Written evidence from INQUEST (AET0038)

About INQUEST

1. INQUEST welcomes the opportunity to contribute to this important inquiry. We echo the committee's assertion that human rights 'are only valuable if they are enforceable'. In our work, access to justice is hindered by inequality of arms between state bodies and those bereaved by a state related death. This undermines the potential preventative role of a properly conducted Article 2 investigation into a state related death and the uncovering of human rights violations.

2. INQUEST is the only charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. INQUEST's specialist casework focuses on deaths in prison and other forms of detention, and mental health settings, as well as deaths where wider issues of state and corporate accountability are in question, such as Hillsborough and Grenfell Tower. Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people.

3. INQUEST co-ordinates a national network of over 250 lawyers, who provide specialist legal representation for bereaved families. This network of lawyers is unique in providing an overview on how the coronial and wider investigation systems are operating in practice.

4. INQUEST's Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody. She has given oral evidence to the JCHR previously, most recently to the Deaths and Mental Health in Prison Inquiry.

Introduction

5. Reflecting on INQUEST's work on contentious deaths and their investigation, in particular those in custody and detention or involving public authorities and state agents, it is clear that the incorporation of the European Convention on Human Rights (ECHR) by the Human Rights Act (HRA) 1998 into domestic law and the direct incorporation of Article 2 of the ECHR (right to life), has resulted in significant changes to the laws, procedures, policy and practice on the whole way the state is now obliged to investigate deaths and the rights of bereaved people. The core principles developed through the HRA and a body of case law both in this country and Strasbourg has benefited all bereaved people and society as a whole.

6. Inquests are the primary means by which the state discharges the duty to investigate a death under Article 2. Over the last 20 years INQUEST has worked with families on a range of individual cases which have used human rights law, and the right to life in particular, to secure more effective scrutiny of the state when people die. These have ranged from deaths in a police or prison cell or following contact with state agents, to deaths in a health or social care setting, deaths of service personnel or deaths following major disasters such as Hillsborough and more recently Grenfell. Many of these cases raise concerns about the failure of the State to protect life and raise human rights violations.

7. It has been bereaved people, lawyers and NGO's like INQUEST who have been the driving force behind securing the changes, turning Human Rights from the abstract to a practical tool for change, a living instrument. Families have demanded their right to find out the truth about the death of their relative, for those responsible to be held to account, and for other deaths to be prevented.

8. Article 2 has mandated critical changes to the way inquests into these deaths must be conducted. Article 2 places a duty on the state to have in place systems and laws that enable wrongful death or other ill-

treatment to be prevented and the state to take appropriate steps to safeguard and 'protect' life. In certain circumstances, for example where a public authority or state agent may bear responsibility for a death, the state is under a procedural duty to provide an enhanced investigation. This is because it is recognised that people in custody or otherwise detained are in a particularly vulnerable category being dependent on others for their treatment and care and being in the control of the state.

9. However, this obligation to investigate fully and publicly has also been found to extend to hospital deaths and deaths in care homes, through to the failure to take action against people who present a risk to others in the community.

10. Human rights are not the exclusive property of lawyers and the courts. Underpinning INQUEST's work is the monitoring of human rights following suspicious deaths and how public authorities are held to account. Effective accountability requires appropriate policies, procedures and mechanisms of redress. We talk about human rights in the context of the men, women and children who have died whilst in the care or custody of the state where they are dependent on others for their treatment and care, and their right to life and the right to be protected from harm.

11. The high and rising levels of self-inflicted deaths in prison, 'prison suicides', illustrate the importance of rigorous scrutiny of the operation of systems and procedures which are designed to prevent suicide and self-harm. The current situation is bleak and has grown worse over a sustained period of time, with little sign of improvement. In these circumstances, it is more vital than ever that lessons are identified, changes implemented, and sustained improvements are enforced. Such steps will reduce the risk of self-inflicted deaths occurring and are likely to save lives. It is for these reasons – learning lessons and rectifying dangerous practices in order to prevent future deaths – that the Courts have repeatedly recognised the importance of effective State investigations into deaths in custody.

12. Deaths following the use of force by police also have rightly attracted disquiet and focused attention on the mechanisms for holding the police to account. Deaths of those in mental health settings, often detained because of increased risk of vulnerability and self-harm, have raised concerns about the lack of an independent investigation body, and the reliance on internal investigations in which Trusts, and private companies effectively investigate themselves.

13. The Human Rights Act has enshrined in law the rights of those left behind to an effective public investigation into a death. The family has a more central place in the investigation and the right to participate in that investigation, and there is now a general right to disclosure and access to investigation reports. We have worked to try and ensure a rights culture is embedded in the investigation and inquest system in particular to better understand the needs and rights of all bereaved people –underpinned by the Coroners and Justice Act 2009, and the placing of families at the heart of the process.

14. We can see the Human Rights Act as a prism through which we are better able to identify and scrutinise systemic failings of public authorities and the value of having an open and transparent process for scrutinising deaths. This has resulted in more meaningful outcomes and conclusions from inquests that reflect where appropriate state responsibility for the death and how the death may be prevented. There has also been a greater role for coroners to notify relevant authorities about action to prevent further deaths which is an additional safeguard and importantly accessible to the relevant authorities and the public.

15. There are however remaining challenges, not least the attack on legal aid and lack of effective family access to non-means tested public funding for inquests into state related deaths and the resulting

dramatic 'inequality of arms'. There are also those deaths that fall outside the scope of the Article 2 principles but require more effective inquiries.

16. There is also the lack of an effective mechanism to audit and monitor action taken in response to inquest outcomes and coroner's report and the accountability gap this allows. As we reported to the JCHR Inquiry on Mental health and Deaths in prison, the lack of statutory enforcement and oversight of safety recommendations arising from post death investigations is putting lives at risk.[1]

17. In the context of the tragedy at Grenfell Tower, of which INQUEST are coordinating the Grenfell 'Inquest Lawyers Group', it is worth noting that due to LASPO, the Grenfell tenants were unable to access Legal Aid to challenge safety concerns as they arose prior to the fire.

18. In almost forty years of working with thousands of bereaved families, INQUEST has found that access to resources such as independent advice and specialist legal representation has been crucial in helping to establish the truth about how someone has died whilst in the care of the state. As such, this response focuses on addressing the following question on access to resources posed by the committee: Is there the access to justice needed to enforce human rights?

Response

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

- Family member bereaved by death in police custody, Angiolini review family listening day[2]

19. Cuts to legal advice and support agencies have had a detrimental impact on access to justice. Access to justice is dependent on your knowledge of your rights and how to uphold them. Nowhere is this more critical than following a death in the care of the state. It is essential that families are empowered from the outset with information about their rights and how to participate in the legal processes that follow.

20. Since the introduction of LASPO, numbers of firms have ceased practicing or seriously limited their legally aided work as it is simply not financially viable. This has resulted in bereaved families struggling to access legal advice. In the past two years INQUEST has witnessed a marked and disturbing rise in difficulties finding lawyers able to assist families bereaved in contentious state related deaths.

21. INQUEST cases rely on Article 2 of the European Convention on Human Rights which protects the right to life. The procedural limb of Article 2 requires that the state effectively, promptly and openly investigate any contravention of this right by stage agents and stipulates that the next of kin of the deceased must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests. The cases of Jordan and Amin are instructive here.

22. The current inequality of arms between bereaved families and state agencies is a significant obstacle to families being able to have access to justice following a state related death. It runs through every aspect of a families' access to full involvement, information and representation and should sit as a guiding priority for change.

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[1] INQUEST Submission to the Joint Committee on Human Rights: Inquiry into Mental Health and Deaths in Prison (March 2017), available here or at www.inquest.org.uk/justice

[2] INQUEST report of the Family Listening Days held to support the independent review into deaths and serious incidents in police custody (May 2016), available here or at www.inquest.org.uk/justice

23. The current funding scheme that exists is having a damaging and distressing effect on families, is further frustrating the inquest process by adding an additional layer of complexity and delay and is thwarting the process of scrutiny and the potential for learning. It also threatens to undermine some of the positive changes being made to the process following implementation of the Coroners and Justice Act 2009 in July 2013.

24. The suggestion put forward by the Ministry of Justice that inquests are inquisitorial, informal processes and families can either represent themselves and ask questions about the death of their relative or ask others to answer their questions is a myth. Currently an unrepresented family are presented with a bank of lawyers representing each and every person in any given case whose conduct may be open to criticism. An inquisitorial process is in fact highly adversarial and requires specialist knowledge of organisational policies and procedures and the law.

25. For families, the lack of an automatic right to non-means tested, specialist legal representation and the overwhelming and uncertain processes for securing financial support typifies a system stacked against them and weighted in favour of state bodies. This imbalance in representation reduces the chances of an independent fair and balanced investigation into the death. Without representation families are isolated and alienated from the investigation and inquest process and do not have the opportunity to effectively participate.

26. The Hillsborough inquests were a notable exception, where families had access to legal representation administered through a tailor-made Home Office scheme funded by a special grant from four ministries. It covered funding for preparation, client care, advocacy and experts and for travel and accommodation for families, including subsistence where necessary. This meant families did not have to negotiate the legal aid system. This reduced the distress, complexity and confusion of the inquest system and ensured that the Hillsborough families had parity of representation. This should be the norm, not the exception.

27. Without exception, in every state-related death with which INQUEST has been involved in, the state has been represented by publicly funded expert legal teams, routinely supported by relevant experienced professionals and senior personnel. All of this is automatically in place for state bodies. There are no merits or means test, it is paid for at taxpayers' expense and/or from professional organisations, trade unions or private companies. For example, in a prison death inquest it is not uncommon to see separate layers for the prison service, the private escort company, the private healthcare provider, the nursing staff, the NHS Trust which supplies external medical input and individual prison staff and doctors.

28. In contrast, a bereaved family is required to fight at every stage for their right to be represented and heard. A person who has recently lost a child, a partner, a parent, a sibling will be in a state of shock and grief, probably living through the worst experience of their lives. Yet at this traumatic time they are forced to negotiate a complex process to attempt to access justice.

29. Families are forced to take part in a process that they have not chosen to initiate, which will take place whether they are able to participate effectively or not, and which affects them more profoundly than any other participant. Yet while state bodies receive automatic legal representation which is not subject to a merit or a means test, paid for at taxpayers' expense, families have no equivalent right to funded representation.

30. Exceptional Case Funding is available under the Legal Aid scheme subject to a complex merits test which requires families to show not only that the facts of their case triggers to the procedural requirements of Article 2, but also that legal aid is necessary to fulfil those requirements. It is onerous, intrusive and can take many months. In most cases it is not only the only individual legal aid applicant who has their financial means assessed, but also all other close family members and often their partners. This can

create significant family tensions as well as making the relationship with the lawyer difficult or requiring pro bono work in the interim period before the awarding of any funding which is not backdated.

31. This can be a very stressful period for the family who are left in limbo not knowing whether they will be granted legal aid or will have to try to raise the funds themselves, or what steps can or cannot be taken on their behalf. Obstacles to securing ECF funding hit further crisis following the LAA's introduction of its new provider pack in April 2017. Without consultation or pre-warning, the LAA withdrew the long standing and routine practise of granting the backdate of legal help waivers in Article 2 inquest cases. They say the Regulations do not provide for this and that they had made an error is previously allowing funding on these terms. The change has had a catastrophic impact on inquest funding, placing significant extra cost and financial risk on bereaved families and the lawyers that represent them.

32. INQUEST has witnessed a crisis in legal representation since the changes, with many families struggling to secure legal representation. The direction of these changes sits at odds with the wider policy picture with the now wide scale support for automatic public funding advocated (Angiolini, Bishops James, both Chief Chief Coroner).

33. The increasing restrictions and limits imposed on Legal Help eligibility has also prevented large numbers of low income families accessing initial advice and assistance previously available. An elderly bereaved parent who owns their own home may no longer be able to access free initial advice. This is particularly concerning on 'grey area' cases where questions around the application of Article 2 need to be explored and argued. Many families face are forced to make stark decisions around whether to go it alone or the stress of finding funds they don't have to pay privately.

34. In most state-related inquests, if families are lucky enough to secure legal representation, they will have one lawyer. This is in contrast to the multitude of lawyers representing various detention and health bodies, custody-related services and employees, often represented by their trade union or professional association. The increased involvement of private sector companies in the detention and health sectors has added significantly to those numbers.

35. For example, in cases of prison deaths it is common to see separate lawyers for the prison, private escort company, private healthcare provider, nursing staff, NHS Trust, and for individual prison staff and doctors. Families feel heavily outnumbered and overwhelmed when they see banks of lawyers. They usually reach the conclusion that the inquest process is stacked against them.

36. It feels to families that the key focus of lawyers for state bodies is to avoid potential criticism, damage limitation and defence of policies and practices rather than contribute to the prevention of future fatalities. Families who wish to Judicially Review a Coroners decision or inquest outcome face difficulties in obtaining Legal Aid funding and also face the threat of costs should permission not be granted.

37. By establishing the facts surrounding state-related deaths, inquests can save lives by identifying mistakes and make recommendations to prevent future deaths. When families have access to the right legal support and advice, they are empowered to take part fully in the process to expose unsafe practises.

38. These issues are explored in full in the INQUEST submission to Rt. Rev Bishop James Jones', Review of the Hillsborough Families' Experiences. The full response is available here and is attached to this submission. Part one describes in more detail the issues surrounding inequality of arms and access to justice. INQUEST organised Family Listening Days for this review. Both reports are attached and provide unique insight into the challenges faced by bereaved families, illustrating the importance of access to non-means tested legal representation.[3] [4]

[3] INQUEST report of the Family Listening Days held to support the independent review into deaths and serious incidents in police

39. Notwithstanding these problems there is no doubt that the HRA has provided a tangible difference to the protection of people in the care or custody of the state. Critically the Human Rights Act recognises the need for a democratically accountable state and the importance of holding the state to account where people die in its care and for any human rights abuses and violations that may occur. However, families are routinely and critically disadvantaged by the current funding regime and by the failures to ensure a level playing field in the legal processes following a death. This impedes access to justice in upholding Article 2 of the European Convention on Human Rights.

RECOMMENDATIONS

INQUEST recommends the following:

40. **Ensure access to justice for bereaved families**.
Families should be allowed access to justice through non-means tested public funding for representation at inquests into state related deaths. There is now a groundswell of support for this. Most recently in 2017, this recommendation has been supported by the previous and current Chief Coroner[5] and in two recent reviews by Dame Elish Angiolini[6] and Bishop James Jones[7]. It has also been supported by the Bach Commission. Historically the importance of families' legal representation has been recognised by parliamentary bodies, independent reviews. Notably the Joint Committee on Human Rights itself recommending in 2004 that *"participation of the next-of-kin in the investigation into a death in custody is an essential ingredient of Article 2 compliance. …[I]n all cases of deaths in custody, funding of legal assistance should be provided to the next-of-kin.";* and the Harris review 'Changing Prisons, Changing Lives' Report of the Independent Review into Self Inflicted Deaths in Custody of 18-24-year olds (July 2015).

41. This should include:
- Automatic non-means tested funding to families for specialist legal representation immediately following a state related death;
- Funding to an equivalent level to state bodies, with reference to: funding for silks and juniors, rates and brief fees, attendance at pre-inquest reviews;
- A relaxation of the current rules to enable funding of more than one family legal representative where a real and insurmountable conflict exists;
- Funding support for family, with reference to: travel and subsistence, overnight accommodation, loss of wages;

42. This would help ensure proper public scrutiny, equality of arms with state funded or corporate lawyers and would help maximise the preventative potential of coroner's inquests and help to facilitate learning.

43. **Build a national oversight mechanism on deaths.**

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custody (May 2016), available here or at www.inquest.org.uk/justice

[4] INQUEST report of the Family Listening Day held to support the Rt. Rev Bishop James Jones' Review of the Hillsborough Families' Experiences (April 2016), available here or at www.inquest.org.uk/justice

[5] Chief Coroner, (2017) Report of the Chief Coroner to the Lord Chancellor. Fourth Annual Report 2016-2017

[6] Angiolini, E. (2017) Report of the independent review of deaths and serious incidents in police custody

[7] Jones, J. (2017) 'The patronising disposition of unaccountable power': A report to ensure the pain and suffering of the Hillsborough families is not repeated

The lack of statutory enforcement and oversight of safety recommendations is putting lives at risk. An independent body should be set up tasked with monitoring, auditing and reporting on the accumulated learning from post death investigations and inquest outcomes. This would ensure greater transparency in terms of tracking whether action has been taken to rectify dangerous practices and systemic failings, and by better protecting the right to life would mean better compliance with Article 2.

44. This was a recommendation of the Angiolini review on deaths in police custody and has previously been drawn attention to in the Harris review. The Government has rejected these recommendations, preferring to rely on the current system as sufficient to meet its obligations, including under Article 2 ECHR [Government response to Harris Review, p.27, para 81 and p.28, para 83

2 March 2008