

# NO MORE DEATHS

**Learning, action, and accountability: the  
case for a National Oversight Mechanism**

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Melanie Leahy, mother of Matthew Leahy who at just 20 years old died within seven days of entering a so called, "place of safety", under the care of Essex Partnership University Trust in 2012.

# INTRODUCTION

For forty years INQUEST has monitored inquests into deaths in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. This includes work around the Hillsborough football disaster and the Grenfell Tower fire.

We have worked with families and lawyers to enhance the preventative potential of investigations into state-related deaths. Post-death processes should be a forum in which systemic failings can be identified, and from which essential changes can follow.<sup>1</sup>

However, our work has highlighted how the possibility for prevention is undermined by the lack of a framework to monitor compliance with, and/or actions taken in response to, the findings and recommendations that emerge from post-death investigations. Every year we see countless preventable deaths occurring because of systemic failures to enact meaningful change. INQUEST is not alone in documenting this – many other organisations have raised similar long-standing concerns.<sup>2</sup>



*The only thing that makes sense of the loss of your loved one is that maybe lessons will be learned and the same thing will not happen to someone else.*

Andy McCulloch, father of Colette McCulloch, who was a voluntary patient at a residential care home when she died in July 2016.

This is why we are calling on the Government to establish a National Oversight Mechanism, which would be an independent public body responsible for collating, analysing and following-up on recommendations arising from four post-death processes:

- Investigations
- Inquests
- Public Inquiries
- Official reviews

We believe a National Oversight Mechanism would provide better learning, prevention, transparency and accountability for bereaved families following a state-related death.

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<sup>1</sup> INQUEST, Learning from Death in Custody Inquests: A New Framework for Action and Accountability, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b826fe00-307c-40e3-8e35-9cd604207a04>, September 2012

<sup>2</sup> See Annex to this briefing.

# RECOMMENDATIONS: WHERE DO THEY GO?

A striking and consistent feature of INQUEST's work is the long history of repeat recommendations and the experience of attending inquest after inquest where the same issues are identified as possibly contributing to a death. Public and corporate bodies often do not properly consider and act upon recommendations from previous deaths or provide an adequate response as to why a recommendation was rejected.

INQUEST also commonly see an institutional indifference to change: many public bodies and their legal representatives show more concern for reputational damage management than for learning.

Delays in the investigatory system further hinder the learning process. Inquests, reviews and inquiries often take place many years after other investigations have concluded. At the inquest stage, we see earlier recommendations have not been implemented, even though they were accepted at the time by the public bodies concerned, or that delays are used as an argument to dismiss concerns as being out of date.



**THE CURRENT SYSTEM RESULTS IN FRAGMENTED, PIECEMEAL AND AD HOC INITIATIVES TO ACT ON RECOMMENDATIONS.**

The current system results in fragmented, piecemeal and ad hoc initiatives to act on recommendations. To the extent that change is achieved, it is often not sustained. People move on, actions peter out only to be raised again several years later, often when there have been further preventable deaths and in circumstances involving the same issues. There is no organisational memory and previous promises to act are forgotten.

This is, in part, because of gaps in the legislation around post-death processes.

## INQUESTS

With regard to inquests, a coroner is required to make a Prevention of Future Deaths report (PFD) under Schedule 5, paragraph 7 of the Coroners and Justice Act 2009, where the evidence suggests that future deaths may be prevented. This report is also sometimes referred to as a Regulation 28 report.

Although the recipient is under a legal duty to consider and respond to the coroner's report, there is no sanction if they do not properly consider and act on the report, or indeed if they do not respond at all.

## PUBLIC INQUIRIES

With regard to public inquiries, there is similarly no legal mechanism to require consideration, action, or reasoned rejection of a recommendation made in the course of a statutory inquiry under the Inquiries Act 2005.

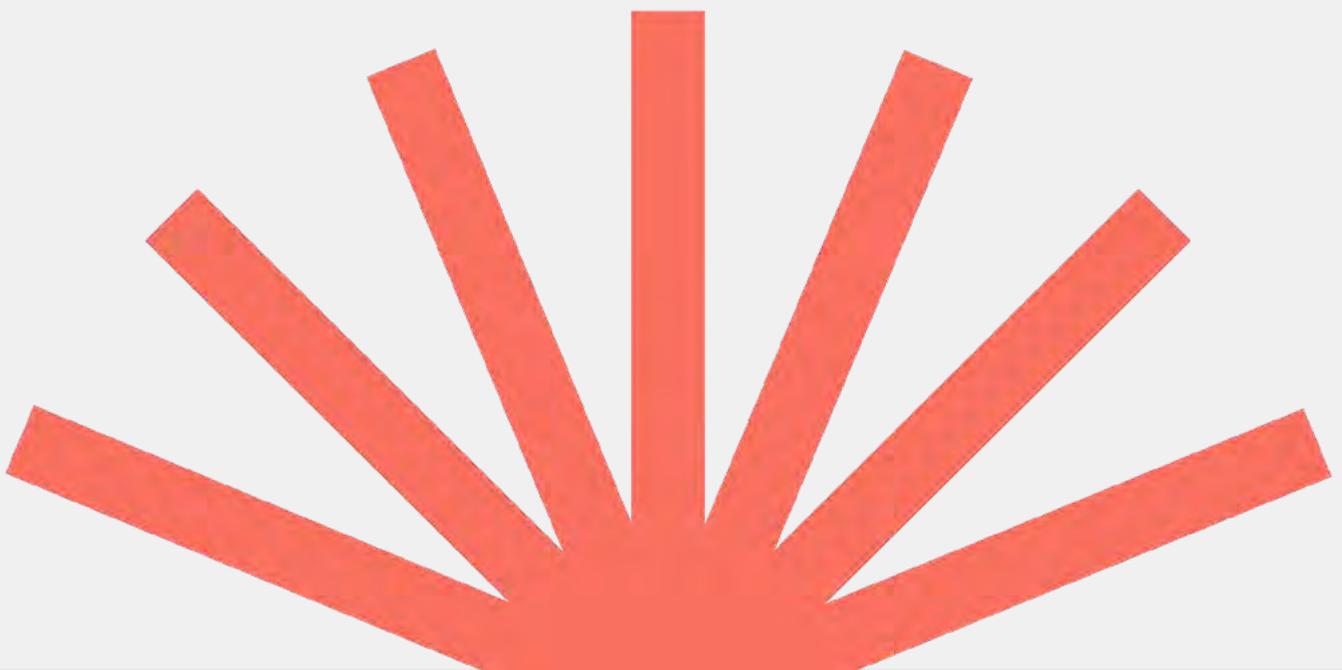
In other words, recommendations made by a statutory public inquiry, or a non-statutory inquiry, have no legal force on the Government, public authorities, corporations, or anyone else.

## INVESTIGATIONS AND OFFICIAL REVIEWS

Investigations into deaths, such as those done by the Prisons and Probation Ombudsman or the Independent Office for Police Conduct, Serious Incident Reviews and other safeguarding investigations also issue recommendations which are non-binding yet contain vital learning. The same is true for official reviews on state-related deaths commissioned by Government.

**We believe a mechanism is urgently needed to ensure proper oversight and follow-up of these important and potentially life-saving recommendations.**

The following cases illustrate why.



# CASE STUDIES

## EMILY HARTLEY AND PETRA BLANKSBY

Emily Hartley, aged 21, was the youngest of 22 women to die in prison in 2016. That year saw the highest number of deaths in women's prisons on record. Emily was imprisoned for arson in HMP New Hall, having set fire to herself, her bed and curtains. She had a history of serious mental ill-health including self-harm, suicide attempts and drug addiction. This was Emily's first time in prison and proved to be a sentence that cost her her life. On 1 February 2018 the inquest investigating Emily's self-inflicted death concluded with deeply critical findings about her care, in particular the failure to transfer Emily to a therapeutic setting.

What made her premature and preventable death more shocking is that ten years earlier, to the day of Emily's inquest, the same coroner had dealt with the strikingly similar death of Petra Blanksby. Nineteen-year-old Petra was also imprisoned in HMP New Hall for an arson offence, having set fire to her bedroom in an attempt to take her own life. Like Emily, Petra had a history of mental ill-health and suicide attempts. Two women, ten years apart, were criminalised for being mentally unwell.

INQUEST reported to the coroner during Emily's inquest that he had in fact made a recommendation in relation to Petra ten years previously. Specifically, the coroner recommended that "the Prison Service and the Department of Health ... work together to achieve a situation where suitable, secure, therapeutic environments outside prison can be available for those like Petra, suffering from such disorders."<sup>3</sup>

In the absence of any mechanism to review recommendations, the coroner had not recalled this. At the conclusion of Emily's inquest, the coroner David Hinchliff wrote: "I repeat ten years later that the Prison's Department and the Department of Health should conduct a collaborative exercise to achieve the provision of suitable, secure, therapeutic environments in order to treat those with mental health problems".<sup>4</sup>

The recommendation for better provision for women with mental ill health outside of the criminal justice system was issued with the sole purpose of preventing more deaths. Yet the coroner's PFD was left to gather dust for ten years in the absence of an agency charged with the task of monitoring follow-up.

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<sup>3</sup> West Yorkshire Coroner's Court, Inquest into the death of Petra Blanksby, Rule 43 Recommendations, 2008

<sup>4</sup> Regulation 28 Report to Prevent Future Deaths, Emily Hartley, [https://www.judiciary.uk/wp-content/uploads/2018/06/Emily-Hartley-2018-0063\\_Redacted.pdf](https://www.judiciary.uk/wp-content/uploads/2018/06/Emily-Hartley-2018-0063_Redacted.pdf), March 2018

## LAKANAL HOUSE INQUEST AND THE GRENFELL TOWER INQUIRY

In 2009, the Lakanal House fire killed six people in a 14-storey tower block in Camberwell. Following the inquests into their deaths the coroner, Frances Kirkham, made recommendations to the Secretary of State, the Mayor of London, the London Borough of Southwark, and the London Fire Brigade. These included making crucial improvements to building regulations; control room and incident command system training; awareness of the risks posed by cladding fires; and guidance on high-rise residential evacuation.

In 2017, the Grenfell Tower fire killed 72 people in a 24-storey tower block in North Kensington. The Grenfell Tower Inquiry exposed the fact that many of the Lakanal House recommendations were not implemented before the fire. Implementation was not considered to be urgent and was instead included in a medium to long term programme of work.

During the inquiry, Dame Melanie Dawes, former Permanent Secretary for the Department of Housing, Communities and Local Government, told the inquiry “there was no tracking mechanism put in place, something that I think was really important and there should have been”.<sup>5</sup> The lack of a mechanism was described as a gap in the civil service “that could have happened in any department.”<sup>6</sup>

The Department itself stated that it missed the opportunity to look beyond recommendations and consider the widespread use of non-compliant materials on high-rise buildings and the associated risk of a fire.<sup>7</sup>

The Lakanal House recommendations provided an opportunity to make crucial changes to ensure that no more lives would be lost in another tower block fire, however there was no action taken. Had several of these recommendations been prioritised and implemented, the Grenfell Tower fire may not have occurred.



<sup>5</sup> Grenfell Tower Inquiry, Grenfell Tower Inquiry RT Day 249 at [188], <https://assets.grenfelltowerinquiry.org.uk/documents/transcript/Transcript%2016%20March%202022.pdf>, 16 March 2022

<sup>6</sup> Grenfell Tower Inquiry, Grenfell Tower Inquiry RT Day 249 at [238], <https://assets.grenfelltowerinquiry.org.uk/documents/transcript/Transcript%2016%20March%202022.pdf>, 16 March 2022.

<sup>7</sup> Grenfell Tower Inquiry, Closing Statement on Behalf of The Department For Levelling Up, Housing and Communities, Phase 2, Module 6, Part 2, [https://assets.grenfelltowerinquiry.org.uk/CLG00036422\\_Phase%202%20Module%206%20Part%202%20%28Gov%2C%20Testing%2C%20FRA%29%20-%20Written%20Closing%20Submissions%20on%20behalf%20of%20DLUHC.pdf](https://assets.grenfelltowerinquiry.org.uk/CLG00036422_Phase%202%20Module%206%20Part%202%20%28Gov%2C%20Testing%2C%20FRA%29%20-%20Written%20Closing%20Submissions%20on%20behalf%20of%20DLUHC.pdf), 6 June 2022

## JAMES BOOTH AND MATTHEW CASEBY

In the early autumn of 2020, two very similar deaths occurred in mental health units run by The Priory. The inquests into these deaths raised a shared concern about the need for national guidance on the security and height of fences in mental health units.

James Booth, 52, died in October 2020. He had experienced longstanding mental ill health and was detained under the Mental Health Act at The Priory in Altrincham in October 2020. James absconded from The Priory on 7 October 2020, probably by escaping over the garden fencing, and was found dead on 14 October. He had taken his own life.

At the inquest into James's death, the jury found the inadequate security of the garden at The Priory, including the fence's height, contributed to James's death. There had been other escapes over and through the fence prior to James's death. The coroner Andrew Bridgman presiding over the inquest noted it was "striking" there was no existing national guidance for perimeter fencing and security for the outside areas of mental health 'locked wards' in the same way as existed for 'secure units'. He added that it was necessary to establish such guidance "to ensure the correct level of security for vulnerable patients".<sup>8</sup>

In September 2020, a month before James's death, Matthew Caseby was detained under the Mental Health Act for his own safety after he had been picked up running on live train lines.

After three days he absconded over a low fence from The Priory Hospital in Edgbaston and a few hours later stepped in front of a



**THE CORONER WAS CONCERNED THAT PREVIOUS ESCAPES FAILED TO PROMPT ANY FURTHER REVIEW**

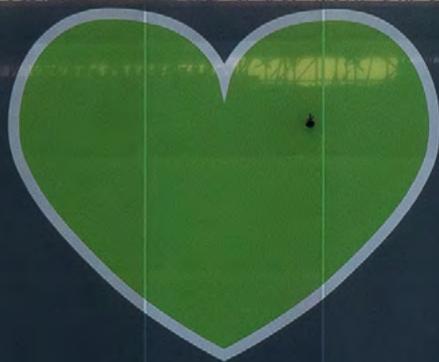
train and was killed. Staff at The Priory had concerns over the height of the courtyard fence and, like in James's case, there had been previous cases of people absconding over the same fence before Matthew's death.

The coroner presiding over Matthew's inquest, Louise Hunt, was concerned that previous escapes failed to prompt any further review. Concerns were also raised about the safety of the courtyard area. In the PFD issued after the inquest, the coroner recommended the Department for Health and Social Care establish national guidelines for perimeter fences and security in acute mental health units.<sup>9</sup>

The prevalence of this safety issue is clear from these two cases alone. In fact, during the inquest into Matthew's death it was reported that another patient had absconded over the same fence. However, there is no central body dedicated to collating and analysing the Government's follow-up to these recommendations to encourage positive action to prevent further deaths. Instead, it falls to families, lawyers, charities and coroners to join the dots.

<sup>8</sup> Regulation 28: Report to Prevent Future Deaths following the inquest into the death of James Booth, [https://www.judiciary.uk/wp-content/uploads/2022/09/James-Booth-Prevention-of-future-deaths-report-2022-0214\\_Published.pdf](https://www.judiciary.uk/wp-content/uploads/2022/09/James-Booth-Prevention-of-future-deaths-report-2022-0214_Published.pdf) May 2022

<sup>9</sup> Regulation 28: Report to Prevent Future Deaths following the inquest into the death of Matthew Caseby, [https://www.judiciary.uk/wp-content/uploads/2022/04/Matthew-Caseby-Prevention-of-future-deaths-report-2022-0116\\_Published.pdf](https://www.judiciary.uk/wp-content/uploads/2022/04/Matthew-Caseby-Prevention-of-future-deaths-report-2022-0116_Published.pdf), April 2022



**GRENFELL**

**FOREVER IN  
OUR HEARTS**

# WHY CHANGE IS NEEDED NOW

**We believe there are several vital reasons why a National Oversight Mechanism should be established.**

## IMPLICATIONS FOR BEREAVED FAMILIES

The current accountability gap has significant implications for bereaved families. Bereaved families report that they participate in protracted, intrusive, and distressing processes following a death in the hope of establishing the truth about how their loved one died, holding those responsible to account, and for there to be learning to prevent other deaths in the future. It is only by contributing to that objective that many say some meaning can be given to their loss. The gap in accountability – from recommendations made to actions completed – is a disservice and insult to bereaved families seeking change. The impetus for systemic change comes not from the system but from families.

INQUEST has observed the lack of candour and culture of defensiveness of state bodies towards change and learning during investigations.<sup>10</sup> The psychological impact families experience when hearing about another similar, avoidable death cannot be over-stated.



*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.*

Hanan Wahabi, Grenfell Tower survivor, whose brother and his family died in the fire

<sup>10</sup> For more on this, see INQUEST submission to the Rt. Rev Bishop James Jones review of the Hillsborough family experiences <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=02aadb9f-0b93-46d7-a612-039327086cd5> and our Family Listening Day report on this review <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=cfef2529-cebb-4620-8694-b9b8cbf0a804>, April 2017

Having expressed their hopes, the hollow words of ‘lessons will be learned’ amount only to placations. The system’s failure to enact meaningful change only adds to the harm and trauma already done to bereaved families.

## LACK OF TRANSPARENCY

There is also a lack of transparency on the extent to which public bodies are actually implementing recommendations from investigators, coroners, reviews and inquiries. INQUEST’s experience shows the learning from the contents of coroner’s reports and recommendations are far too frequently lost: they are analysed poorly or ignored; misunderstood or misconstrued; or dismissed. Moreover, while coroner’s reports and some responses are now published on the judiciary website, there is no audit of progress made on the recommendations to ascertain the impact of these reports at a national or local level. The judiciary website does not publish any analysis of the types of recommendations being issued across different sectors.<sup>11</sup>

There is also no central location where the public can view the progress on the outcomes of, or recommendations emerging from, other inquiries or review reports on state-related deaths. In addition, rarely are families informed as to what changes may have been put in place.

In 2022, coroners issued 403<sup>12</sup> PFDs across England and Wales,<sup>13</sup> but as the UK Parliament’s Justice Committee observed “there is no follow-up to see if coroners’ reports have had the desired impact”.<sup>14</sup>

<sup>11</sup> The Chief Coroner has now said he intends to begin publishing learning bulletins on PFDs, Courts and Tribunals Judiciary, Speech by the Chief Coroner: Death in Custody Symposium, <https://www.judiciary.uk/speech-by-the-chief-coroner-death-in-custody-symposium/>, March 2023

<sup>12</sup> Coroners Statistics 2022: England and Wales, <https://www.gov.uk/government/statistics/coroners-statistics-2022/coroners-statistics-2022-england-and-wales#prevention-of-future-death-reports>, May 2023

<sup>13</sup> The Chief Coroner states there are ‘roughly’ 600 PFDs issued each year, Courts and Tribunals Judiciary, Speech by the Chief Coroner: Death in Custody Symposium, <https://www.judiciary.uk/speech-by-the-chief-coroner-death-in-custody-symposium/>, March 2023

<sup>14</sup> Justice Committee, The Coroner Service, <https://committees.parliament.uk/publications/6079/documents/75085/default/>, May 2021

It is not sufficient to place some of the information in the public domain and hope that it will be put to good use.



*Like many other aspects of judicial practice and procedure in our system, the real value the coroner process adds is a detailed examination of the individual case – or in this case, a detailed examination of the circumstances of a death and the potential to avoid similar deaths in the future. That granular detail can then form part of the picture drawn on by others with the time, resources and skillset to draw out themes, trends or other outcomes.*

Thomas Teague KC,  
Chief Coroner for England and Wales

## LACK OF CENTRAL RESPONSIBILITY

There is no central responsibility to ensure actions are taken in response to key recommendations. For example, the responsibility to follow up on issues arising out of investigations, inquests and inquiries does not sit within the remit of any of the regulation, investigation, and oversight bodies. Post-death recommendations arising from a death in prison may be reviewed by HMI Prisons, for example, but this could be



## WHAT PURPOSE DO MULTIPLE LAYERS OF INVESTIGATIONS INTO DEATHS SERVE IF PUBLIC BODIES AND CORPORATIONS ARE NOT OBLIGED IN SOME WAY TO FOLLOW-UP ON RECOMMENDATIONS MADE?

many years after a death. In HMI Prisons' most recent annual report, they found that "in just under half the prisons we inspected, learning from Prisons and Probation Ombudsman investigations into deaths in custody was not well enough embedded."<sup>15</sup>

Equally, there is rarely oversight by Government or Parliament: of the 68 public inquiries which have taken place between 1990 and 2017, only six of them have been followed up by a parliamentary select committee to examine the implementation of recommendations.<sup>16</sup>

The absence of this responsibility to follow up on PFD's and inquiry recommendations means that unless bereaved families, lawyers or organisations like INQUEST follow up or generate publicity around a death there is no pressure to implement change.

### PUBLIC TRUST

INQUEST also believes a National Oversight Mechanism would help improve the value of post-death processes and increase public trust in the UK's investigation system. Not adequately learning from post-death

investigations undermines the legitimacy of, and public trust in, the UK's complex investigatory framework. It also affects confidence in public bodies. What purpose do multiple layers of investigations into deaths serve if public bodies and corporations are not obliged in some way to follow up on recommendations made?

We believe a National Oversight Mechanism would ensure information on post-death recommendations is easily available to those conducting investigations, as well as the families involved in them, helping to facilitate more coordinated and informed investigations.<sup>17</sup>

A more robust response to recommendations could help to prevent deaths and serious harms, and create safer practices.

### HUMAN RIGHTS CASE

There is a strong human rights case for establishing a National Oversight Mechanism. Article 2 of the European Convention of Human Rights contains obligations to respect, protect and fulfil the right to life. This requires a comprehensive approach where the UK

<sup>15</sup> HM Chief Inspector of Prisons for England and Wales, Annual Report 2021–22, <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2022/07/HMIP-Annual-Report-web-2021-22.pdf>, July 2022

<sup>16</sup> Institute for Government, How public inquiries can lead to change, <https://www.instituteforgovernment.org.uk/summary-how-public-inquiries-can-lead-change>, December 2017

<sup>17</sup> Speech by the Chief Coroner: Death in Custody Symposium, <https://www.judiciary.uk/speech-by-the-chief-coroner-death-in-custody-symposium/>, March 2023

has a wider obligation than simply protecting the right to life and ensuring that deaths are subject to proper investigation. It must also learn from the circumstances of deaths and work to prevent similar instances occurring.<sup>18</sup> As Lord Justice Sedley observed, the obligation to investigate is “not only to identify officials or authorities who bear responsibility for what has happened but to learn lessons for the future”.<sup>19</sup> The requirements of Article 2 are also powerfully expressed by Lord Bingham in the case of *R(Amin) v Secretary of State for the Home Department* following the racist murder of Zahid Mubarek: “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”.<sup>20</sup> This obligation is consistently overlooked in the UK. A National Oversight Mechanism aims to put that right.

## THE COST OF NOT MAKING VITAL CHANGES

As described above, the human cost to families of the current fragmented system is of primary importance. Additionally, there are significant financial implications involved in post-death investigations and in not making the necessary changes.<sup>21</sup>

Post-death investigations can have serious financial implications for families, particularly those who are not entitled to public funding for their legal representation at inquests or who have to pay for travel and subsistence.

Investigations also cost the public purse. For example, as of March 2023, the Grenfell Tower Inquiry had cost the taxpayer £170 million.<sup>22</sup> This figure continues to increase, all while recommendations are not implemented to prevent future deaths.

INQUEST also received information from Government departments on the cost of their legal representation at inquests: for 2020-21, the Home Office and Department for Health and Social Care spent over £350,000 on their legal representation at inquests.<sup>23</sup> In 2017, the Ministry of Justice spent £4.2million on Prison and Probation Service legal representation at inquests into deaths in prison.<sup>24</sup> Had a Mechanism such as the one we are proposing been in place, lives may have been saved, and the number of legal processes triggered decreased.



**OF 68 PUBLIC INQUIRIES,  
ONLY SIX HAVE BEEN  
FOLLOWED UP IN  
PARLIAMENT TO EXAMINE  
THE IMPLEMENTATION OF  
RECOMMENDATIONS.**

<sup>18</sup> Courts and Tribunals Judiciary, Speech by the Chief Coroner: Death in Custody Symposium, <https://www.judiciary.uk/speech-by-the-chief-coroner-death-in-custody-symposium/>, March 2023

<sup>19</sup> *R (Lewis) v Mid and North Shropshire Coroner* [2009] EWCA Civ 1403, para 11.

<sup>20</sup> *R(Amin) v Secretary of State for the Home Department* ([2003] UKHL 51 [2004] 1 AC 653 §31

<sup>21</sup> Dame Elish Angiolini, Report of the Independent Review of Deaths and Serious Incidents in Police Custody, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/655401/Report\\_of\\_Angiolini\\_Review\\_ISBN\\_Accessible.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf), January 2017

<sup>22</sup> Grenfell Tower Inquiry, Grenfell Tower Inquiry Financial Report to 31 March 2023, <https://assets.grenfelltowerinquiry.org.uk/inline-files/Grenfell%20Tower%20Inquiry%20financial%20report%20to%2031%20March%202023.pdf>, 2023

<sup>23</sup> Data received by INQUEST through Freedom of Information requests shows that the Home Office spent £498,887.11 on their legal costs at inquests in 2019-20 and £346,001.62 in 2020-21. This relates to 49 inquests for both years. We also received data showing that the Department of Health and Social Care spent £57,701.53 on their legal costs at inquests in 2019-20 whereas they spent £17,546.32 in 2020-21

<sup>24</sup> INQUEST, <https://inquest.eu.rit.org.uk/legal-aid-inquest-figures>, April 2019. INQUEST was not able to find more recent information on the Ministry of Justice's spending on legal representation at inquests.



Aji Lewis, mother of Olaseni 'Seni' Lewis, who was 23 years old when he died as a result of prolonged restraint by 11 Metropolitan police officers whilst a patient at Bethlem Royal Hospital in 2010.

# KEY PRINCIPLES OF A MECHANISM

INQUEST believes that a National Oversight Mechanism should be guided by the following principles. The National Oversight Mechanism should be:

- 1. Structurally and operationally independent.** We believe the National Oversight Mechanism should be accountable to Parliament, for example to a relevant parliamentary select committees such as the Joint Committee on Human Rights who have expertise on the Human Rights Act and Article 2 of the ECHR.
- 2. Accountable to bereaved families** by establishing an advisory panel made up of bereaved families and community groups to enable them to voice their concerns.
- 3. Required to produce an Annual Report** which would be presented to Parliament and would report on lack of follow-up to recommendations, highlight best practice in responding to recommendations and outline key trends from an analysis of post-death investigations over the year.
- 4. Given powers to highlight concerns** about a lack of follow up to recommendations. We acknowledge that a duty to enforce follow-up or consideration of recommendations may be difficult and that there are a range of different organisations already with enforcement powers. However, we believe the National Oversight Mechanism should have the capacity, set out in its statute, to inform the relevant Minister about lack of proper consideration or action on recommendations, and to request urgent measures to address the specific area of concern. The Mechanism could also assist existing enforcement bodies to review and reconsider action.
- 5. Given powers to require information from the relevant stakeholders.** To enable the National Oversight Mechanism to operate, it would need to be able to receive information from the public and corporate bodies who have been issued with recommendations. Data-sharing provisions should include robust sanctions for failure to provide material and information within a reasonable time.
- 6. Underpinned by standards on combatting discrimination and racism.** Given INQUEST's work on the distinct issues involved in the deaths of Black and racialised people,<sup>25</sup> the Mechanism should follow domestic and international legislation and UN treaty obligations on standards for non-discrimination.

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<sup>25</sup> See INQUEST report on the Deaths of racialised people in prison 2015 – 2022, <https://inquest.eu.rit.org.uk/Handlers/Download.ashx?IDMF=b7f9a0d0-0f48-48a2-b995-c8870f5a5e6a>, October 2022 and INQUEST's report 'I Can't Breathe': Race, death and British policing, <https://inquest.eu.rit.org.uk/Handlers/Download.ashx?IDMF=edfc7c01-e7bb-4a17-9c33-8628905460e6>, February 2023

# WHAT WOULD REAL ACCOUNTABILITY LOOK LIKE?

Inquests and inquiries often reveal that Ministers and public or corporate bodies had already been warned about potential risks to life, but failed to act upon them.

While decisions on action following official recommendations is a democratic process for public or private bodies to take, they must be accountable for their action or inaction in response to life-saving recommendations. This means publicising information on action taken in response to recommendations, within a reasonable time, or issuing statements on the reasons for a rejection to a recommendation. There should be sanctions on those public bodies who do not disclose this information.

A National Oversight Mechanism would enable accountability in this way by increasing transparency of the action, or inaction, of state and corporate bodies in response to life-saving recommendations.

We believe a National Oversight Mechanism should have the three following functions:

- Collation
- Analysis
- Follow-up

## COLLATION

The Mechanism should create and manage a new publicly available database which collates all recommendations made following post-death processes, highlighting the public agencies the recommendations are addressed to.

The database should make clear when an agency has implemented, partly implemented, rejected or not responded to a recommendation. The agencies in question should be required by law to respond with the correct information to the Mechanism.

## A NATIONAL OVERSIGHT MECHANISM WOULD ENABLE ACCOUNTABILITY[...]BY INCREASING TRANSPARENCY OF THE ACTION, OR INACTION, OF STATE AND CORPORATE BODIES IN RESPONSE TO LIFE-SAVING RECOMMENDATIONS.

To supplement the information collated, the Mechanism should include detail on inquest jury conclusions, which are not routinely published but contain valuable information about the circumstances of an individual's death.

The database should categorise recommendations by type of death, detention setting and protected characteristics and act as a hub for coroners, inquiry panels, lawyers, researchers and the public.

### ANALYSIS

Building on the information collated in its database, the Mechanism should issue regular reports to analyse the emerging themes and patterns in recommendations issued.

The Mechanism's annual report should bring together information on, for example, individual NHS Trusts which regularly reject recommendations or Government departments which routinely do not respond to recommendations issued.

The Mechanism should carry out thematic analysis on recommendations related to

protected characteristics such as race, gender, disability or other emerging concerns.<sup>26</sup>

### FOLLOW-UP

Due to its collation of information and analysis, a Mechanism will have oversight of the implementation of recommendations, or lack thereof. It is important, then, for a Mechanism to be equipped with robust powers to follow up and alert the relevant bodies to escalate its concerns.

One example of this should involve notifying the relevant Government departments, ministers, and secretaries of state when public agencies do not provide information to the Mechanism.

Another example of the Mechanism's follow-up powers should involve alerting select committees to its thematic findings.

In certain circumstances, the Mechanism should follow up on specific areas of concern with existing prosecutions bodies such as the Crown Prosecution Service, Health and Safety Executive or Equality and Human Rights Commission.

<sup>26</sup> See Ontario 2022 coroner's inquests' verdicts and recommendations, <https://www.ontario.ca/page/2022-coroners-inquests-verdicts-and-recommendations>, April 2023



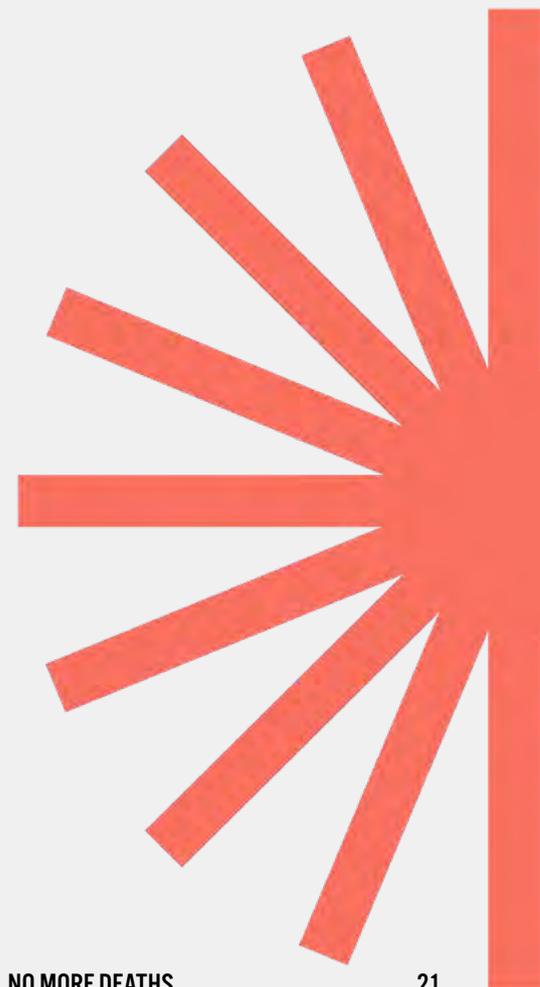
Donna Mooney, sister of Tommy Nicol who took his own life, aged 37, at HMP The Mount whilst serving an indeterminate IPP sentence in 2015.

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# ORGANISATIONS A MECHANISM SHOULD WORK WITH

Although independent, the National Oversight Mechanism should work alongside Government departments and parliamentary select committees involved in state-related deaths. The National Oversight Mechanism should also work with bodies with prosecution powers, such as the Health and Safety Executive, Equality and Human Rights Commission, Care Quality Commission and the Crown Prosecution Service as well as inspectorate and monitoring bodies who are members of the UK's National Preventive Mechanism and the Independent Advisory Panel on Deaths in Custody.

After collating, analysing and following up on the progress of implementing recommendations, the Mechanism should work in collaboration with these bodies, utilising their expertise to escalate concerns and determine the best course of action.



# CURRENT GOOD PRACTICE

## AVIATION SAFETY RECOMMENDATIONS

The Civil Aviation sector has a legal obligation, as per the Chicago Convention 1944, to conduct investigations of accidents and has a well-developed system for tracking the implementation of safety recommendations to prevent future accidents and incidents.<sup>27</sup>

The UK's Air Accidents Investigation Branch, part of the Department of Transport, issues safety recommendations following an investigation into accidents and serious incidents. Whichever body receives a recommendation must respond in 90 days and explain what action has been taken or is under consideration, as well as the time necessary for completion.

The Branch can then issue a response if it does not think the reply is adequate and request further justification. Responses

are classified as 'adequate', 'partially adequate' or 'not adequate'. The Branch can follow up further if necessary.

There is also a central database of all recommendations called the Safety Recommendations Information System, which collates all safety recommendations from across the EU.

## MILITARY SAFETY RECOMMENDATIONS

The Defence Safety Authority in the UK conducts investigations into deaths or serious injuries in order to learn from accidents and prevent them from happening again.<sup>28</sup> The Defence Accident Investigation Branch is independent of the Ministry of Defence. Recommendations are issued to individuals who 'own' the recommendation who are often high-ranking officers.

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<sup>27</sup> Article 1, Council Regulation (EU) 996/2010 of 20 October 2010 on the investigation and prevention of accidents and incidents in civil aviation and repealing Directive 94/56/EC [2011] OJ L264/25, incorporated in UK law in Regulation 8, The Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 2018 S.I. 2018/321.

<sup>28</sup> Ministry of Defence, <https://www.gov.uk/government/organisations/defence-safety-authority/about>

The owner is responsible for ensuring the recommendation is actioned in a timely manner.

The recommendations and actions are logged on the Recommendations Implementation Tracker database. If timely progress is not made, the issue can be raised up to the level of Director General.

## MANCHESTER ARENA INQUIRY

The Manchester Arena Inquiry was established to investigate the deaths of twenty-two people killed in a bomb attack at a concert in May 2017. Alongside general recommendations, the Inquiry Chair made specific Monitored Recommendations to be monitored and reviewed during the course

of the public inquiry, stating, "I intend to scrutinise what has been done in response to the Monitored Recommendations and use all of the powers available to me, if required, to achieve transparency and accountability."<sup>29</sup>

The Chair then heard evidence on the progress of implementation of the inquiry's recommendations and the organisations' approach to learning.

Although a positive example, there are limitations in that the Chair's power to monitor the implementation of recommendations cannot extend beyond the period the inquiry sits. Additionally, monitoring recommendations in this manner is discretionary, with many inquiry Chairs choosing not to follow this practice.



**ALTHOUGH A POSITIVE EXAMPLE,  
THE MANCHESTER INQUIRY CHAIR  
CAN'T MONITOR THE IMPLEMENTATION  
OF RECOMMENDATIONS BEYOND THE  
PERIOD THE INQUIRY SITS**

<sup>29</sup> Manchester Arena Inquiry Volume 2: Emergency Response, Volume 2-II Report of the Public Inquiry into the Attack on Manchester Arena on 22nd May 2017, para 21.47, pg. 162

# CONCLUSION

**Post-death inquests, inquiries, investigations, and official reviews should be a forum in which active and accountable learning can be achieved and from which necessary changes can follow to prevent future deaths. In other words, they can save lives.**

Properly conducted investigations, inquests, and inquiries – where families play a meaningful part and are represented by fully funded, specialist lawyers – have been crucial in shining a light on the closed world of state care and detention and other areas of public importance such as fire safety, NHS failures, police shootings, child sexual abuse and terror attacks. Bereaved families and campaigners also hope ongoing public inquiries into COVID-19 will effectively scrutinise the actions of all UK Government's in their handling of the pandemic and identify learning.

However, INQUEST has identified a clear accountability gap in post-death processes, with no framework for the systematic overview and scrutiny of recommendations arising. INQUEST's casework shows that state-related deaths occur at the extreme end of a continuum of state harm. A more robust response to these recommendations is therefore a powerful tool for harm prevention.

The consequences of the State's failure to adequately prevent future deaths are significant. Beyond the loss of human life

and the traumatic bereavement of family and friends, such cases often given rise to significant political scandals, loss of faith in the institutions of the State and ongoing legal and financial liability before domestic and international courts.

The accumulated knowledge gleaned from these post-death processes, when contact between the citizen and state has ended in disaster, death and tragedy must be put on a more secure footing in this sensitive and important area.



***It's traumatizing for any family and I don't think that ever goes away. We understand that our loved ones will never come back. What we want is for it to not happen to another family. What we want is really effective change.***

Marcia Rigg, sister of Sean Rigg who died in Brixton in August 2008 following police use of restraint

# ANNEX

## Public acknowledgment on the need for a National Oversight Mechanism or similar body

[Report of the Independent Review of Deaths and Serious Incidents in Police Custody, Dame Elish Angiolini, 2017](#)

[Mental Health and Deaths in Prison: Interim Report, Joint Committee on Human Rights, 2017](#)

[Final report of the Independent Review of the Mental Health Act 1983, 2018](#)

[David Lammy MP in Parliamentary debate on Grenfell : Jan 21st 2020](#)

[Justice Select Committee report on The Coroner Service, 2021](#)

[When Things Go Wrong: The response of the justice system. JUSTICE, 2020.](#)

[Independent Advisory Panel on Deaths in Custody](#)

[Next steps from the Keeping Safe conference 2020](#)

[Independent Review of the Response to Deaths in Prison Custody November 2021, Scottish HRC, HMIPS, Families Outside](#)

[Mayor of London evidence to Grenfell Inquiry, Nov 2021](#)

[Independent Advisory Panel on Deaths in Custody Royal College of General Practitioners Secure Environments Group Protecting lives: a cross-system approach to addressing alcohol and drug-related deaths within the criminal justice system, January 2022](#)

[Closing submission Leslie Thomas QC at the Grenfell Inquiry Jan 24 2022](#)

[Closing submissions of Mayor of London – Anne Studd KC at the Grenfell Tower Inquiry, 22 June 2022](#)

[Closing submissions on behalf of legal teams representing Bereaved, Survivors and Relatives \(BSR\) – includes submissions from Danny Friedman KC, Michael Mansfield KC and Imran Khan KC at the Grenfell Tower Inquiry, 7 November 2022](#)

[Closing submissions of Mayor of London – Anne Studd KC at the Grenfell Tower Inquiry, 9 November 2022](#)

**INQUEST** 

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