnerable people, not necessarily those suspected of serious crime but the behaviour of

[702] Kathlyn Taylor Gaubatz, *Crime in the public mind* (University of Michigan Press Ann Arbor 1995); Jock Young, *The exclusive society: Social exclusion, crime and difference in late modernity* (Sage 1999); David J Harding, 'Jean Valjean's dilemma: The management of ex-convict identity in the search for employment' (2003) 24 Deviant Behavior 571; Thomas P LeBel, 'Perceptions of and responses to stigma' (2008) 2 Sociology Compass 409; Paul J Hirschfield and Alex R Piquero, 'Normalization and Legitimation: Modeling Stigmatizing Attitudes toward Ex-offenders' (2010) 48 Criminology 27; E Goffman, *Stigma: notes on the management of spoiled identity* (New York 1963)

[703] Gerhard Falk, *Stigma: How we treat outsiders* (Prometheus Books 2001)

[704] 11-13% of prison population in England and Wales from January to June 2016 were on remand: 68-71% of those on remand in the same timeframe were untried. See Table 1.1, Prison Population Statistics at https://www.gov.uk/Government/uploads/system/uploads/attachment_data/file/541229/population-q1-2016.xlsx

[705] The proportion of individuals in prison sentenced to an immediate custody sentence for a non-violent offence was on average 47% from January to June 2016. See Table 1.2b, Prison Population Statistics at https://www.gov.uk/Government/uploads/system/uploads/attachment_data/file/541229/population-q1-2016.xlsx. Violent offences are defined by the Ministry of Justice as violence against the person, sexual offences and robbery: all other offences are defined as non-violent. See response to FOI here: https://www.whatdotheyknow.com/request/non_violent_crime

[706] Richard D Schwartz and Jerome H Skolnick, 'Two studies of legal stigma' (1962) 10 Social problems 133

[707] Regina G Lawrence, *The politics of force: Media and the construction of police brutality* (University of California Press 2000)

people suffering from an acute mental health condition may arguably be seen as combative by police.[708]

It is also true that families generally do not have pre-existing links to the media when a death occurs, so any initial narratives about the deceased will be presented by State agencies. Snow and McHugh found the public nature of the inquest (with the possibility of media presence) can make families feel powerless.[709] For example, Mark Duggan was portrayed in the media as an incredibly dangerous criminal, although he only had a criminal record for two minor offences.[710] In this case, the family found it challenging to persuade the media to present an alternative view.

The second situation where misleading details about the circumstances surrounding a death might be presented in the media also links to the fact that initial details about a death (whether in prison or in police custody) will be released by the State agencies. As families would be unlikely to know the facts immediately after a death, if there are any inaccuracies, they cannot correct them at this stage. Many people will remember press reports about Jean Charles de Menezes jumping over a barrier and running from police before he was shot on the tube, but will not realise this report was inaccurately based on a witness statement given to the media. In fact the witness was referring to one of the police officers, not Mr de Menezes, who actually calmly went through the barrier and walked to the tube.[711] It is particularly important that families are able to counter distorted views as they can become embedded in the consciousness of the public. Where families are well supported by experienced legal representatives, they may be able to present alternative views about the deceased or the death itself but if not, it is only where the press report inquest hearings that families can have the opportunity to ensure there is a fair and accurate representation of the deceased in the media. Interviews showed

[708] Her Majesty's Inspectorate of Constabulary, *The Welfare of Vulnerable People in Police Custody* (2015)
[709] Snow and McHugh, p 144
[710] http://www.independent.co.uk/news/uk/crime/mark-duggan-among-europes-most-feared-and-violent-criminals-before-his-death-sparked-the-2011-riots-8835363.html
[711] http://news.bbc.co.uk/1/hi/uk/4177082.stm; Independent Police Complaints Commission, *Stockwell Two: An investigation into complaints about the Metropolitan Police Service's handling of public statements following the shooting of Jean Charles de Menezes on 22 July 2005* (2007)

that a key benefit to fair and effective participation for families is so they are able to ensure the deceased is fairly represented both during the inquest hearing and consequently in media reporting.

8.3. Family participation benefits accountability and legitimacy of the system

8.3.1 Accountability via the inquest system

The interviews linked the role of a bereaved family participating in an inquest to ensuring State accountability in a number of ways. Firstly, participants suggested families have an instrumental effect by optimising the likelihood an inquest would reach a fair and accurate outcome. Secondly, families were argued to play a key role in disseminating the inquest outcomes, which is particularly relevant where media interest is either non-existent or inconsistent. Thirdly, families were argued to drive through positive change; both in calling for any necessary reforms to prevent deaths and improving the inquest system itself.

The instrumental effect of families was argued by participants to have two main aspects. The first involved cases where the family either provided or uncovered evidence relating to the death.[712] One example given was the case of Sean Riggs; his family, along with their legal representation, identified important CCTV evidence which had not been presented to the IPCC and therefore not investigated. The CCTV evidence was then presented at the inquest hearing, where it helped establish the circumstances surrounding Sean Riggs' death. It can also be important where families ensure the deceased is seen by the coroner and jury as a rounded individual (as discussed above), which means they can better understand the deceased as an individual and therefore interpret the facts of the case

[712] The *O'Brien* case is another example where pre-disclosure allowed the legal representation for the family to scrutinise the evidence and realise vital forensic evidence was missing. Referenced in Section 3.4.5.3.

more accurately. The second way families' participation has an instrumental effect is via the scrutiny they can provide during an inquest hearing. The coroner can question witnesses but a number of participants argued that the best way of establishing the truth was through cross-examination; which is most appropriately carried out either by the family or on their behalf, as they are likely to be sceptical of the evidence.

In England and Wales, the inquest system is the primary route by which non-criminal State actions relating to protecting the life of individuals are scrutinised in a public hearing.[713] An inquest hearing provides two aspects which are vital to discharging the procedural obligation of Article 2 which are not always ensured by investigatory bodies. The first is public scrutiny, not just of the conclusions to any investigations but of the evidence itself. The second is an opportunity for families to scrutinise the evidence provided by any investigation. Case law indicates that both these elements are vitally important to ensuring compliance with *Jordan*.[714] Participants agreed that participation of families is key to ensuring accountability through scrutiny of the evidence.

The instrumental effect provided by families participating in the inquest system arguably leads to improvements in how the State detains or restrains individuals. Fair participation for families allows them to provide evidence as well as scrutinise and question evidence provided by the State; this maximises the likelihood of an accurate outcome and the more accurate the outcome, the more likely it is to identify any systemic failings. Any failures identified in part either due to the assistance of families or via their scrutiny of the evidence can lead to changes which provide greater protection for people in custodial settings or interacting with police. An example of this would be the issue of positional asphyxia which has been identified in a number of inquests over the last ten years. Positional asphyxia is the name given to a condition that can lead to a severe risk of death when an individual is restrained for any length of time by being bent over forwards with their arms secured

[713] *R. (on the application of Middleton) v HM Coroner for Western Somerset* [2004] UKHL 10 (House of Lords)
[714] *Jordan v United Kingdom*; *McCann v United Kingdom,* para 161; *McKerr v United Kingdom*; *Letts v Lord Chancellor (2015);* para 70

behind their backs. This method of restraint was previously sanctioned for use in youth custodial settings but the official guidance was changed after it was shown to severely restrict an individual's breathing, leading to a risk of asphyxia.[715] This risk was identified during the inquest into the death of Gareth Myatt, who was restrained in this way.

Participants felt that ensuring families' fair and effective participation in an inquest could improve the accuracy of the outcome, and therefore the likelihood that failings were identified. However, concerns were expressed that the current system did not provide adequate accountability for two reasons; firstly because of a failure to identify culpability and secondly because there was no assurance that further deaths would be prevented. Participants felt the inquest system was not always able to sufficiently identify any State culpability, particularly as it is not possible to name a particular individual as being culpable in a death. It was pointed out, however, that the scrutiny provided by an inquest could be key to identifying those cases where further investigation, and possibly prosecution, should be considered. Participants also felt that it was a problem if, even where inquests produced clear evidence of culpability, there was a lack of will to prosecute such cases, which did ultimately limit accountability.

Participants indicated that holding the State to account was not solely concerned with securing prosecutions of State agents. Finding the truth could be sufficient, even in cases where there was perceived immunity for State agents. This supports research suggesting that victims of police brutality or their families can be satisfied with acknowledgement of the truth.[716] However, it was clear that participants thought establishing the truth was only sufficient when it ensured necessary changes were subsequently made to prevent future deaths. Whether participants felt prosecutions were needed to achieve accountability, or whether establishing the truth could be sufficient; it was clear

[715] INQUEST, *Gareth Myatt Briefing* (2007); Ministry of Justice, *The government's response to coroners' recommendations following the inquests of Gareth Myatt and Adam Rickwood*
[716] Walsh and Conway, p 67

that both were linked to what participants saw as the fundamental priority for achieving accountability, which was to identify failings and ensure changes were made to prevent future deaths.

Participants were not confident that this happened in practice, due to the lack of follow-up after individual inquest verdicts made recommendations on necessary reforms. Further concerns mentioned related to the lack of a framework by which institutional learning could be guaranteed, beyond any specific institution involved in a particular death. The problem of national learning is illustrated by the example of positional asphyxia as the issues were identified in 2007 by the inquest into Gareth Myatt's death but systemic learning did not occur; which is why privately employed individuals acting on behalf of the State to deport Jimmy Mubenga were still using the dangerous hold which resulted in his death.[717] Some participants pointed out that the newly appointed role of Chief Coroner would hopefully be putting in a place a system to allow national learning from any systemic failings identified at an inquest.[718]

The views of participants that the inquest system has a key role to play in ensuring accountability reflects the importance of the inquisitorial system in identifying failings of the State. Accountability requires independent investigation into State actions which identify and punish individuals culpable for any deaths; criminal and civil courts are one framework for achieving this, with the judiciary usually seen as independent in Western liberal societies.[719] However, there are disadvantages in utilising the adversarial criminal court system to hold police or prison officers to account. Particularly in relation to the police service, it is argued there can be a negative impact internally on police morale and respect for those managing the service in imposing legal liability.[720] In addition, it has been illustrated that adversarial procedures can intensify differences between parties rather than resolve them.[721] An inquisitorial system can be a mechanism for allowing the truth to be identified and published,

[717] INQUEST, 'Updated briefing on Jimmy Mubenga'
[718] The Office of the Chief Coroner has committed to publication of PFD reports, and some summary findings from inquest, which does facilitate some national learning.
[719] Walsh and Conway, p 66
[720] Ibid, p 64
[721] Richardson, p 63

instigating a change in policy and behaviour without punishing individual officers. The inquest system can therefore play a part in ensuring accountability by finding the facts surrounding a death and identifying any State failings, without some of the negative effects of an adversarial process. In addition, participants understanding that accountability means going beyond finding the truth and ensuring future potential violations are prevented fits with potential benefits to family participation established in case law.[722]

There are established principles that a fair justice system must ensure equal treatment for all people before the law. The rule of law demands that each individual should be treated equally and fairly by the law, regardless of race, gender or economic status.[723] Fundamental to human rights is the principle that all humans must have access to the same rights and be considered equal. Article 2 of the Universal Declaration of Human Rights states that, "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind".[724] It is important that everyone believes they are equal before the law, otherwise they will not have equal vested interest in complying with the law.[725] Another important aspect of equity is described by Simmel, who says the unwritten contract between Government and citizen sets up an expectation that the authorities will abide by their own laws.[726] Fuller argues that authority is internally legitimated by its own compliance to the laws when exercising its own power.[727] The inquest system is where State actions are scrutinised to ensure they are lawful; other procedures such as prosecutions are required where actions are deemed unlawful but identifying legality is often part of an inquest following a death in custody. In order to be confident that State actions are lawful, there must be confidence that the inquest system is a fair and rigorous process, which is able to adjudicate legality of State actions. It has been argued that inquisitorial systems as a method for achieving accountability partially depend on the will of the authorities to not

[722] *Letts v Lord Chancellor (2015)*
[723] Principe, p 371
[724] United Nations, *Universal Declaration of Human Rights* (UNG. A. Res 1948)
[725] Fuller, p 210
[726] Georg Simmel, *The Sociology of Georg Simmel*, vol 92892 (Simon and Schuster 1950)
[727] Fuller, p 211

just acknowledge failings but to act on findings to prevent further violations.[728] This is relevant in respect of inquests which do not establish legal liability.

The system by which coroners must produce reports identifying actions that have to be taken by institutions to prevent further deaths was discussed in Chapter 6. Concerns were raised by participants that these Rule 43 reports[729] did not always ensure suitable learning across institutions; although the Chief Coroner is working to improve this.[730] In addition to the new system publicising PFD reports, which allows all public agencies to learn from inquest findings, media campaigns can be successful in highlighting failings. Media interest can result in public pressure being placed on key stakeholders to ensure necessary changes are made. Case law is also important in sign-posting relevant agencies to unlawful practice. Participants suggested that bereaved families have an important role to play in both instigating, or encouraging, media campaigns and bringing important legal cases. In addition to assisting with the identification of specific systemic failings relating to deaths, family involvement can also lead to wider systemic changes in the investigatory processes, thereby improving investigations into deaths in custody and increasing accountability. The next section will look at how media reporting can impact not just on ensuring accountability but also increase public confidence in the legitimacy of the system.

8.3.2. Public confidence via a transparent inquest system

Participants all agreed that the fact an inquest process is open to the public could have a positive impact on public perceptions about the legitimacy of the system. However, it was also pointed out that there is little public understanding of the inquest system which, it was suggested, impacts

[728] Walsh and Conway, p 68

[729] Now called PFD (Preventing Future Death) Reports but the old name of Rule 43 reports has been used throughout this thesis.

[730] The Chief Coroner publishes most PFD Reports: https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/

negatively on perceptions of the legitimacy of the system. A number of legal representative and coroner participants felt the public nature of inquests was very important but highlighted that the public rarely attended hearings, so that the press were vital in ensuring the public was informed about the process. Questions were raised about the accuracy of the press reporting, though, especially as participants felt it was rare for reporters to attend the whole inquest hearing, and that usual practice was for them to witness only the verdict being given. Participants said all parties could feel dissatisfied when only verdicts or snippets of a hearing were reported, without the media providing a detailed context. Although it was acknowledged that families were likely to be present for the whole hearing, because families have a unique interest in the death, participants did not feel families could be said to represent the wider public. Generally, though, participants felt families wanted a true account of what happened to be in the public domain; although the IPCC were concerned that families were more interested in disseminating verdicts which were critical of State actions, which could be argued to have both negative and positive connotations. It is likely that press departments for State institutions would prefer verdicts that found no failings to be disseminated to maintain public confidence.

It is a core principle of Anglo-Saxon legal systems that justice is carried out transparently so everyone can see that a judgement is reached in a fair and understandable way.[731] The expression "justice must be seen to be done"[732] means that, in general, judgements are accessible to all so they can validate the legitimacy of the decision.[733] The public nature of inquests is therefore vitally important. However, with evidence that public attendance at hearings is negligible, media reporting is very important.[734] It could be argued that if the family are the ones publicising cases, this will only happen where the State authorities have acted wrongly or negligently. Two participants were concerned that if the public only

[731] J. Jaconelli, *Open justice: a critique of the public trial* (Oxford University Press, USA 2002), p 5
[732] *R v Sussex Justices; Ex parte McCarthy* 1 KB 256, para 259
[733] Important exceptions include in the interests of security and privacy for vulnerable individuals such as victims or children.
[734] Following the implementation of the Coroners and Justice Act, the Chief Coroner now published "Prevention of Future Deaths" reports written by individual coroners following the conclusion of inquests. These reports focus on the changes that should be made to prevent future deaths: a brief description of the circumstances of the death are included but they are not detailed records of the inquest process. See https://www.judiciary.gov.uk/subject/prevention-of-future-deaths/

heard about the negative actions of State agents, they may have skewed or inaccurate perceptions about State use of detention and restraint; and that if the public only know about negative examples, it would reduce public confidence in the legitimacy of State. This has been supported by research illustrating there can be a more wide reaching effect of lowering public confidence in police in response to a well-publicised direct conflict between the police and a private citizen in court.[735]

This thesis argues the opposite view that it is positive for transparency to be assured in those situations where State actions are considered questionable, as transparency shines a light on any poor behaviour. In addition to the role the inquest system plays in holding the State to account, a fair system is important in maintaining public confidence in the legitimacy of State actions. It has been argued that procedural requirements for legal processes overseeing actions of public agencies "promote the rule of law" in ensuring that such agencies act fairly and consistently.[736] Public confidence is linked to perceptions about the legitimacy of State actions and inquests can illustrate State compliance with two important principles which relate to holding State agents to account; equality for all before the law and transparency. Equality before the law is a fundamental principle that does not just describe the fact that all citizens must be treated the same, but also ensures that no one is above the law, including State officials. Transparency allows citizens to understand the laws in place but in relation to legitimising authority, it can go further in allowing public scrutiny of their actions (from law making to use of power to detain or restrain individuals). Public confidence in the existence of a robust system which complies with rule of law principles, by ensuring State officials actions are accountable and scrutinised for any actions which may have caused or contributed to a death, is therefore vital. It can be argued that if the public are aware of critical outcomes identifying any State failings, they can be confident that there is a robust system scrutinising State actions in relation to detaining or restraining individuals. This however raises a further concern. Given that the current system relies on families to liaise with media to disseminate inquest outcomes, critical verdicts

[735] G. Smith, 'Police complaints and criminal prosecutions' (2001) 64 The Modern Law Review 372
[736] Richardson, p 18

will only be brought to the public's attention when there is family involvement. Cases with no family involvement may therefore remain hidden.

8.3.3. Increased perceptions of legitimacy via procedural fairness

Participants all explained that a family's perceptions about the inquest process impacted on whether they felt the process and consequentially the outcome were legitimate. Perceptions about legitimacy were then linked to whether families expressed confidence and trust in the system. The main aspects identified as influencing perceptions of legitimacy were the independence, transparency and fairness of the process. Interviews also showed that participation could influence those perceptions positively, although how families were treated during the process was key.

Perceptions about independence were linked to the confidence that families had in the system's ability to find out the truth and reach an accurate outcome. This was understood by all participants, although two lawyers said that in their experience, families often felt the system was biased in favour of the State. A clear distinction was made between perceived independence of investigatory bodies and of coroners themselves. In particular, questions were raised about whether the IPCC was independent of the police that they were required to investigate. Participants felt that the fact IPCC investigators were often ex-police, as well as the fact they often had to rely on existing police officers to carry out some investigatory duties (such as collecting evidence or interviewing witnesses), all influenced perceptions of bias. (It should be pointed out that the PPO rely on the police in the same way but this does not impact on perceptions of bias in the same way as the PPO are investigated prison staff, not police officers). However, it was acknowledged that the inquest process (although reliant on reports drafted by investigatory reports) could improve confidence in the independence of the process, if coroners were perceived to be unbiased. Some coroner participants felt this was an important part of their role, but family and legal representative participants felt coroners were not

always seen as independent; especially when coroner's officers were either ex-police or current police officers. The fact coroners rely on investigatory body investigations and reports was another issue raised, as it was questioned whether a coroner could be truly independent and impartial if they only received evidence produced by an investigation that was perceived to lack independence. Two participants (CO1 and SP1) highlighted the difficult position coroners could find themselves in, as if they were perceived to be biased towards families, they were seen as not protecting State agents sufficiently. Most participants felt that perceptions about whether the investigation or process was not independent resulted in the family having little confidence or trust in either the process or the outcome. Conversely, people expect a decision-maker to act impartially when adjudicating between parties.[737] So the importance of a coroner acting in a way that is seen as independent from State parties and investigatory bodies, by acting in an unbiased way, has a significant impact on confidence in the system.

Participants' perceptions about how transparent officials were with families during the process were also linked to how confident the families were that the right outcome was reached. Family participants said they felt if State officials were not being honest and up front in sharing details about circumstances surrounding the death, they lost confidence in the whole process. Although again a distinction was made between State officials who were present or in some way involved in a death and the coroner. If families only received information after the coroner compelled the State to produce the information (maybe by relying on legal rights for families), then families might not feel the State officials were being transparent. This could result in families having confidence and trust in the coroner and the inquest system as a whole, but less confidence in, and distrust of, the State agency or officials involved in the death. It is important to note, though, that if coroners were perceived as being open with families throughout the process, families would be more confident in the process and therefore the outcome reached.

[737] Leventhal

It is clearly important for families to feel they have been treated fairly during an inquest process. Participants mentioned a number of aspects that could be considered as unfair to families, including bias by coroners (or their staff), inequity with State parties having access to all the evidence and being represented by teams of specialist lawyers throughout the process, whereas families struggle on both counts. It was also clear that families sometimes felt they were disadvantaged due to lack of knowledge about the process. In these situations, coroners need to ensure sufficient advice and support is in place for families, often through their officers. It is likely that to perceive a process as fair, families would have to receive support and advice from the coronial team. This could be argued to leave a coroner open to suggestions of bias towards families. It is a complex situation if, by remaining unbiased, coroners allow the process to be unfair to families. Any perception by parties that the decision-maker has acted improperly will lead to concerns that the process itself is invalid, even if parties have been able to participate effectively.[738] Coroners therefore have to balance unbiased and transparent decision-making with ensuring families are able to participate effectively.

A number of participants linked perceptions about how fair the inquest system was to whether families accepted the outcome and felt satisfied at the end of the inquest process. It should be noted, however, that coroners are obviously in a difficult position to ensure fair treatment to all parties and it must be acknowledged that certain rights of State actors must be protected by a process which can sometimes lead to either civil or criminal cases. Participation is key, as it ensures families are able to judge for themselves the fairness of the decision-making: including hearing explanations from the coroner as to why particular decisions were made. Even in situations where families were concerned about lack of independence, if they believed the correct process was followed by the coroner as "that is only fair and proper" (FA4), they could trust the outcome. Families having the opportunity to positively engage in the process was suggested to ensure they ended up with positive perceptions about how fair the process was, allowing any concerns they had to be resolved. Participation was

[738] Lind and Lissak

argued not just to influence perceptions of fairness but result in increased trust in the process and therefore the outcome. Research has indicated that decision-makers providing parties with justification for any decisions that might be perceived as negative can negate perceptions that the process is unfair.[739] So even if a family are concerned about the validity of the process, a coroner who explains their decision-making can improve perceptions about the fairness of the process.

Participants clearly identified the benefits of families being treated respectfully through a complex inquest, including positive perceptions relating to increased confidence and trust in the outcome and therefore legitimacy of the process. Positive engagement with families from the earliest point of contact was identified as fundamentally important. This should include not just ensuring families are informed about the process and their rights but also appreciating that families are bereaved and therefore should be treated with patience as well as respect. Family participants were clear that respect should include taking the time to talk to them and explain the process as it was going forward. Simple acts such as acknowledging families and offering condolences to them at the start of a hearing were suggested to have huge and positive impacts. Additional examples of good practice mentioned were coroners keeping the process as informal as possible, avoiding complicated legalese and checking with families to make sure they understood the process. Participants pointed to two factors which were unique to families compared with other interested parties, firstly that they had no experience of inquests or even the processes relating to detention, so they struggled to understand what was happening or being discussed if care was not taken to explain things properly. Secondly, it is the families who had the personal connection to the deceased and therefore were grieving. Family participants mentioned how important it was for everyone else involved in an inquest to remember that for them it was a very emotional experience, not just another day in the office. Some participants identified challenges for coroners in treating families differently from other interested parties without influencing the process unduly and opening themselves up to accusations of bias (see above).

[739] Bies and Shapiro

However, coroner participants suggested that treating families respectfully could ensure they had positive perceptions about the process without interfering with the fairness of the process or the outcome. An example was given of a photograph of the deceased being placed on the bench during the inquest hearing; it was suggested this could be beneficial for the family as they could be sure the deceased was central to the proceedings but it did not influence the process itself.

The views of participants followed procedural justice theory (discussed in Chapter 3) as perceptions about the procedural fairness of a process were shown to impact on perceptions about the legitimacy of the process and consequently the confidence in the outcome.[740] Tyler and Blader proposed a four component model involving four criteria by which people evaluate the procedural fairness of a process.[741] The criteria put forward were general and specific; with the general being the rules governing both the decision-making and the established rights of parties and the specific relating to how decisions are made and parties treated in specific instances. Aspects of participation raised in Chapter 5 which impacted on perceptions of legitimacy, confidence and trust correlated with the four component model. Participation in the inquest system ensures families have the opportunity to assess the independence, transparency and fairness of the process; which was linked to increased perceptions about the legitimacy of the system and the outcome of the process. In terms of the general criteria, the transparency, equity and independence of the process can all be related to how parties might perceive the fairness of the rules governing the process. Both the transparency and independence of the inquest system can correlate to perceptions on the fairness of the rules governing how decisions are made during inquests. Similarly, whether the system ensures equity of parties can be seen as an illustration of whether the rules ensure parties are treated fairly. The other aspects raised by participants can be linked to the specific criteria of the four component model by looking at how decisions are made in practice and how families perceive they are treated during the

[740] Sunshine and Tyler; Tyler, 'Procedural justice, legitimacy, and the effective rule of law'; Tyler, *Why people obey the law: Procedural justice, legitimacy, and compliance*
[741] Blader and Tyler

process. The independence of the coroner as it is perceived to relate to unbiased decision-making can influence perceptions about whether decisions are fair to all parties. Also, how families perceive they are treated by a coroner and their staff during the process directly correlates with the last criteria of the four component model. Where families perceive the inquest system to be independent of State bodies, transparent and fair then they believe the system to be legitimate; which ensures they have trust and confidence in the outcome.

It was argued by a few participants that family participation did not just influence their own perceptions about how legitimate the investigation was but also perceptions of the public. Again, perceptions about legitimacy were linked to confidence and trust in the system. So the public could perceive the process as more legitimate if families were seen as being able to participate fairly, leading to the public having more confidence in the process. The converse was also said to be true, with one family participant believing that when families were not treated fairly and therefore unable to participate fully, public confidence in the system was diminished. This is supported by Richardson, who asserts that, even though common law protections tend to rely on the instrumental benefits of fairness in traditional adjudicatory processes which involve disputing parties, to infer rights on parties who have substantial interests which could be affected by the process can also guarantee decisions "reflect the public interest".[742] Another aspect of whether fair participation for families might impact on public perceptions on the legitimacy of the system is linked to whether families can be argued to be representing the public. Research has shown if the public can be confident that a party is representative of the public voice, then the fair participation of that party can have a positive impact on the public's perceptions about the procedural fairness and therefore confidence in the legitimacy of the process.[743] However, as explained above participants did not generally see families as representing the public view, except for their role in scrutinising and therefore holding the State to

[742] Richardson, p 35

[743] Hiroshi Nonami and others, 'Effects of voice and similarity on procedural fairness and trust: A dual process model of public acceptance based on representatives' participation' [2015] Asian Journal of Social Psychology

account for their actions. It is also worth considering that what may be perceived as fair by families might not be viewed the same way by the wider public. Concerns have even been expressed about whether it is in the public interest for resources to be targeted towards funding complex and lengthy inquests or whether other processes are more appropriate for learning lessons.[744] The arguments set out above about the importance of ensuring accountability and public confidence in any system which scrutinises the actions of the State should answer any such concerns.

8.4. Important factors in ensuring fair participation of families

8.4.1. Access to the process

The first step for families' participating in a complex inquest is ensuring they have access to the process. This can include fundamental aspects such as families being informed about the process, what their rights are in relation to participating and practical issues such as how to communicate with stakeholders (for example the investigatory bodies) and attend meetings or hearings. A coroner must identify interested parties, who are then entitled to participate in the inquest process.[745] The next of kin will often have been identified before being designated as an interested party, as they will usually be the first person informed about the death. The rights of the next of kin include being able to either be present or represented at any post-mortem examination, so it is important they are identified soon after the death.[746] The coroner will generally declare the next of kin as an interested party automatically but there may be issues either with identifying who is the next of kin or with split families who all want to participate but separately instead of as one interested party. The rules state

[744] For example see discussions around the Bloody Sunday Inquiry & the inquest into the Hillsborough disaster. Bill Rolston and Phil Scraton, 'In the Full Glare of English Politics Ireland, Inquiries and the British State' (2005) 45 British Journal of Criminology 547; Dominic Elliott and Martina McGuinness, 'Public inquiry: panacea or placebo?' (2002) 10 Journal of Contingencies and Crisis Management 14

[745] Coroners and Justice Act 2009, Section 47

[746] Coroner's Rules 1984. No 552, Rule 7

the next of kin should be designated as an interested party but coroners can designate as many different people as interested parties as they think necessary. It was clear from some of the family experiences that even in the most cohesive family, it could be difficult for them to be designated as one interested party.[747] For families that were split, it is sometimes impossible for them to work together as one interested party through a designated next of kin or point of contact. It was pointed out by both ESP1 and IPCC that good practice in the police was to designate multiple FLOs in situations where the family is split. The benefits in coroners similarly allowing families to be represented by multiple interested parties are that it not only relieves pressure within the family; it also improves equity as it is common for State parties to have multiple interested parties. For example, after a prison death, the prison as an institution, the prison governor, National Offender Management Service[748] and individual officers will all be designated as separate interested parties. An additional challenge for families is that it can be very difficult to get legal aid for anyone other than the next of kin. This means that, even if more than one family member is designated as an interested party by the coroner, they may struggle to participate effectively unless they can afford to cover the expense of an experienced legal representative. It should be pointed out that all State interested parties will be legally represented individually.

Participants in the interviews were clear that the inquest system is unique and distinct from other legal or quasi-legal processes. Chapter 3 explained how complex inquests were neither fully inquisitorial nor adversarial but a hybrid process. Public knowledge about the inquest system in general is poor;[749] and most inquests are very straightforward, therefore even less is known about complex inquests such as those following a death in custody. Participants said that at first families felt out of their depth and "at sea" (FA5) in relation to the process without expert advice and information

[747] The Guide to Coroners Services encourages families to nominate one next of kin; Ministry of Justice, *Guide to Coroner Services*
[748] Re-named as Her Majesty's Prison and Probation Service in April 2017; https://www.gov.uk/Government/organisations/national-offender-management-service
[749] Raised by CO1

about the system. Families reported INQUEST, and through them specialist lawyers, were very useful in explaining the system to them. Some coroners gave examples of how they, with their team of coroner's officers, could ensure families had all the necessary information about the system. Certain basic information can be provided relatively easily (see the INQUEST handbook[750] or toolkit[751]) but it is also clear that it is useful for families to have someone to answer their questions; whether that is a support worker, legal representative or members of the coronial staff is probably not as important as the engagement itself. Although it is important for the individual offering support to be independent of the State agencies under scrutiny; some participants raised the fact that families would not necessarily trust police FLOs if they knew that their primary responsibility was as a police officer. Similar concerns were raised about some coroner's officers, who are often police officers themselves. Coroner and legal representative participants explained that early engagement with families was very important and managing expectations from the start could lead to more positive experiences for families and therefore greater satisfaction with the process.

As well as being given general information about the system and how it works, more specific information such as what rights families have in relation to the inquest system is also very valuable in ensuring access for families. Some families found that without specialist support or advice, they were not informed about their rights in relation to participating in the inquest. This can start from the earliest point, when families are not told about their right to either witness or send a representative to witness the post-mortem as well as not being aware of their right to be involved in the investigation. Families should be kept informed about the investigation itself as well as being given access to documents or evidence in good time before the inquest hearings. Family participants acknowledged their confidence and trust in the process was greatly affected by how much information they were

[750] INQUEST, *The Inquest Handbook; A Guide for the Bereaved Families, Friends and their Advisors*
[751] See http://info.inquest.org.uk/toolkit/

given about their rights. Access to this information is fundamental not just for families to be able to engage but also to allow them to scrutinise and therefore influence the process.

Access to the process goes beyond being given all relevant information and support but also includes ensuring families can physically attend meetings and hearings. Families also identified how important practical concerns were in relation to attending inquest hearings. Everything from getting time off work or organising childcare arrangements through to parking availability at the location can be additional worries for families during an already stressful time. Again, advice or information from either coronial staff or good legal representation can help families feel more confident and relaxed about attending hearings. It should be pointed out that in the most complex cases, families may have to attend multiple meetings or hearings over years if they wish to participate fully. One participant mentioned witness support schemes as provided in criminal cases, and although there is a voluntary system for inquests, it only covers 30 out of 92 coroner[752] areas.[753]

One important aspect for families accessing the process is legal representation. The benefits of good legal representation will be discussed fully in Section 8.4.4 but it important to note here that accessing legal representation can be an issue where families are not informed of their rights. Families are not necessarily made aware that it is their right to have legal representation or that this can be very important in assisting them participate. When taken in conjunction with how beneficial it can be for families to have good legal representation at an early point in the process, failure to inform families of this right can be very damaging.

[752] http://www.coronerscourtssupportservice.org.uk/about-the-ccss/index.html

[753] It is also unclear whether the volunteers would have either the expertise or capacity to support families through lengthy complex inquests which are so distinct from the majority of inquests.

8.4.2. Participation allowing families to influence the outcome

The theoretical framework set out in Chapter 4 explained that the right to participate required a party to be heard and have a real opportunity to influence the outcome. This is particularly relevant when considering whether families are able to influence decisions before the inquest occurs relating to what evidence and witnesses are put to the inquest as well as questions to be left to an inquest jury.

A number of participants pointed out that in order to influence the outcome of an inquest, it was important for families to be able to participate in the investigation, as the investigatory reports often framed the evidence heard at the inquest. Although one legal representative said they had experienced varied approaches by coroners; with some holding inquests before the investigatory report is completed, other participants felt that coroners often relied on the detailed investigations by police, IPCC or PPO to determine witnesses and evidence to be heard at an inquest. It was clear that coroners do not usually have the resources to carry out thorough investigations themselves, so they rely on investigatory bodies who in turn, usually rely on the police to carry out most of the investigatory duties such as collecting evidence and taking witness statements. It was therefore argued by some participants that if family participation should enable them to influence the outcome; they should be involved in the investigations so they could influence questions asked and evidence gathered. One participant said families had more opportunities to participate than fifteen years ago, with some examples of investigatory bodies taking family views and incorporating them into their investigation where possible. Unfortunately, it was clear from participants that family involvement in investigations was still not always meaningful enough to be able to influence the process. State official participants pointed out there had to be limits on how much families were able to influence investigations, which is understandable as investigations should be independent of all parties. (See earlier references to the importance of independent investigations). This is in line with the current legal situation, as family participation in the investigation process is not legally protected; with recent

case law stating Article 2 requirements are discharged by the inquest hearings themselves not any preceding investigations.[754]

The need for family participation in the investigation process was not just raised because of the importance of the investigation in framing the inquest but it was also linked to concerns about the lack of independence from the police or prison authorities of the relevant investigatory bodies. In particular, the IPCC links to the police were pointed out to result in concerns that investigatory bodies could bias the inquest process by controlling the evidence presented. One example given was the failure of the IPCC in the Rigg case to investigate obvious lines of enquiry such as collecting and watching the CCTV evidence from the police station where the death occurred. The importance of factors such as access to documents and legal representation in ensuring families have an opportunity to input into the investigation will be discussed later.

It was noted by participants that, as families were not always able to participate in investigations carried out looking at deaths in custody, participation in the inquest process was even more important, as it was often their only opportunity to both represent the deceased and influence the outcome. As well as feeding into the investigations prior to the inquest hearing, participants were clear that in order for families to be able to influence the outcome, they should be able to scrutinise and question the evidence produced by the investigation for the inquest hearings. The importance of families being able to ask questions during the inquest process was raised as very important for a number of reasons. Firstly, it was clear that for families to feel involved and that the process was fair, they should be able to have their questioned answered. Secondly, it was suggested that if the objective was for families to be able to understand what happened to their loved one; they had to be able to ask questions to clarify any queries they had. (This was thought to be particularly important as families were not necessarily going to understand either the police or prison processes involved in any interactions

[754] *Antoniou, R (on the application of) v Central and North West London NHS Foundation Trust & Ors* [2013] EWHC 3055 (Admin) (England and Wales High Court (Administrative Court))

previous to the death.) An additional factor raised by some participants was whether families should be able to influence the verdicts available to the jury. Article 2 or similarly complex inquest verdicts include both a specific verdict (such as unlawful killing) and a narrative that includes relevant details about the circumstances or failings which contributed to the death. The narrative part of the verdict is normally created by the responses given by the jury to a number of questions put to them by the coroner. It is common practice for interested parties to propose questions to the coroner who makes the final decision as to which questions should be put to the jury. Participants thought this approach was preferable as it ensured different views of parties could be represented and it made sure families felt they were able to fully participate by being offered a real opportunity to influence the outcome.

Coroners also decide which stand-alone verdicts are available for the jury to choose. Participants were less clear about whether families should be able to influence which stand-alone verdict options were left to the jury. In one case, a family felt very strongly about which options should be available to the jury to decide upon; and good legal representation ensured families views were heard by the coroner. Other participants were concerned that the system should ensure consistency of verdicts, and that families' personal views should not be able to influence verdicts unduly, or public confidence in the system could be damaged. Clearly consistency of verdicts can be very important in identifying patterns; for example, the high incident of suicides in a particular institution might suggest systemic failings.[755] Patterns can only be identified if there is consistency of practice in relation to verdicts; however, the current system leaves the decision to the discretion of the coroner, which may not produce consistency in practice. One concern is where coroners are unduly influenced by families who may not want a death to be labelled as a suicide if they feel their loved one did not intend to die but acted as a cry for help, thus making the death accidental.[756] It is also important that certain verdicts

[755] For example the suicides at Scottish YOI Glenochil or Styal women's prison in 2002-3; Alison Liebling, 'Suicides in prison: ten years on' [2001] Prison Service Journal 35; Baroness Jean Corston, *The Corston Report: A Report of a Review of Women with Particular Vulnerabilities in the Criminal Justice System* (Home Office 2007), p 14

[756] L. Biddle, 'Public hazards or private tragedies? An exploratory study of the effect of coroners' procedures on those bereaved by suicide' (2003) 56 Social Science & Medicine 1033

may have impacts beyond the inquest; for example in a civil case or even linked to the requirement that the Director of Public Prosecutions (DPP) must re-examine any decisions not to prosecute following an unlawful killing verdict.[757] It is therefore important that appropriate verdicts are left for the jury to consider. However, as in the questions left to the jury, there should be no objection in all interested parties being able to make representations on which verdicts they feel should be available to the jury. Some coroners already follow this practice. In any situations where interested parties are able to make representations to influence a decision being taken by a coroner; the importance of equity for all parties is vital (see next sections). In addition, it is important coroners explain their decisions so there is transparency of decision-making, which can affect perceptions of how fair and unbiased the coroner is; impacting on confidence in the outcome.

8.4.3. Access to documents

Families access to documents or evidence during an inquest is established in law but participants identified a number of problems in practice. Difficulties revolved around families having to fight to get full access in a timely manner. Participants raised issues with only being given access to documents specifically asked for, which relied heavily on a good knowledge of both the law and custody processes themselves. It was also clear that access was not given in a timely manner; in some particularly bad examples, documents were only provided to families at the start of, or even during, an inquest hearing. Family participants said it was important for them to know what happened as early as possible so their grief process was not negatively affected. Participants also said it was important for families to have access to the evidence early on in the process so they could ask questions and influence both the investigation and the inquest itself. The role of families in scrutinising the evidence as described earlier relies on families getting access to information all the way through the process

[757] Crown Prosecution Service, Prosecution Policy and Guidance: Deaths in Custody

and having knowledgeable legal representation to assist them. One of the benefits of knowledgeable legal representation for families (to be discussed later) is in scrutinising the evidence, which can be invaluable in helping families understand the evidence.

Some participants thought it could be difficult to judge at what point it was appropriate to share information with families; clearly families being given information only during an inquest hearing (often years after a death) was inadequate but State participants pointed out it could be difficult to give families information early on in the process as giving families inaccurate or uncorroborated evidence could be very damaging. Investigatory bodies mentioned it was good practice to be sure information was accurate before they passed it on to families. Of course, even when it is accurate, sharing evidence can be potentially damaging if families struggle to understand or assimilate the information correctly. Isolated bits of information given to families out of context can cause additional and unnecessary confusion. Family participants clearly felt it was important for them to see all the evidence for themselves so they could make their own judgement about what happened, and that they would not want to be presented with edited, contextualised evidence setting out a particular scenario. Providing families with access to information which has been corroborated and assessed as accurate in a structured way is important; not just because families have a right to the information but also because if State agencies are seen as being open and transparent with families it can foster positive and trusting relationships.

Another issue raised by participants was that, although access to documents for families is a legal right, families often had to fight to get access to everything. Even where families were supported by good legal representatives who ensured they got full access to documents in a timely manner, families could feel very negatively to both State parties and the coroner if full access was not offered freely. Families felt State parties were hiding things if they only provided documents when forced to; and similarly if coroners were not ensuring State parties complied with the law by providing access to families, families perceived the process as biased against them.

The IPCC representative raised another concern about sharing information with families, which was that some information should remain out of the public domain and there could be issues around trusting families to respect this. One coroner participant also mentioned this but pointed out, even if some information should not be made public, families still had a right to that information. This coroner said they were always comfortable trusting families to respect the need to keep some material out of the media, as long as time was taken to explain to families why this was necessary. When linked to the earlier issue of families' trust and confidence in a fair process as explained by procedural justice theory, it is clear that being open and transparent with families is the best approach to optimise a positive outcome in any situation. If families perceive the process as fair and trust the coroner to reach a fair outcome, they are far more likely to comply with directions relating to restricting what information can be shared with the public or media. It should also be noted that inquests are public hearings, so in saying there are issues about information not being put in the public domain, it is usually the timing of when that information should be made public which is considered sensitive, as ultimately the evidence will be presented during the inquest hearing and therefore in the public domain.

8.4.4. Legal representation for bereaved families

Problems with families accessing both evidence in a timely manner and legal representation were raised by participants as potential areas for inequity. All participants raised the issue of legal representation for families, with a number of them saying it was the most important aspect for effective participation. Participants agreed that families' legitimate interests could not be fully protected unless they had legal representation. This is partly due to the disadvantaged position of families who have no experience of the inquest system or knowledge of custodial processes as well as the fact that while grieving, it can be very difficult for them to engage objectively in an inquest.

Participants identified how much the process of a complex inquest is at the discretion of a coroner, which is one reason why it is so important for families to be ably represented. It was not just families and their lawyers who saw the benefit of families being represented, other participants (including coroners) felt it benefited the whole process. Legal representatives can support, advise and assist families, so coroners are not in the difficult position of having to provide those things to families and therefore risk perceptions of being biased towards families to ensure effective participation.

Participants generally agreed that complex inquests became adversarial in nature, especially when there were controversial aspects to a death. Families will nearly always have many questions where a loved one has died in custody and State parties will have their actions closely scrutinised. Although the purpose of an inquest is to find out what happened, emotions are heightened as there is a death at the centre of the process and any actor whose actions are being questioned will want to defend themselves strongly. Although inquests are not allowed to identify culpability, it is undeniable that underlying the whole process is an attempt to find out who, if anyone, might be responsible for a death. It is therefore inevitable that the process will become adversarial. State party participants felt that, although understandable, it was unfortunate when inquests became contentious. In terms of equity, it is undeniable that in order for the process to be perceived as fair, families must have legal representation to represent their interests.

It is sometimes argued that as well as being inquisitorial, inquests are straightforward processes in which families can participate without legal support. However, all participants agreed that inquest law as it relates to death in custody is complex and therefore it was impossible for families to participate effectively without specialist support. Legal support for families can also assist coroners in deciding complex legal matters as it ensures different interpretations and viewpoints are put forward. It is worth noting that the Government acknowledged the legal complexities of inquests when changing the law so only legally trained individuals could become coroners, excluding medically trained

individuals who were previously able to act as coroners.[758] The unique and complex nature of inquest law is why it is so important for families to have specialist legal representation. Participants were clear that without specialist knowledge it was impossible for a lawyer to adequately represent a family. Specialist lawyers did not just understand the complexities of inquest law but if they are experienced in such inquests, they have good understanding of law and processes governing detention as well. It is important for lawyers to understand the terminology used by custodial institutions as well as the rules governing detention practices to be able to assess and scrutinise all the documents. In order to assess whether actions are in compliance with expected standards, a lawyer must have an understanding of those standards.

State parties are legally represented all the way through an inquest process, often with a team of lawyers representing each different State actor and agency. Two participants gave examples where State parties had numerous lawyers representing different individuals or agencies who appeared to work together with the same objectives, leading to perceptions that there was a lack of equity. Family participants felt (even when legally represented themselves) they were outnumbered or "ganged up on" (LA1) due to the number of different State parties and the multiple lawyers representing each one. Lack of equity due to multiple State parties was referenced, not just in leaving families with perceptions that the process was unfair, but also that the process was biased towards the State. This was explained by the fact that with numerous State parties, if they worked together, there were numerous opportunities for them to present or question evidence in line with an agreed view point; but if families were only seen as one interested party they only got one opportunity to present their view point. Lack of equity was also raised in respect to the experience and the number of legal representatives for each State interested party. An example was given of one State party having a team of lawyers including a couple of experienced barristers, whereas families were lucky if they could get a barrister, rather than relying on one solicitor to assist them in preparing and during the inquest.

[758] Coroners and Justice Act 2009

The fact families often struggled to fund specialist legal representation (even if they received legal aid funding, it was unlikely to cover all the costs) was another aspect of perceived unfairness. In general, all aspects relating to costs could lead families to perceive the process is unfair. An example given during the interviews was that State actors were paid to attend inquest hearings (as an important part of their job) whereas families had to take leave as well as cover travel and other expenses themselves.

Participants provided examples of why good legal representation was necessary for families to be able to effectively participate in the inquest process. It was noted that good legal representatives could ensure families rights were fully exercised, including full access to documents and hearings as appropriate. It was especially relevant where there were issues of non-disclosure on the part of the State parties, with legal representatives being identified as vitally important in getting full disclosure for families. As mentioned previously, full disclosure to families in a timely manner allows them to assess and scrutinise the evidence; actions that experienced and knowledgeable legal representatives can also assist with. It is important that legal representatives have knowledge of custodial rules and practices so they can identify gaps in evidence or assess and explain what is meant by particular documents which may be indecipherable to families.

Families (as an interested party) have the right to question the evidence presented and witnesses at an inquest hearing.[759] However it is clear that without legal representation this can be very difficult; particularly as questions can be disallowed if the coroner decides they are irrelevant.[760] Families are vulnerable during hearings as emotional and upsetting issues are being discussed so the ability to calmly and objectively assess and question is very challenging; even if they have the knowledge and skill to do so. The scrutiny provided by families is vital in reaching a fair and correct outcome but cross-examination is a skill, not something that families can be expected to carry out effectively. Where

[759] The Coroners (Inquests) Rules 2013, Section 19
[760] Ibid, Section 19

families are not legally represented, coroners can either assist families or ask questions on their behalf. However, in the more contentious cases, this does open coroners up to accusations of bias.

Participants also identified good legal representation as providing families with necessary support during very lengthy and difficult inquests. FLOs will usually be available for families but it is a concern that where State actions are being scrutinised, it can be difficult for families to trust FLOs who are provided by the institution in question. Legal representatives are obviously seen by families to be on their side, which can be very important in situations where families feel either attacked personally or that their deceased loved one is being attacked. For example, police FLOs are there to support families but as police officers their primary responsibility is to investigate and feedback relevant items to the investigatory team. This is obviously very different to the role of a legal representative whose primary responsibility would be to the families themselves.

Participants were clear that legal representation for families could benefit the process as well as families themselves. It was suggested that the benefits were most often seen when families got legal representation early on in the process. Coroner participants said they would recommend families find legal representation as quickly as possible. It was pointed out that if families only got legally representation late on the process (for example, near the inquest hearing but months or years after the death) it could actually be frustrating for other parties, including coroners. Families accessing legal representation late on in the process could mean delays; if families were struggling to participate or engage fully before they found legal representation.[761] Looking at all the benefits that legal representation can bring to families, including managing expectations about the process; making sure families understand both the process and the evidence; assisting families to assess and scrutinise evidence; and providing overall support to families: early access to this representation is incredibly important.

[761] For example, if they have not been given full access to all the evidence, they may have questions that need answering (such as wanting additional or repeat tests on forensic evidence) and at a late stage in the process, this can be difficult.

Legal representatives for families help manage expectations, explain their rights, the inquest process and understand the evidence presented; and to do that a lawyer requires specialist knowledge and experience. Rules governing State detention are very specific and inquest law is very complex (especially as consideration has to be made of European case law). Lawyers might have experience of straightforward inquests that last less than an hour, with the deceased and cause of death being easily identified. A complex inquest process can take years before the final hearing even takes place, and the hearing itself can then last weeks and involve complex legal arguments. Participants agreed that specialist legal representatives were vital for families, with some going as far as to say that families could be better off unrepresented than being represented by inexperienced lawyers. One concern raised was the lack of specialist lawyers outside of London, leaving families struggling to get specialist support. Again the issues of equity was relevant, with participants saying State parties could afford to be represented by experienced, specialist lawyers from London.

One negative of having a small number of specialist lawyers who support families is difficulties for families finding specialists, but another is that some parties feel those specialist lawyers can work to their own agenda rather than supporting a specific family by following their directions. It is true that lawyers in the Inquest Lawyers Group will have seen many similar cases, which can be an advantage in helping families but will mean they bring any negativity or prior views with them to a new case. So they may have preconceived ideas about how State parties are going to act based on negative experiences but this may lead to an unnecessarily adversarial attitude from the start, without allowing State parties to engage with families openly and willingly. This thesis illustrates that the benefits of specialist lawyers override any potential disadvantages and the experience of the researcher at INQUEST in supporting families, taken together with views expressed in this thesis, suggests families are often the driving force in the process with lawyers actually being a rational voice advising caution. Certainly the researcher has no experience of lawyers driving the agenda or using unwilling families to fight for change and a coroner would be able to step in if they felt questions or interjections were not fully representative of the views of a family.

Funding for legal representation was an issue seen as incredibly important by participants both in respect to ensuring fairness and equity for parties (with State parties being funded) but also due to access to justice issues with specialist legal representation being expensive. An example given by a participant was for the cost of one experienced legal representation running into tens of thousands of pounds for the duration of an inquest process. But it was also clear from participants that families struggled to get funding via the LAA. Guidance on exceptional funding for legal aid for inquests has been updated recently, and it must be noted that the experiences of participants relate to the situation under the previous guidance but it is important to identify problems as many of the same issues will be relevant.

Problems identified about accessing legal aid funding by participants were the need for inquest to be categorised as Article 2 inquests, family members who were applying for the funding having to be next of kin and the complexity of the application process. It is clear the Human Rights Act 1998 has had a positive impact on achieving funding for Article 2 inquests but this does depend on a coroner clearly identifying the inquest as engaging Article 2 at an early stage. Some coroners prefer to wait until the later stages if it is not clear whether Article 2 is engaged; whereas others take the position that if there is doubt, Article 2 can be presumed to be engaged, allowing full investigation but verdicts can subsequently be restricted if it becomes apparent Article 2 is not engaged. This, of course, relies on coroners having a clear understanding of Article 2 case law. This is why getting legal aid funding is still a difficult, if not impossible situation for many deaths in secure mental health institutions. Participants said they believed one difficulty was that inquests were defined as inquisitorial processes, so it was not always fully appreciated how important it was for families to be represented. This is why, without a death being identified as engaging Article 2, the LAA do not generally grant legal aid.

The LAA also only generally fund representation for the next of kin, which can be very difficult in a split family or if some members of a family do not want to engage with the process (for example a parent may not wish to engage but a sibling may wish to). A recent case in 2015 found the law had

been correctly applied when funding was refused for a relative due to the fact one member of the family had already been granted funding.[762] In addition, strict criteria about financial assets are in place governing who is eligible for legal aid. These criteria do not just relate to the individual applying for funding but the financial details of an individual's close relatives are examined to ensure family funds are not available.[763] Of course, just because a relative has sufficient funds does not mean they would be happy to release them to fund participation in a complex inquest. In split families it can put people in an impossible situation of having to ask relatives they are not close to or they are distanced from for financial details.

Participants pointed out the contradiction that experienced legal representatives were actually very important in assisting families with negotiating the legal aid process and getting funding for legal representation. A recent report by the Law Society highlighted how challenging it could be for lay people to complete applications through the Exceptional Case Funding (ECF) without legal assistance.[764] The complexities of the legal aid process as well as the legal arguments around Article 2 engagement which are needed to achieve funding create a situation where families without experienced legal representatives are unlikely to get legal aid. This contradiction means either there are delays before a family can get legal representation while they are struggling to get funding or lawyers have to agree to work on a case without being sure whether the family will legal aid funding (which often requires a lawyer to be willing to work pro bono or at a low rate). A recent case highlighted the difficulties a delayed decision in respect to receiving funding can have in relation to family participation, with the inquest going ahead in this example before the LAA had considered the application for funding.[765] This can leave either the family or the lawyer (or both) out of pocket at the completion of an inquest. Participants pointed out that even when legal aid funding was granted, it

[762] *R. (on the application of Joseph) v Director of Legal Aid Casework* [2015] EWHC 2749 (Admin); (Queen's Bench Division (Administrative Court))
[763] Legal Aid Agency, *Inquests - Exceptional Cases Funding – Provider Pack* (2013), p 6
[764] The Law Society, *ACCESS DENIED? LASPO four years on: a Law Society review* (2017)
[765] *R. (on the application of Wiggins) v HM Assistant Coroner for Nottinghamshire* [2015] EWHC 1658 (Admin) (Queen's Bench Division (Administrative Court))

was unlikely to cover the full costs of experienced legal representation for a complex inquest, partly because the LAA did not understand the complexities, the preparation necessary and the number of pre-trial hearings or meetings required to support a family to participate effectively.

8.4.4. Impact of families struggling to participate

It was discussed earlier how important it was for families to be treated respectfully during the whole process and this is one aspect of participation that legal representation does not necessarily improve. It was mentioned previously that if State agencies are seen to be acting obstructively to families; requiring intervention by coroners or family lawyers to ensure families have access to the process and documents, then family confidence and trust in those agencies might be damaged. Similarly, to ensure families perceive the process to be legitimate, they must feel respectfully treated by coroners and their staff. It is important for families to not feel they have to fight or argue to be able to participate fairly and effectively but perceive decision-makers to be respecting their rights fully and freely. Good legal representation can support and assist families but the responsibility to ensure families' rights are fully exercised should not be devolved to their legal representative. It is clear that support offered by experienced legal representatives is vital in ensuring bereaved families are able to effectively access the process and be appropriately informed about their rights, the process and the evidence; all of which is necessary for participation. However, for families to perceive the process as legitimate, their access to the process and relevant information must be given by the decision-maker freely. Coroners and investigatory bodies should ensure families know their rights, and, along with State parties, provide aspects relating to participation, such as access to documents, freely to ensure families' rights are fully exercised. If it is perceived by families that it is only through the good work of their legal

representative that their rights are being respected, they might be able to effectively participate but still have negative perceptions about the legitimacy of the process.[766]

The Government have published a guide which sets out the process for interested parties.[767] However there was disappointment among some charities that the Government initially intended this charter to focus on bereaved families[768] but in the end, although the guide is primarily for bereaved families, it did not set out expectations for families above any other interested parties. Also, the guide does not cover the specific complexities of inquests following deaths in custody.

8.5. Conclusion

The legal right for bereaved families to participate in Article 2 compliant inquests is established but in practice, challenges to accessing that right mean effective and fair participation is not always possible. The legal framework states that family participation must be allowed in order to protect their legitimate interests. The interviews carried out for this thesis indicate these can be varied and unique but generally cover knowing the truth of the circumstances leading to the death, a public apology for any State failings and confidence that lessons have been learnt so future deaths are prevented. Participants also made it clear how effective participation for families could directly impact on the grief process; with early involvement and support being very important in limiting negative and prolonged complicated grief. In addition, it is clear that family participation can improve some aspects of holding the State to account for its actions. This occurs in two ways; firstly, effective participation for a bereaved family increases the likelihood of a fair outcome which assures failings are identified.

[766] Jacinta M Gau, 'Procedural justice, police legitimacy, and legal cynicism: a test for mediation effects' [2014] Police Practice and Research 1
[767] Office
[768] House of Commons Constitutional Affairs Committee, *Reform of the coroners' system and death certification: Eighth Report of Session 2005–06* (2006), p 11; INQUEST, *Response to Consultation Paper CP 5/2011 "The draft Charter for the current coroner service"* (2011)

Secondly, the bereaved family are often responsible for disseminating the outcomes of the inquests, which can be linked to both forcing change and ensuring the system is transparent and therefore that the public can be confident it is robust.

Richardson argues that the need for fair procedures can be justified in two ways: the instrumental affect which states fair processes optimise fair outcomes, and the process value affect which states fair processes protect values (including human dignity) irrespective of impact on the outcome.[769] The benefits of a fair process were further set out by Lord Reed in *Osborn v Parole Board,* where he stated there were three positive "virtues of procedurally fair decision-making": to optimise the likelihood of better outcomes, to ensure parties affected by the outcome feel they have been justly and respectfully treated in being able to participate in the process and to ensure actions by decision-makers are correctly governed by the rule of law.[770] Ensuring effective participation for families as representatives of the deceased, victims in their own right and those most directly affected by the death is a key aspect of a procedurally fair inquest process. Family participation can therefore be linked to the legitimacy of the system, both by ensuring the process follows rule of law principles and by improving perceptions of a fair process which positively correlate with perceptions about the legitimacy of the process. Key aspects of a procedurally fair process are ensuring equity of all parties, transparency, independent decision-making and treating parties with respect, which were all identified by participants as important for families participating in an inquest.

The support and advice of experienced legal representation can assist families in accessing the process, accessing information (both about the system and the case itself) and participating fully and effectively during the inquest; therefore optimising the opportunity for all the benefits of family participation to be realised. However, although legal representation is a vital necessity in ensuring a fair process and effective participation, for families to trust the process and be confident in the

[769] Richardson, p 26-30
[770] *Osborn v The Parole Board* [2013] UKSC 61, paras 67-71

outcome, how the process itself and any State parties involved treat the family is also important. If the family feel that State parties (or even in the worst cases, the coroner themselves) are obfuscating and not engaging with families transparently about what happened right from the start, this will impact negatively on perceptions of the legitimacy of those State parties, which ultimately leads to a lack of trust. The framework of the system itself must ensure families are able to easily access appropriate support and advice; if families feel they have to fight to access any parts of the process, they are unlikely to feel the system is fair. One specific example is access to information about the death itself; by definition the State parties involved will have access to the details but if families feel evidence is being kept from them, they will see the system as biased towards State parties. Lastly, the coroner and their team must ensure families are treated respectfully, as this impacts on increasing perceptions of fairness and therefore the legitimacy of the system.

Where discretion exists, decision-makers must be aware of what is required for effective participation and what optimises the opportunity for positive perceptions by families. Negative perceptions around State parties as well as sometimes coroners themselves, do not just leave families angry and resentful, they also result in a lack of trust and confidence in the system and therefore the outcomes. The purpose of complex inquests relate to complying with Article 2 requirements and mean fundamental questions about the use of State powers have to be answered. The legitimacy of the system is therefore fundamentally important and procedural justice theory illustrates correlations between trust, confidence and perceptions of legitimacy. It is therefore important for decision-makers, in particular coroners, to be aware of the key aspects of procedural justice to ensure families effectively participate and have positive perceptions about the process.

Chapter 9: CONCLUSION AND RECOMMENDATIONS

This thesis started from the position that bereaved families often struggle to participate in the inquest system following the death of a relative in custody, even though their right to participate is established in law. A recent debate in the House of Lords discussing family participation in complex inquests highlighted this struggle with Lord Rosser stating, "Many bereaved families can find themselves in an adversarial and aggressive environment when they go to an inquest".[771] Lord Paddick explained that his experience was that, for bereaved families, "[…] a search for the truth turns into a bruising adversarial encounter."[772] The right of families to participate is established in law, but it appears that implementation of that right is not fully achieved. In order to improve participation in the inquest process, this thesis re-evaluates why participation is so important and establishes important criteria that should be in place to ensure fair and effective participation for families is secured in practice. The dissertation explores the legal framework which governs a bereaved families' right to participate and considers theoretical explanations for why participation is important. As well as this legal and theoretical work, the study has drawn on a unique series of interviews with stakeholders who have experience of being involved in inquests following a death in custody in order to collect their detailed views and perceptions of the processes involved. Two main research questions were asked: firstly, what are the benefits of family participation in an inquest (to families themselves, to the outcome of the inquest and the wider inquest system)? Secondly, what factors need to be incorporated to ensure fair and effective participation which could optimise the achievement of those benefits?

The interviews sought to identify why the different stakeholders thought family participation was important and what such participation should involve in practice. These views were collated, analysed and discussed with reference to relevant legal and theoretical frameworks, as well as real life

[771] House of Lords Committee Stage Policing and Crime Bill, (December 7th 2016), Column 756
[772] Ibid, Column 759

examples. The process undertaken for this thesis has enabled the identification of the reasons why families should be able to participate in the inquest process and what is needed in terms of participation to achieve the identified benefits.

In relation to bereaved family participation in the inquest system following a death in custody, the legal framework established a right to participate in order to protect the legitimate interests of families. Early judgements focused on financial benefits to a family via a civil case or compensation as legitimate interests but the recent *Letts* case provided a wider understanding of a family's interests; including finding out the truth, identification of state culpability and knowing further deaths will be prevented.[773] The participants interviewed agreed that while families might have unique reasons for participating in an inquest, generally they understood their legitimate interests in terms of receiving redress in the form of an apology, discovering the truth, or obtaining a commitment that lessons have been learned. In addition, this thesis identifies the important role a family has in representing the deceased throughout the inquest process. This can be particularly relevant following a death in custody where there is potential for the deceased to be stigmatised due to their interaction with either the police or prison services. Effective participation for families can ensure the voice of the deceased is heard through an inquest, which provides a rounded picture of them as an individual beyond the circumstances surrounding their death.

Recommendation 1: The voice of the deceased can be represented by allowing a bereaved family sufficient support and space to represent the deceased throughout the inquest process.

Interviews also introduced the important impact participation could have on a families' grief process. Complicated grief theory states that extending a grief process can have negative impacts on an individual; and there are a number of reasons why someone bereaved following a death in custody may suffer from complicated grief. A healthy grief process following a sudden or unexpected death involves a bereaved person having a narrative which explains why the death occurred. Delayed access

[773] *Letts v Lord Chancellor (2015)*

to the truth can leave a grieving individual struggling to come to terms with a death. Also, when a grieving person creates a narrative to explain a death which is then challenged at a later date (when the truth is established) this can result in a renewed sense of grief. This thesis has reaffirmed arguments put forward by campaigners that an inquest is vitally important in allowing families to understand the true account of a death. Effective participation at an early stage ensures families can incorporate facts about a death into their narrative. Unfortunately, delays in the inquest process can still prevent families being able to move on until all the hearings are finished.

Recommendation 2: The impact of an inquest on the grief process of a bereaved family should be understood, especially in relation to the delays in the system. The obligation to hold an inquest in a timely manner must take account of negative impacts on the grief process if a family have to wait years for closure. As well as steps to minimise delays, ensuring families are provided with support and accurate information about the process and the death should be a priority.

This thesis has gone beyond the current definition of participation benefitting families themselves and introduced how participation can also be beneficial to the legitimacy of the inquest system itself. One function of the inquest system is to fulfil Article 2 requirements to identify the circumstances leading to a death, ensure culpability is established and to ensure future deaths are prevented. Family participation can have the instrumental benefit of improving the effectiveness of the system in relation to all three of these objectives to hold the State to account for any deaths that occur in custody. Family participation can help maximise the likelihood of a fair and accurate outcome, therefore ensuring any State failings are identified. Families can provide relevant information to the process and the families (with the support of their legal representative) can play a vital role in scrutinising the evidence presented at an inquest. As well as influencing the outcome of an inquest, families also play an important role in disseminating verdicts following a critical inquest; which can improve transparency and therefore public confidence in the process. Disseminating outcomes can also improve the opportunities for lessons to be learnt beyond specific institutions or individuals

involved in the death. Families have also been involved in bringing legal challenges which have resulted in changes to the investigatory process as well as specific practices in relation to how State agents use their power to detain and restrain individuals.

Recommendation 3: The benefit of fair and effective participation of bereaved families to the outcome of an inquest is acknowledged in policy provisions. This may well necessitate additional scrutiny or follow-up of learning by an independent party where a bereaved family is unwilling or unable to participate in the inquest process. There are broader positive implications for appointment of an independent party to participate in the process (including representing the public) but with an understanding of resource restrictions, prioritisation should be for those cases where families are not able to scrutinise the evidence.

Participation of bereaved families can go beyond having an instrumental effect on the inquest process. It can have an impact on the legitimacy of the process. Rule of law principles reflect the need for processes to be transparent and to treat all parties equally. This is particularly relevant in a democratic society when State parties are involved in a legal process, as it is important they are seen to be held to the same standards as individuals. Procedural justice theory also links perceptions of how fair, transparent and unbiased a process is with perceptions about the legitimacy of the system governing the process. Fair and effective participation of bereaved families can increase their sense of having been treated fairly and their perceptions of the fairness of the inquest system, therefore influencing how legitimate they believed the system to be and ultimately how much trust and confidence they have in the outcome of the inquest. In addition to procedural justice theory governing perceptions of legitimacy about the inquest system, issues of fairness and justice can also influence family perceptions of other agencies involved in an inquest. So family involvement increases their perception of the legitimacy of the inquest system, and family interaction with State parties can also influence their perception about those agencies. It has also been shown that wider views about the legitimacy

of the system can also be positively impacted through positive family involvement and perceptions that the processes are fair to all parties.

Recommendation 4: Any decision-maker who can influence and impact the participation of bereaved families in an inquest process (particularly coroners) should receive training and guidance to ensure they are aware of the positive impact that fair and effective participation of bereaved families in an inquest process has on the legitimacy of the process and the system itself.

Procedural justice theory also highlights the importance of parties being treated respectfully by decision-makers during a process. In relation to the inquest system, it is obvious that where families feel they are treated respectfully by the coroner and their staff, they will perceive the process to be more legitimate. However, this also relates to how families perceive their treatment by State parties involved in an inquest; where families perceive that State parties (either in the form of institutions or individual State officers) treated them fairly and with respect during the whole inquest process, they were more likely to perceive them as legitimate. Conversely, if State parties were perceived to be disrespectful by obfuscating, lying, or not treating families with respect, confidence and trust in them and the legitimacy of how they utilised their powers to restrain or detain was damaged. So if a loved one died in police custody, a family's interactions with both the police involved in the death and the IPCC influenced the family's views of those separate institutions. If the police themselves were seen to fight the family and hide facts from them, the family ended up with negative views about the police but if (in the same case) the IPCC were seen to be helpful to the family, then this positive experience resulted in families trusting this investigatory body.

Recommendation 5: Any decision-makers who can influence and impact the participation of bereaved families in an inquest process should receive appropriate training and guidance so they ensure the family are treated with respect and dignity throughout the process. Particular focus should be on providing all coroners with training about how procedural justice theory relates to the legitimacy of an inquest.

This dissertation has shown varied benefits resulting from families participating in an inquest including the protection of their legitimate interests; providing confidence in the legitimacy of the investigatory system and wider State agencies; and improving the effectiveness of an inquest, including as a means of holding the state to account. In order to achieve these benefits, what forms of participation are needed? The legal right for a bereaved family to participate in an inquest following a death in custody is clear, but in order to ensure this right is protected, participation must be effective not just in law but in practice. Fair and effective participation relies on the right for a family to be heard at all stages of an inquest. It also demands that family participation is able to influence the outcome. This means families should have effective access to the different stages of the inquest process and be able to engage positively with opportunities to be heard and to influence the process. Families should be supported and informed about the inquest process, as well as how they will be able to participate. Ensuring access to specialised legal representation at an early stage as well as providing families with full and early access to all documents relating to the case are vital aspects in ensuring families able to effectively participate. If families are able to participate in a fair, independent and transparent process, they will perceive it to be legitimate, which will in turn ensure they have trust and confidence in the outcome. The dissertation shows that two important factors are particularly important: providing early access to all the evidence surrounding the death and funding specialised legal representation for families. Support and advice provided by specialised legal representation can ensure families are informed about the inquest process, get access to all the evidence, and are able to participate in the process through being heard and influencing the outcome. Fair and effective participation maximises the potential for families to influence the outcome and secure an accurate verdict.

Recommendation 6: Families should be assured of fair and effective participation which requires:

a) **Bereaved family members who indicate they would like to participate must be given interested party status;**

b) **Bereaved families are signposted to independent advice and support relevant to the inquest system;**

c) **Bereaved families are informed of their legal rights in relation to participating in an inquest;**

d) **Information should be provided to families on the unique aspects of complex or Article 2 inquests;**

e) **Relevant decision-makers (including LAA staff) should recognise complex inquests following a death in custody as adversarial, not inquisitorial processes;**

f) **Bereaved families have an established right to legal aid funding, to ensure they can access experienced legal representation from the start of an inquest process. Legal aid must be the presumed default to allow families to access specialised legal representation soon after any death, rather than having to negotiate the complex exceptional funding system;**

g) **Bereaved families are given access to all documents or evidence relating to a death as soon as practically possible. It must be agreed that where there are concerns about information being in the public domain, this should not prevent families being provided with said information. Measures can be taken during an inquest process to restrict public access to information, but families must have access to all relevant information in order to participate effectively and fairly.**

h) **Reasonable steps should be taken to support families' attendance at the inquest: including giving families information about the location of the inquest, including nearest accessible parking, and providing a separate waiting room during the inquest.**

This thesis has explained how participation of a bereaved family following a death in custody can protect their legitimate interests by ensuring they know the truth, receive an apology and can be confident lessons are learnt. Participation can ensure the voice of the deceased is represented and also allow the inquest process to have a positive impact on the family's grief process. As well as benefitting the families themselves, participation can benefit the process by maximising the likelihood

of an accurate outcome and positively impacting on the legitimacy of the process and the system itself. Confidence and trust in the process only comes from families being able to fairly and effectively participate without having to fight for their rights. It is therefore important that all decision-makers actively protect and promote families' participation.

The inquest system is described as inquisitorial and therefore it is inherent within the system that the decision-maker (in this case the coroner) has wide discretionary powers, allowing for adaptation of rules depending on context, with the aim of ensuring the process finds the truth. Although inquests are governed by legislation, at many points the rules empower coroners to use their discretion to decide how the process will be conducted. In addition, there are many opportunities for decision-makers to influence the participation of families, from the LAA deciding on whether to provide legal aid funding for legal representation to State investigatory bodies controlling family involvement in an investigation prior to the inquest hearing. It is therefore very important that all decision-makers understand the benefits of family participation and how to ensure that the participation is fair and effective.

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ANNEX I

Participant information sheet for the PhD research of Jo Easton

September 2012

Please read the following information carefully before reading the consent form below. You may want to save this document or print it out to keep.

Project title: Impact of bereaved families participating in the inquest system following a death in custody

Principal researcher: Jo Easton, PhD candidate at the Human Rights Centre of Essex University

Supervisors: Professor Maurice Sunkin and Ms Lorna McGregor

I would like to invite you to participate in my research project. It is important that you understand what the aim of the project is and what your participation may involve so please read the following information carefully. Your participation in this project must be your own choice- there will be no negative consequences if you decide not to take part. If anything in this document is not clear or you have any questions regarding my research please contact me at jeeast@essex.ac.uk.

What is the purpose of this study?

This aim of this research is to gather information from varied stakeholders involved in the inquest system in relation to deaths in custody. I would like to investigate the perceptions of fairness within the process- both whether participants feel the current procedures allow for fair treatment of all those involved and how important participants feel fairness is within the process. An inquest is an inquisitorial process that stands apart from both civil and criminal justice procedures- however in relation to deaths in custody, cases can raise issues of conflict between parties. I would like to consider how important procedural fairness as a principle may be to an inquest that is investigating a death in custody. The issues I am interested in include equity of parties, respectful treatment and any other aspects to the process that participants feel are important in ensuring effective participation and fairness for all interested parties.

Why have I been invited?

You have been invited as a stakeholder in the inquest process. I will be speaking with a variety of people who have been involved in inquests following a death in custody – including interested parties, lawyers who have represented parties and coroners themselves. You may choose to remain anonymous, in which case no one other than myself and my two supervisors will know your name or that you have participated in the project: we will ensure your details remain confidential. In this case, some details may have to be edited to ensure you cannot be identified through the information you give me.

What do I do if I decide to take part?

You can contact me at jeeast@essex.ac.uk to discuss your participation. I have a questionnaire prepared and preferably we will set up a time that is convenient to you so that I can interview you (either in person or over the phone). I can send you a summary of some of the issues I would like to discuss so you can prepare your thoughts. The interviews will be recorded to ensure the information is accurately recorded. I will be carrying out the transcription of these recordings myself- so no one else will have access to the information. If an interview is either inconvenient or otherwise not possible- I may agree to send you a copy of the questionnaire to complete in your own time. At any point; if you decide you no longer wish to take part, you may withdraw from the process without giving a reason.

What are the possible benefits of taking part?

I hope that the opportunity to express your views on the inquest process may be a positive experience.

What are the possible risks of taking part?

The questions may involve issues or memories that are painful or distressing- you are under no obligation to answer any questions that you are not comfortable with.

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Confidentiality

All data will be collected and stored in accordance with the Data Protection Act 1998.

This means that all of the personal information that you give for this survey will be treated as confidential. It will only be used for the purposes of my PhD and will not be available to anyone other than myself and my two supervisors. The data will also be stored on a secure computer and hardcopies will be held in a locked cabinet.

Giving informed consent

If you are still interested in participating in the research – please read the Informed Consent Form below and sign it if you agree with the statements.

If you have any queries in regard to your participation- please contact me at jeeast@essex.ac.uk or either of my supervisors Professor Maurice Sunkin at sunkm@essex.ac.uk or Lorna McGregor at lmcgreg@essex.ac.uk

Informed Consent Form

Thank you for your interest in taking part in this research. Before you agree to take part you must be clear about what the project involves. If you have any queries: please contact the researcher Jo Easton at jeeast@essex.ac.uk

If you complete this form you are giving your consent to take part in a survey on your perceptions of the inquest system.

- I have read the Participant Information Sheet and understand what my participation in the research would involve.

- I understand that if I ask for my name or contact details to remain anonymous- the information I give will only be available to the researcher and her supervisors and if referenced, this information will not be able to identify me.

- I may choose for my name to be published, in which case details of particular cases that I discuss may be referenced and I may be identified alongside the information I give.

- I agree to any interviews between myself and the researcher, Jo Easton, as part of the project to be recorded to ensure the information is accurate.

- I understand that the information I give will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

- I understand that I can choose whether to participate or not, and that I can withdraw at any time prior to the interview being completed without having to give a reason and without any adverse consequences

- I understand that the information I have divulged will be used to produce a PhD research project and may be published.

Name:……

Signature:……

Date:……

Please tick one

• I would like to remain anonymous and for it to be assured that it will not be possible to identify me from any publications ☐

OR

•I give my permission for my name to be used in relation to the information given within this questionnaire in any publications resulting from this project ☐

ANNEX II Useful Acronyms

ACCT	Assessment, Care in Custody and Teamwork
ACPO	Association of Chief Police Officers
CO	Coroner Participant
ECHR	European Convention of Human Rights
ECtHR	European Court of Human Rights
ESP	Ex-senior Policeman Participant
FA	Family member participant
FLO	Family Liaison Officer
HRA	Human Rights Act
IPA	Interpretative Phenomenological Analysis
IPCC	Independent Police Complaints Commission
PFD	Prevention of Future Deaths (Reports)
PPO	Prisons and Probation Ombudsman
PO	Police Officer Participant
LAA	Legal Aid Agency
LA	Legal Representative Participant
SP	Senior Policeman Participant