Written Evidence from Pete Weatherby KC and Anna Morris KC (STI0014)

Pete Weatherby KC

1. I have been a barrister for 32 years, 12 of them in silk. A significant part of my practice has related to Public Inquiries, non-statutory reviews, and inquests, relating to disasters, bombing outrages, police shootings, and prison deaths.

2. I provide this evidence consequent to a written request dated 11 March 2024. I will be happy to provide further material as advised.

3. I led legal teams representing twenty-two of the Hillsborough families, eighty bereaved, survivors and residents of the Grenfell Fire, seven of the families bereaved by the Manchester Arena bombing outrage, the partner of Anthony Grainger who was shot by police, the family of Sonny Lodge who died in Manchester Prison, and I currently represent a number of groups in the Undercover Policing Inquiry, and seven thousand bereaved families in the Covid Inquiry.

4. I was a panel member on the Independent Review into the Events Surrounding the 2022 UEFA Champions League Final, and I have advised on other international inquiries.

5. I have appeared in a number of leading cases relating to Inquiries and inquests, at all levels of the legal system up to and including the Supreme Court.

6. I was one of the lawyers who drafted the Public Authority (Accountability) Bill 2017[1] ('Hillsborough Law'), which would provide a statutory 'Duty of Candour'.

7. I have given evidence to the Joint Committee on Human Rights on similar matters. I also gave evidence to the JUSTICE Working Group on Inquiries and Inquests, which was led by three former senior judges who had chaired high profile inquiries and produced the Report 'When Things Go Wrong'.[2]

8. I am a trustee of INQUEST, a charity which supports families bereaved by circumstances to which the state may have contributed.

Anna Morris KC

[1] https://publications.parliament.uk/pa/bills/cbill/2016-2017/0163/17163v2.pdf

[2] https://justice.org.uk/justice-launches-timely-report-on-urgent-reform-for-major-inquests-and-inquiries/ The report supported calls for a statutory Duty of Candour and an independent agency to monitor recommendations.

9. I have practised in inquests and inquiries for 15 years. I specialise in representing bereaved families in complex inquest and inquires involving mass fatalities, homicide, femicide and infanticide. I have represented bereaved families at the historic Hillsborough Inquests, and at the Manchester Arena Inquiry. I currently lead a team representing bereaved families in 3 modules in the C19 Public Inquiry.

10. Throughout my career I have developed expertise in representing the families of young people who have died whilst under the care of mental health services. I currently represent multiple families in the Northeast of England who have made submissions to the Secretary of State for Health for a public Inquiry into the alleged failings of the mental health care Trust that may have contributed to the death of their children.

11. I have been appointed at Counsel to the Inquest in a sensitive multi agency inquest involving the death of a young child. I have sat as an Assistant (part time) Coroner for 7 years.

12. I have recently given evidence to the Joint Committee on Human Rights on the Public Authority (Accountability) Bill 2017 or "Hillsborough Law" on the Duty of Candour and the importance of proportionate funding for bereaved families at inquest and inquiries.

Summary

13. Based upon our experience, there are at least four significant problems with Public Inquiry and related processes, in this jurisdiction:

    a. They take far too long,
    b. They are far too expensive.
    c. Recommendations are not properly considered or implemented.
    d. The right to effective participation by those most affected is not properly respected.

14. In our view, the reasons for these problems are largely down to three things:

    a. A pervasive culture of institutional defensiveness, sometimes referred to as a culture of denial.
    b. An inability to recognise the importance of having those most affected embedded within the process.
    c. Weaknesses in the procedural processes to address the above.

15. Whereas there are no perfect solutions, there are some clear measures which in our view would make a very substantial difference:

a. Codifying a 'Duty of Candour' with practical and effective compliance and enforcement mechanisms.
b. Providing a process which supervises the expeditious consideration and implementation of recommendations from Inquiries, reviews and inquests (INQUEST terms this a National Oversight Mechanism).
c. Provisions ensuring that those most affected are able to access representation related to that available to public authorities within the same process.
d. Provisions which expressly require Inquiries and reviews to facilitate the effective participation of those most affected. For example, the right to consultation about scope, the nature and sufficiency of evidence to meet the terms of reference, and the right to question witnesses.

Discussion

Too long. Too expensive

16. The second Hillsborough inquests were similar to a public Inquiry. Even after the Hillsborough Independent Panel had exposed the wrongdoing which had led to the miscarriage of justice at the initial inquests, and the High Court had quashed their verdicts and ordered fresh inquests, the process took another three and a half years to reach conclusions. The hearings themselves took over two years, and are the longest jury process in our jurisdiction's history.

17. The Bloody Sunday Inquiry took 12 years from establishment to report. The Grainger Inquiry reported 7 years after Anthony Grainger was shot. The final report of the Manchester Arena Inquiry was published six years after the outrage. The Grenfell Inquiry report remains outstanding, seven years after the fire. There are many other similar examples. In our view, all the above inquiries were successful in achieving their aims but took far too long and cost far too much.

18. These inquiries related to very different circumstances but they have two common threads: in each case, those who stood to be criticised went into institutional defensive mode, subverting inquisitorial proceedings into an adversarial process. In each case, the Inquiry did not have sufficient 'hard' power to prevent this happening.

19. Unconstrained institutional defensiveness elongates proceedings and makes them exponentially more expensive. It is not inevitable, and can be easily addressed through legal reform.

20. Even in adversarial processes in our jurisdiction there are clear provisions to regulate issues in disputes. In criminal trials, defendants are required to serve defence case statements setting out not only the details of any alibi, but which parts of the prosecution case are disputed. In civil claims, the defendant must lodge a defence at an early stage to set out what is admitted and denied. Yet here, in proceedings which are designed to be *inquisitorial* – a search for the truth, and to prevent future deaths in many cases – there is no such requirement. We ask why not?

21. There has been much debate about inquiries becoming adversarial, and sometimes this has centred solely around the tone of advocacy and questioning. The simple fact is that just because a process is not aimed at determining liability does not automatically lead to witnesses telling the truth where otherwise they would not. Witnesses are just as likely to obfuscate or mislead at an Inquiry as they are in any other proceedings.

22. Sometimes this is due to human frailty – a reluctance to acknowledge that their own failure may have contributed to a catastrophe. Sometimes it is due to putting reputation, either personal or institutional, above the truth, fearing censure or worse. Sometimes it is to try to avoid consequent criminal or disciplinary proceedings, or civil claims. Occasionally it is simple corruption – hiding the truth.

23. The art of advocacy in any type of proceedings is to elicit evidence relevant to your client's case or perspective, in the clearest and most helpful way. Sometimes this involves testing witnesses against contradictory evidence or the assertions of your client. In our view there is no such thing as 'adversarial' or 'inquisitorial' advocacy. Frequently, the most contentious adversarial proceedings require no actual or robust challenge; rather the presentation of an interpretation. Conversely, in or to achieve the statutory purpose of definitively establishing the facts, questioning at inquests and inquiries may well require robust questioning.

24. To take an example from a recent inquest, the inquest into the death of Yousef Maki, the issue before a coroner was whether the deceased had been unlawfully killed, or whether the person who had stabbed him had acted in lawful self-defence. Despite the process being inquisitorial, questioning of the perpetrator had to be as direct as it would be in a criminal trial because the issue was similar, even though criminal liability was not (and could not be) in issue.

25. The same considerations arose in the Hillsborough Inquests, where the jury found that the deceased had been unlawfully killed, the Grainger Inquiry, where the actions of the armed officer who fired the

fatal shot were in issue, Grenfell, where the acts and omissions of various core participants were hotly disputed, and Manchester Arena where the explanations and assertions of Greater Manchester Police and the Security Services were found to be 'inaccurate'.

26. The question is how to get to the heart of the issues in inquisitorial proceedings, and prevent institutions or individuals from obscuring, or hiding the truth? This was the simple question asked by the Hillsborough families at the conclusion of the second inquests in April 2016. Their legacy project – designed to prevent the same happening to others – was a legal reform to require public servants and authorities, and corporations which bear responsibility for public safety, to *proactively* assist inquiries from the outset of investigations: the Public Authorities (Accountability)Bill 2017. Codifying a 'Duty of Candour' may seem like a restatement of the obvious, and a matter which should be clear to all witnesses who give evidence on oath. However, a Duty of Candour which is practical and effective, with tools to ensure compliance and enforcement, puts a proactive duty on the institution or individual to assist the investigation or Inquiry. It provides the investigator or Inquiry chair with the tools by which it can be enforced. It does not interfere with no due process rights (self-incrimination, privacy and data protection, national security, and commercial sensitivity).

27. Through simple processes such as the requirement of 'position statements', an investigation or Inquiry can swiftly understand who had responsibility for what, the central factual narrative through the lens of each stakeholder, and what is and is not likely to be in dispute.

28. In *R(Hoareau) v SSFCA* [2018] EWHC 1508 (admin), at [20], Singh LJ cast the Duty of Candour in public law proceedings as the onus on the public body not only to provide all relevant documents, but also to identify the relevant material and issues for the court: not leave the court to find the "needle in the haystack". The duty extends to identifying "the good, the bad and the ugly", relating it to the "common enterprise with the court to fulfil the public interest in upholding the rule of law".[3] We believe it may assist to give a real example, and then to reflect that experience back to other real inquiries.

The application of a Duty of Candour: the UEFA review

29. The 2022 Champions League Final was perilously close to being a rerun of the Hillsborough disaster 33 years previously. A dangerous crush outside the Stade de France was said by French Ministers and football authorities to have been caused by a mass of 30-40,000

[3] https://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Comm/2018/1508.html&query=(hoareau)

supporters arriving late and without tickets. Although no one died, on all accounts it was a near-miss. Unfortunately for the Ministers and football authorities, journalists, broadcasters and sponsors present at the match denied that the problems had been caused by such a huge number of excess supporters, and UEFA was forced into a position of setting up an independent Inquiry.

30. The terms of reference were wide, and UEFA (sensibly) required that the review was undertaken swiftly in order that lessons could be learned in time for changes to be made before the next such final in 2023.

31. The Inquiry was complex as it involved stakeholders in Switzerland, France, Spain and the UK. It was highly controversial and highly charged. The Panel itself included members from Portugal, the Netherlands, France, England and Scotland. It took live evidence in three different countries and amassed a substantial amount of documentary and witness evidence. The Final Report was published nine months after the event. No stakeholder challenged the factual findings. UEFA claims it has implemented all 21 recommendations. If that is so, no such near disaster should occur again at a major football match in Europe.

32. The key to achieving a comprehensive, unchallenged Report within nine months of the event, was a process which required candour and proactive assistance by all stakeholders. The full process is set out at Section 2 of the Report,[4] however, in summary:

a. The Panel drew up a comprehensive list of stakeholders (about 25 in total).
b. The Chair wrote to each of them requesting their cooperation, and asserted that this included candour. The letters set out that candour required each stakeholder to set out a narrative of their role and responsibilities, and stating what they say occurred, through their own lens: a 'position statement'. In so doing, the Panel expected them to set out what went right and what did not, and what caused the near-miss. To each letter was appended a bespoke number of issues tailored to the known role of that stakeholder, as a prompt to matters that the Panel expected to be addressed. The requests also asked for all relevant documentation to be provided, and for a list of witnesses whom the stakeholder considered may be able to assist the Inquiry through interview.
c. Tight timescales were set because of the imperative to learn lessons quickly. Although this was an Inquiry set up by a private

[4] https://editorial.uefa.com/resources/027e-174e17fd7030-a45785447d2f-1000/uclf22_independent_review_report.pdf

institution, it was public-facing and stakeholders were informed at the outset that there was no legal compulsion to assist, but that the Report would be clear as to who had or had not assisted. Furthermore, subject to privacy and other narrow exceptions, the Panel indicated that it would publish all evidence, interviews and documentation alongside the Report. Despite the fact that engagement with the Inquiry was voluntary, there were compelling reasons why stakeholders should take part. Consequently, almost all stakeholders did so.

d. Once the 'position statements' were received, the panel could see what was and wasn't in dispute, and what further evidence should be sought, and which witnesses should be interviewed. For example, a number of the stakeholders stuck to their original position that a huge surplus of supporters had overwhelmed what would otherwise have been appropriate security arrangements. From media and mobile phone footage, the panel had a very different understanding: there was no evidence of such a large excess crowd. Further evidence was therefore sought from the transport networks to determine how many people had arrived in the locality during the relevant time.

e. Once the panel were satisfied it had sufficient documentary evidence it then interviewed a large number of witnesses, including from the stadium management and operators, the French football authorities and UEFA, the French authorities, supporters, and other experts relating to EU regulation of football events.

f. The Panel then set about analysing the totality of the evidence and compiled its detailed Report and recommendations.

33. The purpose of setting out the above in some detail is to explain how a relatively complicated and highly controversial Inquiry can be conducted swiftly, and effectively (no one has sought to contradict its findings), with due process, and at a fraction of the cost of other such inquiries. The central lesson is that if all relevant stakeholders can be compelled to proactively assist an Inquiry at the very outset, the investigations can be honed, and the whole process can be expedited. The compulsion in that Inquiry was twofold: supporters and some broadcasters and sponsors were vocal in calling for the Inquiry to be effective, and the public and footballing authorities had huge reputational problems if they did not engage. Such 'soft' power is not generally available to inquiries, hence the need for statutory change.

34. With respect to inquiries more generally, history has shown that most stakeholders loudly promise that they will assist, whilst in reality, institutional defensiveness will deliver the opposite: obfuscation, denial, and an approach that amounts to seeing what the institution or individual can get away with.

35. A codified legal Duty of Candour, with provisions to ensure compliance, and backstop provisions for enforcement where there is wilful misleading, would constitute the most significant legal reform in this area of law since the 2005 Act itself. It would lead to far swifter justice and at substantially less cost. Swifter justice reduces stress for the victims and witnesses, and promotes expedited change which may well save lives.

The Impact of Duty of Candour

36. There are numerous examples which illustrate how this would have positively impacted on previous inquiries. If South Yorkshire Police been required to provide a 'position statement' prior to the Hillsborough inquests it would have included the fact that the supporters were not the cause of the disaster (the Chief Constable had asserted this in terms, two years prior to the hearings[5]). Much of the two years of witness hearings was spent on former senior officers trying to prove that the cause of the disaster was hooliganism, whilst those representing SYP sat on their hands or even joined in.

37. The Grainger Inquiry report[6] was highly critical of the candour of a number of senior police officers, and criticised their force for the way it approached the proceedings. Had a statutory Duty of Candour been in force, they could not have acted in this way.

38. At the Manchester Arena Inquiry, the Chief Constable at the time of the outrage admitted he had committed a "very grave error" by asserting incorrect highly material facts to a previous Inquiry.[7] Had a Duty of Candour been in force, it is incredibly unlikely that he would have made such a profound error.

39. The campaign for a statutory Duty of Candour has been supported by just about every victim group in recent times. One of its strongest advocates is the former Bishop of Liverpool, James Jones, who has been a government adviser on such matters. It has been endorsed by a series of Inquiry chairs, and senior judges with great experience in this area. The Public Authority (Accountability) Bill 2017 was signed and sponsored by cross-party MPs. It is hoped to be in forthcoming election manifestos.

Missed opportunities: ignored recommendations.

[5] https://www.bbc.co.uk/news/uk-england-south-yorkshire-19575770
[6] https://assets.publishing.service.gov.uk/media/5d27151a40f0b611b680982e/Anthony_Grainger_Inquiry.pdf
[7] https://assets.publishing.service.gov.uk/media/6363d597e90e0705a35f5754/MAI-Vol2-Part_Ii_Accessible.pdf at §19.49

40. It is frequently said that inquiries seek to do three things:

a. Determine a definitive official narrative of the facts,
b. Establish accountability,
c. Learn lessons and make changes for the future.

41. Recommendations, reached by the stepping stones of the first two - facts and accountability - are the key to progressive change, which in this area may well mean saving lives.

42. Regrettably, experience shows that once the drama of the conclusion of an Inquiry subsides, recommendations are too often left to gather dust. There is perhaps no greater or lamentable example of this than the recommendations (formally, 'preventing future death' reports) which came out of the Lakanal House fire inquests which should have led to changes which in turn would have prevented the Grenfell Tower disaster.[8]

43. Chairs of a number of inquiries have recognised this problem and used (or stretched) their existing powers to try to ensure their recommendations are heeded and actioned. Notably, the Chair of the Grainger Inquiry held supplementary hearings to determine and consider with key stakeholders what recommendations should be made. The Chair of the Manchester Arena Inquiry held hearings after recommendations had been made to take evidence as to what the recipient authorities or corporations had done in response.

This was a remarkable and innovative attempt to address the problem of unaddressed recommendations. Regrettably it highlighted in the starkest of terms that only being called to account will propel people to action. Most of the witnesses gave evidence that responses to recommendations had only been initiated in the weeks before the hearings. Due to the current statutory provisions, the Chair could not keep the Inquiry open any longer, and further efforts to ensure action is taken can only be through existing political channels.

44. The charity INQUEST has been campaigning about this problem for many years, calling for the institution of a National Oversight Mechanism (NOM) – an independent statutory agency to collate, analyse and follow-up on recommendations made following inquests and inquiries and official reviews.[9] We recognise that the 2014 Committee considered that follow-up to recommendations should be done through Parliamentary Committees, and that is certainly one avenue. However, that has proven ineffectual to date, and a specialist

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[8] http://lakanalhousefire.co.uk/grenfell-tower/
[9] https://www.inquest.org.uk/no-more-deaths-campaign#:~:text=INQUEST%20is%20calling%20for%20a,investigations%20into%20state%2Drelated%20deaths.

agency which builds a body of practical experience and expertise would appear to be the better option, but if it were to have a reporting requirement to relevant Parliamentary Committees it would get the best of both approaches.

Respecting and ensuring effective participation of victims.

45. The investigative obligation in Article 2 of the ECHR requires the facilitation of the effective participation of the bereaved.[10] Some Inquiries do this very effectively, some less so. The reality is that once the victims are embedded into the process, the Inquiry is enriched. It is not easy to express how this is so, but our observation would be that Chairs and their lawyers are able to see the issues more closely and viscerally if they hear directly from family witnesses and survivors and encourage their collaborative participation. Inquiries which do not do so foster mistrust and a lack of confidence in the process.

46. Provisions are currently in place which *allow* for proper and effective participation, but do not demand it.

47. In our view the provisions should be amended to *require* consultation about terms of reference, and to provide resources for representation of the bereaved and other victims, related to the level available to relevant public authorities. This does not mean parity, it means setting a level playing field, where the state should not be allowed to 'outgun' victims in circumstances where public authorities may have contributed to disasters or wrongdoing.

48. The statutory provisions should also be amended to require Chairs to consult with all Core Participants with respect to the scope of inquiries necessary to satisfy the terms of reference, and the nature and sufficiency of evidence required, and to require inquiries to hear directly from victims.[11]

49. Finally, the statutory provisions should align the positions in inquests and inquiries with respect to the examination of witnesses. At an inquest, the Coroner or their lawyer leads the questioning of witnesses, but 'interested persons' are entitled to ask further relevant questions. At an Inquiry, the Chair has a discretion as to whether to allow Core Participants to ask questions and in many inquiries they decline to do so.

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[10] *Jordan v UK* at §109 https://hudoc.echr.coe.int/fre#%7B%22itemid%22:[%22001-59450%22]%7D
[11] Chief Coroner's Guidance No 41 encourages the hearing of 'Pen Portrait' material at inquests: https://www.judiciary.uk/wp-content/uploads/2021/07/Chief-Coroners-Guidance-No-41-Use-of-Pen-Portrait-material.pdf

50. In our view, no advocate should be allowed to ask irrelevant or duplicative questions in any legal process - not only Inquiries - but the corollary is that where there are further relevant questions to those asked on behalf of the Inquiry, there can be little logic to preventing them. Once again, our experience is that an Inquiry process is enriched by hearing different voices and approaches, and there is a link between successful inquiries and those which fully consult with CPs and welcome proportionate involvement in eliciting evidence from witnesses. There is absolutely no logic to having a different, more restrictive approach to inquiries which substitute for inquests.

Statutory and Non-Statutory Inquiries

51. We both have experience of representing families engaged in both Statutory and Non-Statutory Inquiries. We have concerns that Ministers establish Non-Statutory Inquiries with the false impression that they will be quicker and more cost-effective than a Statutory Inquiry. In our view, if the above recommendations regarding Duty of Candour, effective participation and oversight were implemented within the Statutory regime, any such perception would be corrected.

In addition, there is a real risk in our view of Non-Statutory Inquiries being more protracted and more costly, with little ability for them to deliver clear findings or robust recommendations within a timely manner.

52. An inquiry under the Inquiries Act is led by a Judge, can compel the provision of disclosure, the attendance of witnesses and may receive evidence under oath. It has the power to designate families as Core Participants, which entitles them to consider the disclosure and the Chair can give them permission to ask questions of witnesses through their legal representatives. This is crucial in the context of an Article 2 ECHR investigation, such as where someone dies in state custody (e.g. a prison, police station or whilst detained under the Mental Health Act) with its requirement of effective victim participation. There are no such statutory entitlements in other forms of inquiry, and the level of public scrutiny and family engagement is at the discretion of the Chair, who is not an independent judicial office holder.

53. it is important to remember the findings of Sir Robert Francis KC, who conducted an independent Non-Statutory inquiry into the failings of the Mid-Staffordshire NHS Trust between 2005 and 2009. In his first report, he concluded that a Statutory Inquiry should go on to investigate the question of what commissioners, supervisory and regulatory bodies did or did not do to allow the situation within that Trust to develop and become manifest.

54. He recommended that a second, Statutory inquiry be set up to examine those bodies in relation to their role in monitoring with the objective of learning lessons about how providers' failings are identified.[12] Sir Robert went on to Chair such a public inquiry which published its critical report in 2013. The report had a seismic impact on the public understanding of the issues, and it is hoped had a significant impact on subsequent health care policy and provision.

55. In 2021 Dr. Geraldine Strathdee was tasked to Chair a non-statutory Inquiry into almost 2,000 deaths of mental health patients across NHS Trusts in Essex. IN 2023, Dr. Strathdee told the Health Secretary that she could not effectively do her job without statutory powers. She said that only 30% of the essential witnesses in the deaths she was investigating had agreed to attend evidence sessions and asked that the Inquiry be put on a statutory footing. A Statutory Inquiry was put in place in 2023, but this has experienced its own problems with delays attributed to by delays in its Terms of Reference being agreed by the Health Secretary.[13] The provisions of the Inquiries Act could be amended to clarify further what "within a reasonable time" under s.5(1) means for the provision by a Minister of the Terms of Reference to an Inquiry Chair to avoid such delays.

56. Had the Inquiry started on a statutory footing, it is not difficult to envisage that this Inquiry would by now have received and analysed key witness evidence and be able to make meaningful recommendations. This delay has a significant impact not only on the delivery of clear findings and recommendations and that could improve the delivery of care and reduce the risk of future preventable deaths, but also has a devastating impact and trauma on the bereaved families, who have pressed for a statutory inquiry from the outset.

57. It is important to put the Essex investigation into context alongside the Independent investigation into care delivery by Greater Manchester Mental Health, and the announcement by the Health Secretary in June 2023 that there will not be an Statutory Inquiry into a significant number of patients in the care of Tees, Esk and Wear Valley NHS Foundation Trust, but instead that there will be an investigation by the Health Services Investigation Body (HSSIB).

58. Ministers should not be afraid of Statutory Inquires, which have the potential to deliver answers and solutions more quickly and effectively than their non-statutory counterpart. Statutory Inquiries are also the most effective model for addressing national issues including systemic

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[12] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Page 14) - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

[13] https://www.bbc.co.uk/news/uk-england-essex-68612364

and regulatory issues, as demonstrated by the Independent Inquiry into Child Sexual Abuse.

59. The state is also under an obligation to discharge its investigative obligations under Article 2 (the right to life) and Article 3 (the prohibition against torture and inhuman treatment) ECHR. Where there are multiple victims, this can be difficult to achieve effectively through individual/multiple inquests and/or claims under the Human Rights Act. Statutory Inquiries can in of themselves discharge the Article 2 investigative obligation (as happened in the Manchester Arena Inquiry) or the Article 3 obligation (e.g. the Brook House Inquiry) because they have the requisite powers to hear from witnesses and (with the proposals made above) to allow effective participation by victims and/or the bereaved. In our view, the Committee should consider amended the Act to require a Statutory Inquiry to be held where it is required to discharge the state's obligation under Article 2 or Article 3 ECHR.

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22 March 2024