INQUEST

Public Office (Accountability) Bill 2025

A joint briefing on amendments to improve the oversight of recommendations arising from inquests and inquiries, Report Stage, House of Commons

January 2026

1. This briefing, signed by 36 civil society organisations, asks MPs to support New Clauses 5 and 6[1] in the name of Andy Slaughter, Chair of the Justice Select Committee, to improve the oversight of recommendations arising from inquests and inquiries.

> ***NC5***
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> ***Review of the merits of establishing a national oversight mechanism for ensuring candour and transparency of public authorities in respect of inquests and inquiries***
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> *The Secretary of State must, within six months of the passing of this Act, carry out a review to determine the merits of establishing an independent oversight mechanism to help ensure candour, transparency and follow up with respect to the actions of a public authority arising from the conclusions and recommendations of inquests and inquiries.*
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> ***NC6***
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> ***Monitoring the standards of ethical conduct of officials in response to the recommendations from inquests and inquiries***
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> *In discharging its duty under section 9(1) of this Act a public authority must monitor the standards of officials in response to the recommendations from inquests and inquiries to ensure they are acting with candour, transparency and frankness.*

2. These amendments would ensure the principles of candour and transparency – central to Hillsborough Law and the objectives of bereaved families and victims – extend to the treatment of important recommendations made to prevent future deaths, so they result in real learning, accountability and systemic change.

What currently happens with recommendations

3. When preventable deaths occur, such as the Hillsborough and Grenfell disasters, Manchester Arena bombing, or a death in the care of a state institution, an inquest or inquiry can reveal the true circumstances of what happened and identify learning to stop the same thing happening in the future. It is in the public interest to ensure the conclusions and recommendations of these processes contribute to meaningful

[1] https://publications.parliament.uk/pa/bills/cbill/59-01/0341/amend/public_office_rm_rep_0107.pdf

change, as they relate to a wide range of areas of public health and safety.[2] However, the preventative potential of these processes is currently undermined as their findings are too often left to gather dust, with no system in place to ensure preventative changes are made.

4. Responses to conclusions and recommendations are a critical element of post inquest/inquiry accountability and yet they are frequently ignored by public authorities. Responses to recommendations are delayed, absent or formulaic[3] and treated as a paper-exercise, without specific detail or proper engagement in the issues to show reflective learning from a death or tragic incident.[4] Coroners and inquiry chairs have documented this trend and as one coroner put it to the BBC, "*all too often the final PFD [Prevention of Future Death report] […] is ignored or downplayed by the agency to which it is addressed […] nothing changes*."[5] In her last annual report, the Chief Coroner raised the absence of a system to oversee or enforce responses to PFDs.[6]

5. Information on action taken in response to inquests and inquiries is fragmented rather than centralised. To the extent that change is achieved, it is often not sustained. People move on and actions peter out only to be raised again several years later. It is often left to families to drive that change or the persistence of parliamentarians to ensure scrutiny. While there have been improvements in making coroner's PFDs and inquiry recommendations publicly accessible, there is no system to see whether these findings are having a positive impact on practice or policymaking. It is not sufficient to place some of the information in the public domain and hope that it will be put to good use.

[2] For example, the issues covered by ongoing public inquiries include the provision of mental health care, the treatment of individuals by the police and the UK's handling and preparedness of a pandemic.
[3] For more information, see the Independent Advisory Panel on Deaths in Custody's report on PFDs, https://cdn.websitebuilder.service.justice.gov.uk/uploads/sites/21/2023/12/IAPDCPFDprojectreportSeptember2023-FINALFORPUBLICATION.pdf
[4] An analysis using the Preventable Deaths Tracker developed by researchers at the University of Oxford found that only 33% of all PFDs reports issued by coroners had expected responses published, with 29% of responses overdue. Further, the researchers found that response rates to PFDs examined in 25 of their studies ranged only from approximately 10% - 60%, with no study resulting in an 100% response rate, Richards, GC. The Preventable Deaths Tracker: Responses to PFDs. 2023. https://preventabledeathstracker.net/database/responses/
[5] The Law Show, https://www.bbc.co.uk/sounds/play/m002db9f
[6] https://assets.publishing.service.gov.uk/media/68bfef2044fd43581bda1ce7/chief-coroner-report-2024.pdf

6. The information which is available on action taken following an inquest or inquiry comes from public authorities themselves rather than by an independent body.[7] This is another instance of the government marking their own homework, which can obscure what changes have really been made. Sir Brian Langstaff, the chair of the Infected Blood Inquiry, stated that in regard to his own inquiry's recommendations, "*assurances have been given, and not kept*."[8]

7. Inquests, inquiries and other investigations therefore lead to a proliferation of recommendations, many of which are the same, without discernible action. It was reported in 2025 that almost 750 recommendations had been made in the last decade related to maternity and neonatal care, yet harmful treatment and deaths have persisted in that time.[9]

Preventable deaths continue

8. As a result of this lack of independent oversight and transparency to recommendations, warnings from coroners and inquiry chairs go unheeded and similar deaths keep happening. INQUEST has worked on many cases over decades in which the same or similar issues have been raised at inquests as contributing to a death.

9. A particularly striking example of this is the Grenfell Tower Fire. The Grenfell Tower Inquiry found "*some important recommendations affecting fire safety were ignored by the government*" leading up to the Grenfell Tower fire, such as recommendations made by the coroner investigating deaths from a fire at Lakanal House in 2009. It was "*obviously unsatisfactory*", the report said, that the relevant government department did not have a system for recording recommendations and keeping track of the action on them following the Lakanal House inquest.[10] The Inquiry found that that all 72 deaths in 2017 were entirely *"avoidable"*.

[7] The Institute for Government have reported that of the 68 public inquiries which have taken place between 1990 and 2017, only six were followed up by a parliamentary select committee to examine the implementation of recommendations, https://www.instituteforgovernment.org.uk/publication/report/how-public-inquiries-can-lead-change
[8] https://www.infectedbloodinquiry.org.uk/sites/default/files/Volume_1.pdf
[9] https://www.theguardian.com/society/2025/dec/09/victims-of-nhs-maternity-failings-in-england-received-unacceptable-care-says-report-head?CMP=Share_iOSApp_Other
[10] https://assets.publishing.service.gov.uk/media/66d818059084b18b95709f86/CCS0923434692-004_GTI_Phase_2_Volume_7_BOOKMARKED.pdf

The impact on bereaved families, victims and the public

10. Bereaved families and victims of state harm are failed by this accountability gap. They go through lengthy, retraumatising legal processes with the hope that the relevant issues will be addressed and rectified, so the same thing won't happen to someone else. This is, evidently, not the case.

11. While these groups bear the emotional brunt of the lack of follow up to inquests and inquiries, the disadvantage is felt by the wider public. Undermining the preventive potential of inquiries diminishes public trust and confidence in the processes themselves and the belief they can lead to positive changes in policy and practice.

12. There are also financial implications. The Institute for Government has reported that since 2005 public inquiries have cost over £730m. In 2023–24, this cost taxpayers £130m.[11] Had an independent national oversight mechanism been in place, lives may have been saved and the number of legal processes triggered reduced.

Recommendation

13. The persistent failure to change following inquests, inquiries and other official investigations has resulted in growing frustration, both from bereaved people at the sharp end of these processes and those charged with investigating deaths.

14. This is not an intractable problem: INQUEST, alongside over 70 civil society organisations including Amnesty International and the Institute for Government, have asked government to establish a national oversight mechanism to increase accountability following inquests and inquiries.[12] There is support for a mechanism from parliamentarians,[13] select committees,[14] investigation bodies,[15] the London Assembly[16] and Scottish Government.[17]

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[11] https://www.instituteforgovernment.org.uk/comment/public-inquiry-reform-targeted-right-problems
[12] See INQUEST's detailed briefing on a national oversight mechanism for more information, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b480f898-7fbd-4c9c-a948-50dd3fad3a04
[13] See Carla Denyer MP's Private Members Bill *State-related deaths (National Oversight Mechanism) Bill https://bills.parliament.uk/bills/3837* and the related Early Day Motion https://committees.parliament.uk/publications/50291/documents/271754/default#:~:text=national+oversight+mechanism
[14] https://committees.parliament.uk/publications/50291/documents/271754/default#:~:text=national+oversight+mechanism
[15] https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/fourth-investigation-report/
[16] https://www.london.gov.uk/who-we-are/what-london-assembly-does/london-assembly-press-releases/new-pressure-independent-inquiry-watchdog
[17] https://www.gov.scot/news/driving-reform-to-prevent-deaths-in-custody/#:~:text=National+Oversight+Mechanism

15. New Clauses 5 and 6 to this Bill would compel government to take decisive action on considering the merits of establishing a mechanism and ensuring public officials are more transparent in their dealings with and reporting on recommendations. During second reading of this Bill,[18] the Prime Minister himself stated that "*there needs to be a better way of ensuring that they [inquiries] are followed through*" – these amendments would do just that.

INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media, and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question, such as the Hillsborough disaster or Grenfell Tower fire.

This briefing is supported by:

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CRAE
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Papyrus (Prevention of Young Suicide)
Prison Reform Trust
ReThink Mental Illness
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The Dan Kay Foundation
The Howard League
The Law Society
TruthAboutZane
United Friends & Family Campaign (UFFC)
United Group for the Reform of IPP (UNGRIPP)
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[18] https://hansard.parliament.uk/commons/2025-11-03/debates/85038B82-AEE0-4029-9E3C-407B5A4B4867/PublicOffice(Accountability)Bill