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DCA meeting with families of military personnel who lost their lives in Iraq

Prepared for DCA by Opinion Leader

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1. Introduction

Opinion Leader was invited to facilitate at a meeting convened by Harriet Harman QC MP, the Minister of State at the Department for Constitutional Affairs, with families of military personnel who lost their lives in Iraq. The meeting was 2 hours long and held in Westminster, on the afternoon of 4th December 2006. It was held in private.

The meeting was designed to allow family members to give their feedback on the investigation and inquest process and coroners' service. We looked at what they thought went well, what did not and what lessons could be learned for families in the future.

DCA sent out invitations to the meeting to 58 next of kin whose inquest had been held and they collated responses. 17 people representing 12 families attended in total. The session was a roundtable discussion between the family members, facilitated by an Opinion Leader facilitator. Participants also completed a short questionnaire on their experiences, to provide another means of capturing the views of participants.

Harriet Harman introduced the meeting and gave a response at the end, having observed throughout. The meeting was also observed by and of DCA Coroners Unit, by James Arbuthnot MP (Chair of the Defence Select Committee) and in part by the Right Honourable Lord Falconer of Thornton QC, the Secretary of State at the Department for Constitutional Affairs and Lord Chancellor. .

This document summarises the main findings from this meeting.

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2. Executive summary

All families had been through extremely traumatic experiences, some of which were very recent. Nonetheless, there was a great deal of openness and constructiveness from participants, all of whom shared a desire to make a difference for others who may go through similar experiences in the future.

A minority was satisfied with the investigation and inquest process from the coroners' service. What they most appreciated was a thorough, supportive and personalised service.

However, the coroners' service had not sufficiently met the needs of most families. The main issues and problems reported were:

- The **lengthy timescale** between incident and inquest (more than 3 years in some cases)
- **Insufficient notification** of the inquest in a number of instances, and a consequent lack of opportunity to prepare
- Not getting **access to key information** (no one felt that they were told what to expect with the process, many wanted fuller disclosure of evidence at the inquest and several have still not received a statement of verdict)
- Some specific problems with the **running of the inquest** (including key witnesses not being present, factual errors and not having the opportunity to ask questions and interrogate evidence)
- A **lack of sensitivity** in treatment of families in some cases (reports of insensitive comments being passed around and not being treated as victims)
- **Cost and logistical issues** (being asked to pay to receive documents, difficulty of lower income families to pay for legal representation, inconvenience for some of travelling to Oxford)

The inquest process is critically important to families who feel they cannot 'have closure' until they understand the circumstances of their relative's death. Currently, many go through a protracted experience which leaves them with substantive questions unanswered. They consequently do not regard the process as being open and transparent, and feel let down as a result.

It should however be noted that some of the complaints that families had did not relate to the coroners' service. In particular, there were a number of criticisms of the media's treatment of families and some complaints also about the army's internal investigation process which in some cases added to the delay between the death and the inquest. .

There were a number of specific changes and improvements that families suggested; these fit within three broad themes:

1. **Faster resolution:** Some suggestions were made for regionalisation of the service as a way of addressing the perceived Oxfordshire backlog
2. **Telling families the truth:** disclosure both before and during the inquest as a matter of course

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3. **Putting families at the centre of the process:** Right to ask questions, victims' advocate to help them negotiate the process, more lead-time for preparation etc.

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3. Main Findings

What went well

Whilst the meeting was critical of the investigation and inquest process in the main, there were some positive comments in discussion and questionnaires also highlighted positive experience.

When asked what went well with the process, a number of participants commented that they valued the support that they received from the Ministry of Defence (MoD) visiting officers and the coroner's officers, particularly on the day of the inquest.

> *"The casualty visiting officer was supportive, arranged transport, kept in touch with us"*
>
> **Questionnaire response**

> *"Our support officer from the army was supportive"*
>
> **Questionnaire response**

There was also positive feedback on the coroner from some, with comment that the coroner was polite and thorough. One family commented that the coroner had contacted them personally, which they appreciated.

> *"He was very thorough. Very, very thorough. How thorough that man was."*
>
> **Participant comment**

What went less well

The time taken for the process was a key concern, with complaints about the length of time relatives needed to wait for an inquest to be held. This time delay was not limited to the coroner investigation and inquest only, but also included military investigations.

> *"What really got me is the timescale between the incident and the inquest itself. Okay I suppose I am quite lucky compared to some people, it has only been 14 months from the incident to the inquest"*
>
> **Participant comment**

> *"We waited three years and three months"*
>
> **Participant comment**

There was also concern about the time taken to receive information, particularly MoD Board of Inquiry reports, which was part of a wider concern about information provision, before, during and after the process. Complaints relating to information provision before the process included comment that they were not given enough notice of the inquest.

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"I got a letter from my casualties visiting officer…asking me if I was going to the inquest…and I had to ring him up saying I knew nothing about this, what is happening? Two weeks later the inquest was on."

Participant comment

There was criticism of the lack of information provided on the inquest process, which led to participants feeling ill prepared and anxious.

"You don't know what to expect. You are just going in blind."

Participant comment

Participants had not appreciated that the inquest hearing would be in public and open to members of the press. There was specific comment around the lack of preparedness for the media involvement in their case and participants were unsure how to handle the media intrusion. They felt that they should have been informed of the possibility of media involvement and advised on how to handle this situation.

There was a main theme around lack of disclosure, both before and during the inquest. Some participants felt that they knew little, if anything, about the circumstances of their loved-one's death prior to the inquest and the thought that they would be presented with new and important information at the inquest was another cause for anxiety. Family members felt bombarded by information at the inquest and found it difficult to absorb what they were being told.

"You get to the inquest and it is like surreal. You think you haven't really got a clue what is going on, because it isn't an experience that most people want to go through. You wouldn't want to go through it again and you are not really prepared for it. I think you think when you get there you are going to get everything, you are going to get the facts and there will be closure, but it doesn't happen like that."

Participant comment

Participants commented on the difficulty of obtaining information prior to inquest and when they were provided with information, the lack of time to interrogate and prepare questions, especially as reports are often lengthy. Those with legal representation also discussed the difficulty that their lawyers had in obtaining information in time to prepare. Family members themselves often wanted to ask questions and were either not allowed or did not have sufficient time to prepare.

"I was sat there. The coroner just mumbled in to his papers. There were loads of things I wanted to ask, I want to ask them about the injuries. I wasn't given the opportunity to ask any questions. We were just bombarded with information."

Participant comment

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"Our barrister only got the statements on the day that we were there and he was just like sitting in the dark. He was in the dark, couldn't prepare."

Participant comment

"We did feel we weren't fully informed. That is the crux of the thing. You don't get full disclosure. If it is going to be read out in an open court, why can't you see those things before."

Participant comment

Whilst new information is presented at the inquest, family members comment that much is still withheld from them at the inquest and the circumstances surrounding the death of their family member is still not clear. This lack of clarity means that participants do not feel satisfied with the outcome. There is comment that they feel they are not getting the truth. They feel they are doing a disservice to their loved ones and that they cannot 'have closure' as they do not fully understand the circumstances of their relative's death.

"We feel if we don't tie all these loose ends up there is no closure for us. It is like as if we are hanging on to something. We can't even put it to bed."

Participant comment

Whilst some accept the principle that facts should be withheld, they struggle to understand why key facts in their case cannot be shared.

In terms of information provision after the inquest, participants comment about the difficulty in getting a written statement of the verdict which would have been read out at the inquest and the difficulty in getting transcripts of the proceedings. Several participants had not received a statement of verdict. Some had chased for verdicts and not received them, and one participant had received a transcript of proceedings on request but had to pay over £600.

"I paid £609.27 for a photocopy…I have had to pay for this. I'm thinking about people who can't afford this. Who don't come from the right background."

Participant comment

Another main theme was around relatives not being at the centre of the process. In addition to not being told what to expect and not being able to ask questions, this also included not being told of their rights, such as the ability to have legal representation, and the lack of sensitivity to their wishes and needs. For example, a few participants commented that they found the detail of how their family members died presented at the inquest distressing. They had either wanted to be warned in advance of the explicit nature of the detail at the inquest or have the choice whether or not to hear this at all. They also want the choice of whether or not to see distressing photographs.

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"I didn't realise how explicit it was going to be. If they had warned us beforehand it would have been helpful."

Participant comment

There was also complaint about insensitive comments at the inquest and participants felt that they were not being treated as victims.

"He had a fishing expedition he kept saying."

Participant comment

The location of the inquest is another common concern. Families can find the trip to Oxford lengthy and stressful and staying overnight in a hotel, far from home, adds to their anxiety.

"Why do we need to come here, you know. How could they not be repatriated at Prestwick…I had to come to Oxford. If I never see Oxford again I'll be a happy person."

Participant comment

There was comment about the apparent lack of collaboration between the armed forces and the Coroner. Participants found the different information sources confusing, especially when the information is conflicting. There was also specific comment that information was withheld from them by the armed forces as it was believed that they would find the information too upsetting. When this information came to light at the inquest it was even more distressing for families.

"If they just came out and said to us everything upfront. This is what happened…It is not until two years down the line you are getting snippets here, there and everywhere and you think 'Why didn't you say that before?' and it's 'Well, we didn't want to upset you.'"

Participant comment

"I don't know if people think they're doing us a favour by not giving us the full facts but the thing is when you find out facts two years later it opens that wound even bigger."

Participant comment

There were also specific negative comments about the coroner who was seen as intimidating and unhelpful. Family members felt that witnesses were not sufficiently questioned by the Coroner and the inquest was allowed to continue when witnesses had not attended. They complained about factual error and they also complained that the process had felt rushed.

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"It became quite clear that even the mildest of questioning wasn't allowed and that the coroner himself was just rushing through statements. And I asked him on more than one occasion, because I found it difficult to follow him, you know, could we take it a bit [slow]. It was just a case of 'look, we've got another inquest to go.'"

Participant comment

What lessons might be learned

After talking about their experiences, participants were asked what lessons might be learned from their experiences and what improvements could be made.

A key suggestion was that participants thought that families should be better supported. There was mention of a 'victim's advocate' whose role would be to help families navigate the inquest process, letting them know what to expect, what their rights are (e.g. to legal representation or access to records or reports) and be a point of contact for any questions and information requests.

"I am not sure how it would work but I would have thought some form of – as independent as it can be – victim's advocate or even victim's advocates office where someone is assigned to you and says 'We'll hold your hand, we'll take you through this process' because either you don't understand it or you are just so bereft with what is going on that it has to be told to you three or four times."

Participant comment

Improved information and communication is also important in helping to supporting families. Families would like to be notified of the inquest date further in advance. They believe they should be better prepared for the process, perhaps having a meeting before or receiving a leaflet which would explain how the process works and tells them what to expect.[1]

"Even if you put like a booklet together that says the key things you can expect from an inquest."

Participant comment

It was felt that details of the case should be released to families in advance of the inquest giving ample time for them to absorb the information and prepare questions if necessary. Families want to be better informed but they thought there should be a choice about what they were told, in case they would find the detail too upsetting.

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[1] Such leaflets currently exist

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Better communication between the armed forces and the Coroner's office is another suggestion, so that all information is made available to families in advance of the inquest. A victim's advocate might be able to facilitate this.

> *"Proper communication between the Coroner's office and army, all at the same time more or less, so that we can prepare ourselves for these things."*
>
> **Participant comment**

> *"The army and the Coroner's service [should] have the same information as you have."*
>
> **Participant comment**

Participants also wanted the transcript of the inquest to be available soon afterward and at an affordable price.

Participants comment that they would like to be informed of their right to have legal representation and furthermore funding should be provided by the State to families who cannot afford legal representation.

> *Participant 1:* *"You need a legal representative really."*
> *Participant 2:* *"Yes, I mean some people can't afford to pay for someone to help them. These people should be helped. Not everyone is in a position where they can pay."*
>
> **Participant comment**

There are also a number of comments about the speed of the process. Families want inquests to happen sooner and they want less of a wait between the death and receiving the Board of Inquiry report.

There are specific recommendations for improving the inquest hearing for families. Participants did not want to feel that the process wass rushed and in particular they wanted enough time to ask questions. They also wanted to ask questions of a wider scope, either personally or by legal representatives. Furthermore they wanted to feel that the inquest was uncovering the whole truth so they wanted as few details as possible to be withheld.

> *"I would just want to be listened to. When you ask something you want the truth."*
>
> **Participant comment**

Lastly there was consensus that inquests should be held more locally, including Scotland. Participants did not necessarily expect to have an inquest in their local town but rather in their region.

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"There should be something in Scotland, there are a few from where we are in Yorkshire, they could do them in Leeds, Huddersfield, even Manchester. I don't see why they have to go, and the other thing obviously is the amount of time it takes."

Participant comment

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