Achieving accountability and embedding recommendations - Learning from bereaved families

Theme: Levers to improve performance and accountability

Related Dame Elish Angiolini Recommendations: Chapter 15 of Dame Elish's *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* covers the need for better support for families. The chapter includes a section on the family as a source of learning. Chapter 17 of Dame Elish's report addresses the importance of learning lessons and embedding recommendations.

Task:

- Address repeat recommendations by identifying those with most impact to reduce deaths in custody and embedding them

Recommendations

Board members are invited to review the paper and accept the following recommendations:

i. The Ministerial Board should agree that the relevant agencies develop systems to involve families to a greater extent in the successful implementation of recommendations as part of the Ministerial Board's work programme.[1]
ii. The Ministerial Board should agree that the systems mentioned in 'i' should be consistent with the set of principles outlined in this paper
iii. The Ministerial Board should agree that bereaved families should be consulted as a fundamental part of developing this work.

Authors: Juliet Lyon CBE, Chair of the IAP, Deborah Coles, IAP member and Andrew Frazer, Head of Secretariat - on behalf of the IAP

[1] This could be managed through a sub-group of the Ministerial Board, as with other workstreams on the work programme.

Independent Advisory Panel on Deaths in Custody (IAP)

Achieving accountability and embedding recommendations - Learning from bereaved families

February 2019

About the Independent Advisory Panel on Deaths in Custody (IAP)

The Ministerial Council on Deaths in Custody formally commenced operation in April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel (IAP)
- Practitioner and Stakeholder Group

The remit of the IAP (and overall of the Council) covers deaths which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAP, an arms-length body, is to provide independent advice and expertise to the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAP's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE was appointed Chair of the IAP in 2016. The other members of the IAP are:

- Deborah Coles
- Prof. Seena Fazel
- Prof. Jenny Shaw
- Jenny Talbot OBE
- John Wadham

Further information on the IAP can be found on the website:
http://iapdeathsincustody.independent.gov.uk/

For more information on this report – or on the IAP more generally - please contact:

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Context of this paper

1. The Rt. Hon Theresa May MP commissioned Dame Elish Angiolini DBE QC to produce a report on Deaths and Serious Incidents in Police Custody. This report, and the Government response to it, was published on 30 October 2017[2]. The Government response states that the Home Secretary has asked the Ministerial Board on Deaths in Custody to take forward further work in two areas: healthcare in police custody and support for families. Following discussions at the Ministerial Board on 1 November 2017, Ministers agreed a work programme for the Board which covers the following themes:

   - Healthcare in police custody - *Reduce the risk of a death in police custody occurring*
   - Support for families - *If a death in custody occurs, ensure better support for families*
   - Inquests and Legal Aid - *If a death in custody occurs, ensure families are supported through the inquest process*
   - Accountability - *Ensure organisations are held to account*
   - Investigations - *Ensure investigations and inquests are timely and effective*
   - Levers to improve performance - *Ensure lessons are learnt and improve accountability*

2. Chapter 17 of Dame Elish's *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* addresses the importance of learning lessons and embedding recommendations:

   > *"Recommendations from past reports have not always been followed up in a coherent or joined-up way. There is no single national body that can monitor progress and maintain the momentum and pressure for institutional change. As a result, progress tends to be piecemeal.* ***The same failings, and the same issues, appear to manifest themselves time and again****."* (Emphasis added).

3. In response to this recommendation, the IAP convened a meeting of investigatory and regulatory bodies to identify the recommendations which, in their view, would have the most impact on reducing deaths in custody. The IAP then provided advice to the Ministerial Board on Deaths in Custody regarding the need to learn lessons effectively and embed recommendations following a death in custody. The paper outlined some of the barriers to progress and difficulties the custodial services and establishments face when attempting to implement recommendations. The paper also discussed possible methods to improve the implementation of recommendations. One of these was the idea of learning from bereaved families:

   > ***"Learning from bereaved families.*** *The Harris, Farmer and Angiolini reviews all recommended learning from, and responding respectfully to,*

[2] https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody

bereaved families as a way in which hard lessons can, and must, be learned. In terms of positive impact, the IAP maintains that this could do more than many other measures to prevent future deaths in custody."

4. The Ministerial Board discussed the IAP's paper at the meeting on 10 October. There was considerable interest in the idea outlined above, and members discussed how such learning from bereaved families could work in practice across the different custodial sectors. Board members noted how the very act of engaging with families could both provide accountability, as well as encouraging the services to improve their implementation of recommendations.

5. The IAP was keen to build on the Board's positivity, and interest in this area. This paper represents the IAP's initial thinking on how learning from bereaved families can best be drawn upon to improve the ability of the state to respond to the recommendations it receives after a death in custody or detention.

Background

Legal background and official reports

6. Article 2 of the European Convention on Human Rights guarantees the right to life. The court has also established a role for the bereaved family in the processes following a death. The European Court of Human Rights' guide to Article 2[3] explains:

> *" … in all cases, the victim's next-of-kin must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests (Al-Skeini and Others v. the United Kingdom [GC], § 167)."*

7. This expectation has been discussed and referenced in a number of reports, which have emphasised the need to involve families and learn from their experiences. For example, the Harris report – published by the IAP in 2015 – had, as one of its recommendations:

> *"Following each self-inflicted death in custody, the Minister for Prisons should personally phone the family of the prisoner who has died to express their condolences on behalf of the State, to promise that a full investigation will take place, and that any lessons from the death will be acted upon."*

8. Dame Elish covered the experience of bereaved families in considerable detail in chapter 15 of her report. She noted one of the prime motivations for families who experience a death in custody:

> *"It became clear during the review that one of the main factors that motivates families is a desire that no one else in future should have to endure what their loved one or they have experienced."*

9. Dame Elish also wrote of the input families can have into training:

> *"Police forces, the IPCC, CPS, Coroners offices and the College of Policing should give consideration to how family experiences can be brought into training and awareness packages. As a result of the tragic experience of the loss of a loved one in police custody many next-of-kin have become experts on a range of issues following a death in police custody and exposing officers to these families and listening to them is an invaluable training resource for all levels of command."*

10. A study[4] undertaken to consider how best to improve the learning from Serious Case Reviews noted with regard to the involvement of families in investigations:

[3] https://www.echr.coe.int/Documents/Guide_Art_2_ENG.pdf
[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331658/RR

> "*Their perspective can be very informative and might result in more meaningful recommendations"*

11. This was quoted in the review[5] undertaken by Stephany Carolan commissioned by Southern Health NHS Foundation Trust, as it sought to take forward the recommendations from the Mazars report[6]. The review noted the top three reasons families gave for explaining why they took part in investigations:

> *"1. Have questions answered;*
> *2. Ensure that lessons have been learnt, and to see that lessons have been learnt;*
> *3. Ensure that other people won't have to go through the same problems again."*

12. Ms Carolan's review made a number of recommendations regarding contact with families including the following:

> *"Sharing updated action plans with the families six months after the report has been completed."*

13. The Amin judgement[7] humanely connects the state's legal duties of an investigation with the motivation of families to stop others from suffering a bereavement:

> *"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."*

14. The CQC's report 'Learning, candour and accountability' concerned the review and investigative process after a death, and a significant feature of this report was concerned with improving interactions with the bereaved family. Recommendation 3 in the report was introduced with a statement setting out a clear expectation that families must be treated honestly and respectfully as 'equal partners'. The full recommendation is included below as it sets out clearly the intention fully to consult families, and ensure that they are involved in the decision-making process:

340.pdf

[5] A review of family involvement in investigations conducted following a death at Southern Health NHS Foundation Trust

[6] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

[7] R. *v.* Secretary of State for the Home Department, *ex parte* Amin [2003] UKHL 51, para. 31

Recommendation 3:

NHS Improvement and NHS England, with support from CQC, should lead work to define what families and carers can expect from healthcare providers when they are involved in the investigation process. This guidance should be developed in partnership with families who have experienced the investigation process and should include how families can be offered access to timely independent advice and understand what resources are available to support them during the process. The guidance should set standards for local services on the information to be offered – for example, how and when families may be contacted about investigations, what local support is available, what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement, and how this will be communicated, nationally and locally. The guidance should ensure that:

- *Families' views are proactively sought and used to inform decisions around whether a review or investigation is needed.*
- *When a decision is made that an investigation should be carried out, families and carers should be involved to the extent that they wish and treated as equal partners in this alongside NHS staff.*
- *Families and carers are involved in setting terms of reference, are kept fully informed of the progress of an investigation and offered an opportunity to shape the report, as well as updated on how this leads to improvements in care (if they wish).*

Coordinating organisations: *NHS Improvement and NHS England supported by CQC*

15. The IAP published its Family Liaison Common Standards and Principles[8] in 2013 which set out the IAP's views on how organisations should interact with bereaved families. One of the principles is:

> *"Families often want to know what will happen as a result of the death of their family member to prevent it happening again. A senior representative of the organisation responsible for the care and treatment of the deceased will inform families about actions taken, in practice and policy, as a result of investigations and inquests."*

<u>Family listening days</u>

[8] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2013/02/Family-Liaison-Common-Standards-and-Principles-IAP.pdf

16. The IAP has drawn on the insight of families on a number of occasions. In September 2011, the charity INQUEST arranged for 11 families (comprising 19 family members and friends), with direct experience of the investigation and inquest system following the death of a relative whilst in mental health detention, to meet members of the IAP. The aim of the event was to share details of family members' experience following a death in custody, the investigative and inquest process, and the aftercare and support provided by Trusts and hospitals. The write-up of the family listening day described the family's experience of the investigation as:

> *" … families were told they could not see the reports following investigation, or participate in the gathering of information, although best practice suggests that Trusts should carry out investigations into the deaths of detained patients reasonably speedily, with a degree of independence and with the involvement of the family. This was not the experience for the majority."*

17. The IAP also used a family listening day to develop the evidence base for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. The families involved expressed their appreciation of such a process:

> *"I am glad that we were invited to this event. I appreciate being here and I think my boy would have liked me being here as well. It is a shame that we did not get this when he was alive".*

18. The families made it clear how much they value hearing about the successful implementation of recommendations:

> *"Where information had been passed to families informing them about changes that had been made in response to the self-inflicted death of their relative this was particularly welcomed. One family described how they found comfort in knowing that ligature points have been removed. One family member described the value of knowing that,*
>
> > *"Two suicides had been prevented in the prison where my son died because of changes made after his death".*
>
> *Another took similar comfort,*
>
> > *"I waited three years for someone to tell me he didn't die for nothing".*

19. This led to the following recommendation from the families:

> *"Families should be notified of action taken in response to the outcomes of the investigation and inquest process."*

20. The family listening day organised in preparation for the CQC's Learning, candour and accountability' report featured a further comment similar to the one made above:

> *"For me, the message which was raised a number of times is that the investigation process should provide hope to surviving family and reassurance that lessons will be learned, that the same thing won't happen to someone else's daughter, brother, mother or husband."*

21. Dame Elish included a quote from the IPCC in her review which gave an insight into the benefit of listening to families:

> *"INQUEST facilitated a family listening day. The advice provided by families was very valuable and as a result we identified several actions to try to improve the experience of families. This has included providing training on bereavement awareness to all IPCC investigators and commissioners, and re-writing the information that families first receive from us."*

22. Recommendations have been made in several other reports from INQUEST family listening days regarding two further important aspects regarding family engagement:

    (i) ensuring that the Government agencies inform families about their rights to play a meaningful role in the investigation and inquest processes and where to go for independent advice and support[9]
    (ii) to be treated with sensitivity and given information is vital in enabling bereaved people to uphold their rights.

[9] The IAP notes that the leaflet published by the Government and co-produced by INQUEST, families, IOPC and Chief Coroner is a positive step in this regard: https://www.gov.uk/government/publications/deaths-in-police-custody-leaflet-for-families

Benefits of greater interaction with families

23. There is growing recognition of the important role families can play in protecting life and reducing the risk of suicide and self-harm in custody. Lord Farmer's review sets out the range of support families can provide and the support they need to do so. In 2017 the IAP's consultation with 60 women in prison and 40 health and justice professionals and its Keeping Safe consultation with 150 men across 60 prisons, both emphasised the importance of family contact. At the same time family members from Nepacs in the North East submitted evidence to the IAP advising that prison managers and staff should deliver '*prompt follow up from phone calls/messages from concerned family and friends – do not dismiss them as worriers, worse still, nuisances.'*

24. There are many reasons to support greater interaction with members of bereaved families, if they are willing, in the weeks and months after a death in custody. The reasons ultimately all come back to providing accountability to the families for the way in which the state investigates and scrutinises these deaths, and helping to implement recommendations. To enable full discussion, these reasons have been grouped into the following four categories – accountability, improving the investigation, gaining the family's perspective, motivation and continuity.

<u>Accountability</u>

25. The death of any individual in the care of the state is a shocking and traumatic event, clearly so for the family grieving for them. When a death occurs, the family will most often want answers and seek to understand what has caused it to happen. On a fundamental human level, the family deserves at a minimum the respect and co-operation of the state, which entails the appropriate sharing of information. Engaging with the family in an open and respectful manner is a necessary but not always sufficient component of providing accountability.

26. Scrutiny bodies who investigate such deaths frequently report that a common desire of bereaved families is for others not to go through a similar experience. They want to know that the implementation of the recommendations will make a difference and limit the chances of it happening again.

27. Establishing a system by which senior agency officials – as a matter of course - offer to meet the family to explain what they have done to make the establishment safer is one way of providing such accountability to families. If a face to face meeting is not acceptable, then senior officials can offer to prepare a report for the family setting out the changes they have made.

Improving the investigations

28. The families' overriding interest is usually in establishing the truth about what happened and ensuring a robust and transparent investigation and inquest capable of uncovering the truth and the identification of any systemic failings. The independent investigation bodies (e.g. PPO/IOPC) have guidelines about engagement with families that should be followed as there is valuable information that can be gleaned from conversations with the bereaved family. The family are best placed to describe their perspective on events, provide additional context regarding the deceased and discuss anything left out of the initial accounts.

29. As the Amin judgement (see paragraph 13) states, not only is involving the families required, but family engagement can ensure the process is one of searching scrutiny. They, more than any other body, have the most vested interest in uncovering the truth and interrogate the facts, highlight failures and the identification of measures to prevent future deaths. In this way, the public interest also benefits. In other words, they can hold the state to account for the way in which is investigates and scrutinises these deaths and that is important.

Gaining the family's perspective on the investigative and coronial processes

30. Following a death, a considerable amount of scrutiny is undertaken including internal reviews, external investigation reports and inquest findings. Here the family can provide helpful feedback on the actions and behaviour of the services following a death in custody and their experience of the inquest process.

Motivation

31. A death in custody will always most affect the family who are bereaved. There is also an impact on the staff of the establishment involved. They are often deeply affected by the death, and there are typically genuine and far-reaching efforts made to prevent another death occurring. Notwithstanding these sentiments, the passage of time, competing pressures and the possible impact of further recommendations from subsequent deaths can all serve to blur the successful implementation of recommendations and, at the least, increase the chances of more limited implementation.

32. Under a system where the relevant senior official is always expected to offer to meet the family after the inquest (for example), there may be less chance of this happening. The knowledge that a senior leader from the relevant service is expected to meet the family and explain, in detail, what precautions and improvements have been made can only help to buttress the motivation to prevent such deaths happening again.

33. If such meetings with families becomes a part of regular practice, the IAP would also hope that this would increase the likelihood of establishments undertaking full reflection and learning processes with colleagues and senior management regarding the event, to ensure that any failings and solutions are rapidly identified.

Continuity

34. While families suffer an enduring loss, the situation for the institutions and their staff inevitably changes over time. It will not be uncommon for the senior leadership of the prison, police force, hospital or immigration removal centre to change between a death in custody and the culmination of the investigative and coronial processes. This change in personnel raises the risk of the establishment losing track of the recommendations they are committed to implement, or reducing their urgency as personal awareness of the circumstances that inspired them disappears with the staff who experienced them.

35. If incoming leaders know that they will, in time, need to meet all families where any investigation or inquest is currently incomplete, it may serve to sharpen the establishment's response and reduce the chance of the recommendations becoming deprioritised as the new administration focusses on its immediate objectives. Put simply, the IAP hopes that this expectation will ensure that the successful implementation of any recommendations remains the priority for each service, regardless of whether the leadership changes.

36. This process could lead to staff and management discussions following the outcomes of investigations and inquest to consider any action needed to be addressed at an individual and collective organisational level. This process of reflective learning could also enable staff to come together to hear of any jury or inquest findings and prevention of further death reports, and increase the chance that these findings will be shared and understood by a wide range of staff.

Consideration of possible negative impacts

37. As with any proposal, it is necessary to consider any possible negative outcomes from its implementation. The main concerns involve the potential impact on both families and staff. Given the sensitivities involved, any development of this idea should be undertaken taking into account the views and needs of these groups.

Principles

38. The IAP advocates the greater involvement of bereaved families, if they are willing, in the learning of lessons and implementing of recommendations following deaths in all forms of state custody. The IAP does consider that any such involvement should be consistent with the following principles:

- Any proposal taken forward under the auspices of the Ministerial Board should be developed in collaboration with bereaved families.
- Involving families in the communication and process of learning must be a genuine process, not a tick-box exercise.
- recognising the emotional impact on families and offering support should be the main priority during any such process.
- Families should be willing and invited to be involved, and the invitation must be sufficiently flexible to the needs of the family to enable them to take part if they wish to do so.
- Family liaison officers – or equivalent – should make clear to families their ability to be involved in helping the establishments to learn from the death at the agreed point.
- When adopting this practice, the services involved should also pay due regard to the needs of their staff meeting with families, and ensure they are trained, supported and looked after appropriately.

Recommendations

i. The Ministerial Board should agree that the relevant agencies develop systems to involve families to a greater extent in the successful implementation of recommendations as part of the Ministerial Board's work programme.[10]
ii. The Ministerial Board should agree that the systems mentioned in 'i' should be consistent with the set of principles outlined in this paper.
iii. The Ministerial Board should agree that bereaved families should be consulted as a fundamental part of developing this work.

[10] This could be managed through a sub-group of the Ministerial Board, as with other workstreams on the work programme.