RECOMMENDATIONS SUBMISSIONS OF
DEBORAH COLES ON BEHALF OF INQUEST

1. INQUEST is a charity and non-governmental organisation with over 40 years of unique expertise in inquests and public inquiries into state-related deaths, including disasters. We are the only charity providing expertise on state-related deaths and their investigations to bereaved people, lawyers, advice and support agencies, the media and parliamentarians.

2. Across our work, bereaved families and survivors have told INQUEST that they participate in post-death processes such as inquests and public inquiries to establish the truth about what happened to their loved ones, and seek accountability and learning. However, their overriding objective is to ensure that nobody else goes through the same traumatic experience. There is a reasonable expectation that these processes will lead to systemic change and the prevention of future deaths in similar circumstances. That way, some meaning can be given to their loss.

3. Throughout the Grenfell Tower Inquiry there has been extensive evidence that following the Lakanal House fire inquest there was a failure to implement the crucial recommendations set out in the Coroner's Rule 43 report.[1] The recommendations provided an opportunity to make life-saving changes to fire safety measures. However, they were not enacted; the lessons were wilfully ignored and there was a culture of complacency, cynicism and inaction. Had several of these recommendations been prioritised and implemented, the Grenfell Tower fire may not have occurred.

4. Bereaved family member Nabil Choucair told the inquiry:

> *"The same way how we are being --how we are cross-referencing Lakanal House and looking back and saying, "Oh, if they had sorted it all out at the time, then Grenfell wouldn't have happened", if we have another catastrophe, they will look back at Grenfell Tower's inquiry and say, "Well, you know, you had these recommendations and that was it". That can't be the case."*[2]

5. We are extremely concerned that despite this knowledge, following the inquiry's phase one report, public bodies have reneged on their promises to implement vital, life-saving recommendations, allowing lives to continue to be at risk without any sanctions. Particularly alarming is the outright rejection of vital recommendations requiring every high-rise building to prepare Personal Emergency Evacuation Plans (PEEPs) for all residents whose ability to self-evacuate may be compromised and keep up to date information of residents and PEEPs. The Home Office's alternative proposal of Emergency Evacuation Information Sharing (EEIS) for buildings with 'known' serious fire safety issues is not far-reaching enough to ensure the safety of residents with disabilities who are not able to self-evacuate in an emergency. In light of the vast evidence illustrating how a lack of PEEPs contributed to the loss of lives at Grenfell, it is unimaginable that such crucial and potentially transformative recommendations can be dismissed whilst people's lives are still at risk in unsafe residential buildings, and whilst the inquiry is ongoing.

[1] On implementation of the Coroners and Justice Act 2009, Rule 43 reports were replaced with Reports on Action to Prevent Future Deaths, under Regulation 28 of the Coroners (Investigations) Regulations 2013.
[2] Choucair T/265/38:16-38:23.

6. The distinct lack of follow up on whether action has been taken following recommendations undermines trust in and the legitimacy of inquiries, other post-death processes and ultimately of the UK's complex and advanced investigatory framework. Lord Bingham recognised the importance of post-death investigations in his October 2003 speech in the House of Lords in the case brought by the family of Zahid Mubarek, who was murdered by his racist cell mate in March 2000 in Feltham YOI:

> *"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."*[3]

7. In essence, to learn from past mistakes and put them right is seen as central to the entire protection scheme of Article 2. Article 2 contains obligations to respect, protect and fulfil the right to life. This also incorporates a more expansive obligation to the state to facilitate and implement learning from past mistakes. However, this obligation and the preventative role that inquiries can and should play is consistently overlooked in the UK, with the lack of any legal or administrative framework. The INQUEST proposal for a National Oversight Mechanism aims to put that right.

8. There is no oversight at Government level and no body with responsibility to oversee or audit responses to recommendations and to track and monitor progress and their implementation. Where recommendations are not implemented there is no requirement for regular updates on progress or for an explanation on why they have not yet been implemented. This hinders the opportunity for long lasting change where life-saving measures are recommended.

National Oversight Mechanism

9. INQUEST is calling for a National Oversight Mechanism (NOM); a central oversight body to oversee the work of all public bodies tasked with implementing recommendations following post-death processes for state-related deaths. Through collating, analysing, and following up on recommendations, the NOM would hold state and public bodies accountable for their decisions in response to recommendations.

10. The NOM would also have a vital role of publishing an annual public report on accumulated learning from recommendations and sharing good practice where recommendations following deaths are actioned. This would serve to increase trust in investigatory processes.

11. INQUEST believes that there are four key reasons for establishing a NOM:
    1) The impact of the accountability gap on bereaved families.
    2) The lack of transparency about the extent to which public bodies are implementing recommendations.
    3) The absence of central responsibility to ensure actions are being taken in response to key recommendations.
    4) The added value a NOM would have on post-death processes.

12. Post-death investigatory processes are re-traumatising for families. The gap in accountability from public bodies – from recommendations made to actions completed

[3] Amin, R (on the Application of) v. Secretary of State for the Home Department [2003] UKHL 51 at [31].

– has significant implications and is a disservice to bereaved families seeking systemic change and improvement. The psychological trauma of hearing about another death or serious incident in similar circumstances cannot be overstated. The current system allows for a fragmented and piecemeal approach to acting on recommendations that lacks continuity.

13. Additionally, prioritising and implementing recommendations in the first instance would result in a more efficient use of resources. Avoidable deaths would be less likely to occur and in turn this would reduce the need for costly multiple post-death processes from the investigatory stage through to inquest and inquiry processes.

14. The Air Accidents Investigation Branch in the UK issues safety recommendations following investigations into accidents and serious incidents. The Branch follows up on recommendations; the relevant body must respond to recommendations within 90 days and set out which action had been taken and the timeline for completion. The Branch has the power to issue a response to the body and request further justification when a reply is inadequate, and for further follow up where necessary. This is an example of an efficient mechanism for following up and responding to recommendations.

15. Conversely, under the Inquires Act recommendations are not legally binding. This is evident in the fact that only 6 out of 68 public inquiries between 1990 and 2017 have been followed up by a parliamentary select committee to examine the implementation of recommendations.[4] Consequently, there is no urgency in the approach to recommendations and no-one being held accountable. The NOM could rectify this accountability gap.

16. The issue was further highlighted in the evidence of Melanie Dawes, who referenced the gap in follow up after the Grenfell Tower fire:

> *"There was no tracking mechanism put in place, something that I think was extremely important and there should have been. You know, because you're always going to have general elections, changes of ministers. That sort of disruption is normal in a civil service department, so you need systems to make sure that things get carried through and continue to get attention."*[5]

This reinforces the importance of having a mechanism in place to ensure that recommendations are not shelved.

17. INQUEST previously wrote to the inquiry requesting that it use its discretion to review the implementation of the Phase 1 recommendations. Where an inquiry is ongoing, it would be effective to have in place a method to audit progress by calling on public bodies to provide updates. An example of good practice is the Independent Child Sexual Abuse Inquiry's process for monitoring institutional responses to inquiry recommendations, which sets out a 12 month timeline for follow up between the inquiry and institutions.[6] Another example is the Manchester Arena Inquiry, where the process for monitoring recommendations was set out[7] and where statements from public bodies in response to recommendations has been published.[8] This holds institutions accountable for any failure to act.

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[4] How public inquiries can lead to change, Institute for Government, December 2017, (p. 26), https://www.instituteforgovernment.org.uk/summary-how-public-inquiries-can-lead-change
[5] Dawes T/249/188:20-189:2.
[6] https://www.iicsa.org.uk/reports/process-monitoring-responses-inquiry-recommendations
[7] Monitored recommendations – Manchester Arena Inquiry
[8] Volume I's Monitored Recommendations – 10 and 11 January 2022 – Manchester Arena Inquiry

18. At present, even where change is achieved it is not sustained and where recommendations are not prioritised, delays in implementation allow further deaths to occur in the same circumstances. Bereaved family member Hisam Choucair told the inquiry:

> *"I hope that through your recommendations, sir, you will make sure that this doesn't happen again, and I hope that your recommendations will be fulfilled, and you will do something in your power to make sure that they are fulfilled.*
>
> *…So I hope that lessons will be learnt, and you will make sure, through your recommendations, and through listening to the bereaved, survivors and whoever else, that this doesn't happen ever again."*[9]

19. The gap in accountability, transparency, and responsibility results in a breakdown in public trust in the system and not only discredits the process but creates a culture of complacency. It is not enough for Government to repeat the tired troupe that 'lessons will be learned' yet fail to ensure that these lessons have been implemented. This amounts to placations and only adds to the harm already done to bereaved families. What purpose do multiple layers of investigations into state related deaths serve if public bodies are not obliged in some way to follow-up on recommendations made?

20. Recommendations can and should be transformative, but there must be a sustained effort to prioritise their implementation. The inquiry, and all other post-death investigatory processes, should be a forum which enables vital learning and from which long-lasting meaningful change follows to prevent future deaths. This can only be achieved through accountability.

21. INQUEST's proposal for a NOM has garnered widespread support and during the inquiry has been endorsed by the Mayor of London and both legal teams representing the bereaved, survivors and residents.

22. We conclude with a quote from survivor and bereaved family member Hanan Wahabi who told the inquiry,

> *'I implore you to make the case and space for learning and reflection, for ensuring we hear from witnesses what they have learnt. Saying they would do nothing differently cannot be an acceptable response if we are serious about learning. 72 people passed away and we can't bring our loved ones back. The impact it's had on our families and our community could have been prevented. We can't change that now, but we can change the lives of those we've lost to count, for their deaths not to have been in vain. There has to be change. We have to learn from this.'*[10]

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[9] Choucair T/265/82:7-82:12 and 83:5-83:8.
[10] El Wahabi P1 T/70/188:14-189:1.