



INQUIRIES & INQUESTS
Deborah Coles, Director of INQUEST



Introducing INQUEST

- Independent charity formed in 1981
- Free specialist casework service to bereaved people following deaths in custody, detention and other contentious deaths such as Hillsborough and Grenfell Tower.
- Evidence based policy, research and legal work; primarily informed by the collective experience of the bereaved people we work with.
- Coordinates INQUEST Lawyers Group, a national pool of lawyers who represent bereaved families and share values and aims of INQUEST.
- Regularly publishes journal INQUEST Law, including relevant articles, case notes and case law updates.

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“Many of us feel that however terrible the disaster that changed our lives, what happened to us in the aftermath has made living with it harder instead of easier.”

- Pam Dix, Disaster Action member



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For us the day of the inquest and the process was something which should have been difficult but necessary in the fight for justice. In fact it became an ordeal and was the most traumatising thing that happened to us, except for the death of our son.

- Mother of a man who died following police restraint
Speaking at an INQUEST Family Listening Day 2017



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*The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost **their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.***

- R. v. Secretary of State for the Home Department ex parte Amin [2003]



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Improving the post death processes

- Pre disclosure protocols
- The Coroners and Justice Act and post of Chief coroner
- a more purposeful interpretation of core rights including a recognition that families, as well as their deceased relatives, can be 'victims' of a violation of the right to life
- a broader scope of inquiry for deaths in state detention
- The opportunity for the delivery of more meaningful conclusions by juries
- Strengthening of the power of coroners to make reports to prevent future deaths



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Positive aspects of the second Hillsborough inquests?

- non-means tested public funding
- wide scope and remit
- pen portraits
- jury



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Key issues

- Access to Justice
- Inequality of Arms
- Delay
- Denial and defensiveness
- Demonization and blaming of the deceased
- Lack of disclosure of evidence
- No oversight and learning



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Access to justice & inequality of arms



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Conduct of State Lawyers



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Delay and denial are anathema to accountability, frustrate the process of learning and protect those responsible for criminality or wrongdoing.

Inquest outcomes: Learning & oversight

- No oversight mechanism for systematically auditing, monitoring or following up
- No statutory requirement to act on recommendations

National Oversight Mechanism

- Duty to collate, analyse and monitor learning outcomes and their implementation arising out of state related deaths.
- Accountable to Parliament.
- Must provide a role for bereaved families.
- Annual review and monitoring of inquest conclusions and Prevention of Future Death reports to track issues and trends.
- Ministry of Justice should provide a response to the annual review, to ensure a high level of political focus and scrutiny.
- Sustained learning should be centralized and rolled out nationally rather than locally or regionally.

Recent reviews

- Bishop James Jones Review of Hillsborough, pending publication
- Angiolini review of deaths in and following police contact, pending publication
- A review of the way NHS trusts review and investigate the deaths of patients in England, Care Quality Commission 2017
- Preventing Deaths in Detention of Adults with Mental Health Conditions inquiry, Equality and Human Rights Commission 2015
- Harris Review into Self-inflicted Deaths in Custody of 18-24 year olds, 2015

Hillsborough Law


Public Authority (Accountability) Bill

CONTENTS

1. Duties on public authorities, public servants and officials and others
2. Code of Ethics
3. Offences and penalties
4. Assistance for bereaved persons and other participants at inquests and public inquiries
5. Debates
6. Short title, commencement and extent

Schedule – Amendment of the Legal Aid, Sentencing and Punishment of Offenders Act 2012

Truth
Justice
Accountability



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Inquiry: Underlying Principles

The voices and experiences of those affected must be at the heart of this inquiry and inform every stage of the process. The Inquiry must:

- Recognise and address the pain, trauma and individual and community damage caused by the tragedy and the lack of public trust and confidence in the state institutions involved;
- At all times ensure that bereaved people, survivors and affected residents have a full and central role in the inquiry process;
- Ensure all those affected are treated with dignity and respect;
- Examine the role played by institutional racism, discrimination and inequality;
- Establish truth and accountability;
- Ensure visibility of its processes and its decision making.



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