Extract from 2020 Justice Report

When Things Go Wrong

VI. LEARNING, ACCOUNTABILITY AND SYSTEMIC CHANGE

Forty-three years and one month before Hillsborough, 33 people died and over 500 were injured at an FA Cup tie between Bolton Wanderers and Stoke City…The Home Office inquiry, chaired by Moelwyn Hughes, criticised the police and ground officials for not realising the significance of the build-up outside the ground…Moelwyn Hughes made many recommendations to prevent such a disaster happening again.
(Professor Phil Scraton)

6.1 A key feature that distinguishes inquiries from other parts of the justice system is the expectation that recommendations will be made to prevent similar events from recurring. Indeed, it has been argued that this is the primary function of an inquiry: "to be forward-looking, to improve government and public services, and to prevent the same mistakes from being made again – is the most important contribution that an inquiry can make to the wider public interest".

6.2 The report by the Institute for Government *How public inquiries can lead to change* noted that many inquiries have delivered valuable legislative and institutional change, citing the establishment of the Rail Accident Investigation Branch, CRB checks and more effective gun control. However, relative to their expense, the expertise they accumulate and the importance of the subjects they address, the success of inquiries in precipitating meaningful change remains questionable. In the Executive Summary of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Sir Robert Francis observed that "the experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent".

6.3. That observation corresponds with the Grenfell experience. Although the Chair found in Phase I that the aluminium composite material (ACM) cladding panels provided the "primary cause" of fire spread up the tower, at time of writing Government has spent less than a quarter of what it promised to replace ACM cladding on other structures, leaving 300 high-rise buildings at risk three years after the disaster.

6.4 Moreover, the Grenfell Tower fire itself demonstrates the consequences of failing to implement previous recommendations. Following the Lakanal House tower block fire in 2009 that led to the deaths of six people, the coroner issued Rule 43 letters in 2013 finding inter alia that the "stay put" policy and Building Regulations were in need of review. These recommendations were not implemented by the time of the Grenfell Tower fire, over eight years after the previous incident.

6.5 Rule 43 letters were replaced by Prevention of Future Death (PFD) reports following enactment of the Coroners and Justice Act 2009 ("the 2009 Act"). Schedule 5, paragraph 7(2) of the 2009 Act provides that a person to whom a Senior Coroner makes a PFD report must give a written response to the Senior Coroner. However, as noted by Dame Elish Angiolini, "coroners are not able to follow up or enforce recommendations in their PFD reports".Dame Elish stressed how in the context of deaths in custody, lack of enforcement creates an

accountability vacuum, exacerbated by the fact that no one is held formally responsible for implementing recommendations arising from IOPC investigations.

6.6 Consequently, a 2018 INQUEST report on the deaths of 25 women in custody since March 2007 found "a series of systemic failures around self-harm and suicide management and inadequate healthcare", in addition to "other contributory factors [including] lack of staff training, poor communication and poor record keeping". This is despite 15 PFD reports relating to the deaths having been issued over the same period.

6.7 The reasons why institutions fail to change – behavioural, cultural, political as well as legal – are complex, and stretch beyond the scope of this review. However, the Working Party felt that it was critical to consider how the justice system might be reformed to promote meaningful implementation following the inquiry process. We appreciate that this is of central importance to those principally affected by catastrophic events, who see recommendations formulated at the conclusion of the legal process, then hear about deaths in similar circumstances months or years later.

Inquiry design

Limited tenure of judicial chairs

6.8 Where judicial chairs are appointed, there is an inherent limitation in their ability to initiate a process of systemic change:

> *By nature of their training and experience, judges tend to see the end of an inquiry as a hard point of separation, after which their involvement ceases…their oaths preclude them from getting involved in politics... However, such a wall between an inquiry and its aftermath entails the loss of the chair's unique standing and moral authority, which often make them one of the most effective advocates for their recommendations.*

6.9 Evidence to the Select Committee on the Inquiries Act 2005 underscores the point. Beatson LJ suggested that "unless an inquiry directly concerns the administration of justice, or where there has been prior agreement about this...a judge should not be asked to comment on the recommendations in his report or to take part in its implementation". Lord Gill added that "once the inquiry chairman has reported, that is the end of it as far as the chairman goes. His job is done, and I would not wish to be involved in any follow-up. The implementation of recommendations is an entirely different exercise. That is for the politicians and the Executive to do".

6.10 One way this inherent limitation can be counteracted is to incorporate timelimits for implementation within the drafting of recommendations. Each of the detailed recommendations arising from the Ladbroke Grove Rail Inquiry was given a time limit paired with an institution responsible for its implementation. This pragmatic approach, however, is atypical.

Scrutiny by inquiries

6.11 Despite the limitations outlined above, inquiries can themselves play a part in monitoring implementation of recommendations. The Independent Inquiry into Child Sexual Abuse (IICSA) has incorporated monitoring into its processes:

How the Inquiry monitors institutional responses to recommendations

The Inquiry expects that where recommendations are addressed to an institution, the institution will act upon those recommendations and publish the steps they will take in response, along with a timetable for doing so. The Inquiry suggests that, unless otherwise stated, institutions should do this within six months of the recommendation being published. The Inquiry monitors the responses of institutions through the following formal process:

- *Recommendation published by Inquiry*
- *After 3 months: 1st letter The Inquiry will send a letter noting the Inquiry's expectation that the institution publishes its response within six months.*
- *After 6 months: 2nd letter If a response is not published, the Inquiry will send a further letter noting the Inquiry's expectations that the institution will publish a response imminently.*
- *After 7 months: 3rd letter If a response is not published, the Inquiry will send a third letter noting the Inquiry's disappointment that the institution has not yet published its response. The Inquiry will publicly state that it has written to the institution.*
- *After 9 months: Request for statement under Rule 9 of the Inquiry Rules If a response has not been published, the Inquiry will request a statement from the institution which sets out their reasons for not having published any response. The Inquiry will publicly state that it has requested this information and the response received will be published on the Inquiry's website.*
- *After 12 months: Witness statement required under the Inquiries Act If an institution fails to provide the requested statement and has not otherwise published an adequate response, the Inquiry's Chair, Professor Alexis Jay OBE, will exercise her powers under section 21 of the Inquiries Act 2005 to require a witness to provide a statement. The Inquiry will publicly state that it has taken this action and the response received will be published on the Inquiry's website.*

6.12 The Working Party agrees that this method of monitoring has considerable attraction, given the continuity that it provides between the formulation and the evaluation of recommendations and the transparent, open nature of scrutiny. The Working Party recommends that where the timescale allows, public inquiries should incorporate a formal processfor tracking the steps 91 taken by addressees of interim recommendations. INQUEST has written to the Grenfell Inquiry asking that it be employed in the Phase II hearings.

6.13 However, this form of scrutiny is only available to those inquiries whose lifespan allows for the formulation of interim recommendations and a period for their implementation (IICSA was announced in 2014 and converted to a statutory inquiry in 2015). It may not be feasible in shorter inquiries. In one frequently cited example, Sir Michael Bichard reconvened the Soham Inquiry six months after it reported, to monitor the progress of his recommendations, which demonstrates that it may be possible to encapsulate an element of review. Nevertheless, while the Working Party strongly supports scrutiny of the implementation of recommendations by the inquiry team where feasible, longer-term scrutiny is very likely to require external oversight.

External oversight

6.14 It is perhaps unsurprising that inquiries often fail to bring about change, as "there is no routine procedure for holding the Government to account for promises made in the aftermath of inquiries". Quite apart from those instances where Government has indicated that recommendations will be implemented, there is no routine procedure for Ministers to explain why they have rejected inquiry recommendations. After initial investigations, several rounds of written and oral evidence, analysis and a final report, there is little to prevent inquiry recommendations vanishing into the ether where the political will to implement is lacking.

A National Oversight Mechanism

6.15 There have been repeated calls for the establishment of a public sector body dedicated to monitoring the take-up and implementation of inquiry recommendations and inquest PFD reports.

6.16 Bishop James Jones has proposed the introduction of an Independent Commissioner for Inquiries. Under this proposal, the Commissioner, supported by a secretariat, would play a role in the sponsorship of inquiries, avoiding conflicts of interests where Government Departments are implicated (see paras 2.8 and 2.12, note 47), and performing advisory functions similar to those envisaged for the Central Inquiries Unit (see paras 2.20-2.24). However, it would also "play a part in relation to the monitoring of inquiry recommendations…[assisting] Parliament and the public in ensuring recommendations are not simply neglected".

6.17 INQUEST has campaigned over a number of years for the establishment of a 'National Oversight Mechanism'. In evidence to the Angiolini Review, the organisation provided the following submission:

> *INQUEST believes that there is an overwhelming case for the creation of a national oversight mechanism tasked with the duty to collate, analyse and monitor learning and implementation arising out of custodial deaths. Any new framework must be accountable to Parliament to ensure the advantage of parliamentary oversight and debate. It must also provide a role for bereaved families and community groups to voice their concerns and help provide a mandate for its work.*

6.18 Dame Elish Angiolini endorsed the proposal, recommending the establishment of an "Office for Article 2 Compliance". There is little material difference between the proposals. Noting that reform of deaths in custody policy concerns not only policing, "but also local government, the NHS and other health providers, and other agencies", Dame Elish stressed that "in order that the findings of this review are properly taken forward, coordinated action taken over a sustained period of time within a broad range of agencies is required. It needs to be concentrated in one place with resources and organisational memory" [emphasis added].

6.19 Despite the substantial body of research marshalled in the Angiolini Review, and the author's finding that the preventative function of Article 2 ECHR processes is "not yet being achieved adequately or consistently", Government dismissed the proposal in a single paragraph, finding that "a new and distinct Office for Article 2 Compliance is [not] the most effective means of driving compliance with Article 2 of the [ECHR]. Rather, it must be

recognised that existing agencies have a role to play here and their collation and dissemination of learning in this area must be made more effective…coroners, inspectorates, watchdogs (such as the IPCC) and the Ministerial Council on Deaths in Custody should work towards strengthening their collaboration in this regard…".

6.20 The Working Party considers that encouraging greater collation and dissemination of information (Chapter II), enhanced collaboration (Chapter III) and the establishment of a discrete national oversight mechanism are not mutually exclusive. Failure of public authorities to implement the findings of the Lakanal House Rule 43 Letters in England, Government's own 2018 Biological Security Strategy and the litany of inquest PFD reports arising from deaths in custody illustrates the need for a new and independent watchdog. The Working Party supports proposals that an independent body be established to monitor the implementation and effectiveness of recommendations arising from death investigations.

Location

6.21 We considered the possibility of the Central Inquiries Unit serving as the new watchdog. The unit should have capacity to act as a secretariat to Government Departments, to monitor and inform them on any obligation to respond to relevant inquiries.

6.22 However, we conclude that independence from Government is an essential feature of any monitoring body and would be a key factor in securing public trust. The new body should be a creature of – and accountable to – Parliament. This may allow for liaison with Parliamentary Select Committees where appropriate (see paras 6.27-6.32 below).

Functions

6.23 The EHRC, whose functions are contained in the Equality Act 2006, may serve as an instructive analogue. Like the EHRC, any national oversight mechanism should be empowered to monitor recommendations and actions taken to implement them; to report on the performance of those tasked with implementation; to give notice of non-compliance (where, for example, no action is taken within a specific time) and to require recipients of such notices to prepare an action plan. However, we do not anticipate the national oversight function would be at anywhere near the scale of the EHRC or require the kind of resources afforded to it. For instance, it would not be expected to make applications to court for injunctions, bring its own judicial reviews or itself provide legal assistance.

6.24 Given the rapid turnover of Secretaries of State, the new body might also play a role in briefing new Ministers on the status of the relevant implementation projects. Ideally, it would also prepare thematic reviews regarding implementation of related recommendations across multiple inquests and inquiries, so that inquiry recommendations and PFD findings are not viewed in silos but rather as part of a broader project to promote public safety.

6.25 As noted by Dame Elish Angiolini, there would inevitably be a cost associated with this recommendation. However, as with our proposal for the SPI (see paras 2.40-2.85 and Annexe), the Working Party considers that the proposal would bring long-term savings in preventing future deaths and the costly investigations, inquests and inquiries that follow.

6.26 In any event, we note that in the last Parliamentary Session, the Government had proposed creating a new arms-length role or office in the form of the Independent Public

Advocate. In the course of consultation on the proposal, JUSTICE expressed concern that as conceived it might "duplicate, or indeed encroach on, the role of [independent] legal representatives". However, the commitment expressed in the proposal that "we should never again see families struggling, as we did in the many years that followed Hillsborough, against the very system that was supposed to deliver answers – and, ultimately, justice" is to be welcomed. The Working Party considers that the best way to achieve this is to ensure that implementation of recommendations is routinely (and transparently) monitored by an external body, so as to prevent the continual recurrence of deaths in similar circumstances.

Parliamentary Oversight

6.27 Whilst we consider that the reform with the greatest impact would be the establishment of an independent monitoring body, more could be done within existing arrangements to monitor the implementation of recommendations.

6.28 Parliamentary Select Committees have been underused in holding Ministers to account for their role in implementing inquiry recommendations. In How public inquiries can lead to change, the Institute for Government noted that only six of the 68 inquiries established since 1990 have received dedicated follow-up by a select committee. The authors formulated a recommendation to address this apparent lacuna in accountability:

> ***The Liaison Committee should consider adding an eleventh core task to the guidance that steers select committee work: scrutinising the implementation of inquiry findings.*** *This scrutiny should be based on a comprehensive and timely government response to inquiry recommendations after the publication of an inquiry report. Departments should update the relevant select committee on implementation progress on an annual basis for at least five years following an inquiry report. In instances where the information provided is unsatisfactory, select committees should move to hold full hearings as soon as possible.*

6.29 Noting an increasing appetite amongst Parliamentary select committees for holding Ministers to account, the Working Party endorses and restates the Institute for Government's recommendation. The recommendation provides a feasible way of ensuring that inquiry recommendations do not simply disappear for lack of political will. Further, it ensures that where recommendations are rejected, Government must explain why, and do so in public.

6.30 We note the response to the Institute for Government's recommendation by the Liaison Committee:

> *The case was well argued, and it is clear that there does need to be some form of follow-through for such inquiries when they have reported, and the absence of any such mechanism is a significant shortcoming which can reduce the impact of these expensive undertakings and let government and others off the hook. However, we also recognise that such monitoring is a significant call on resources and could only be done through an increase in staff. It might also be best done in a centralised way, even within Parliament, rather than left to individual committees for which different inquiries and their outcomes will engage very different levels of political engagement.*

The Working Party acknowledges the argument as to resources; and would suggest that introduction of an independent monitoring body would provide the "centralised" method

suggested by the Liaison Committee without increasing the demands on Parliamentary committees.

6.31 In addition, the Working Party recommends that **Ministers directly accountable for the implementation of inquiry and SPI recommendations should, where recommendations are accepted, be required to report back to Parliament with an Implementation Plan**.

6.32 The Working Party recognises that enacting this recommendation may require amendment to the Inquiries Act 2005. However, we are of the view that this is worthwhile: where inquiries cannot themselves monitor implementation; the Legislature must play a greater role in holding to account the Executive for implementing the recommendations of inquiries it has itself commissioned. The production of an Implementation Plan, against which a Department's actions might then be assessed, would give select committees a meaningful reference point when performing this function.

Survivor Testimony

6.33 In addition to "establishing the facts"; "learning from events"; "reassurance"; and satisfying "political considerations", Sir Geoffrey Howe's suggested "functions" for any public inquiry include "catharsis or therapeutic exposure". Inquiries, Howe reasoned, provide an opportunity for reconciliation and resolution, by bringing protagonists face-to-face with each other's perspectives and problems.

6.34 Many of our professional consultees suggested that inquests and inquiries can serve a cathartic function, but the claim that they actually do so should be treated with caution. As Working Party member Dr Sara Ryan explained to us:

> *There are a lot of assumptions made about the experiences of families within inquiry processes with no underpinning evidence. These assumptions are typically made by (senior) professionals who may base them on their own understanding of how things should be. Embedded within these well-meaning assumptions are clichés, judgements and often a good dose of patronising. A key assumption is catharsis and I find it bewildering and disconcerting that the experience of giving evidence in an enquiry process, being forced to re-live and revisit unspeakably traumatic events and be questioned (or even interrogated) about them is seen as somehow positive.*

6.35 Nevertheless, inquests and inquiries should seek to promote clarity for those affected by catastrophic events, both through their findings, and through the way in which they treat bereaved people and survivors. An entirely voluntary mechanism that appears to have served a cathartic function is IICSA's Truth Project. This facility allows survivors to share their story in a confidential, secure environment. The Working Party understands that the Project has received a 98% satisfaction rate from its users, many of whom disclose that the project represents the first time they have felt listened to by someone in authority since suffering abuse, often several decades prior. The Truth Project does not form part of the evidential base for the inquiry hearings but is used to produce an aggregated and anonymised statistical pool.

6.36 INQUEST's Family Listening Days, including the Grenfell Consultation cited a number of times in this report, provide another forum for bereaved and survivor testimony. These reflective events also "offer public bodies, policymakers and other bereavement-focused

organisations the opportunity to hear directly from family members about the circumstances surrounding a person's death in detention/custody, or in a similarly contentious circumstance" but without the pressure of the formal process and constraint of giving evidence. There is a particular emphasis on hearing families' recommendations for improving current practice.

6.37 Drawing on the strengths of these two models, **inquiry and SPI teams should consider incorporating a non-evidential forum to facilitate the therapeutic giving of testimony by bereaved people and survivors.**