

Mind the (accountability) gap

Public inquiries related to product liability do vital work but are undermined by a lack of accountability & commitment to action, as [Sarah Moore](#), [Stuart Warmington](#) & [Lily Parmar](#) explain



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IN BRIEF

- ▶ The UK has a robust culture of instigating inquiries, but it is less clear whether their recommendations are acted upon.
- ▶ Claimants in high-profile liability scandals often have to campaign for years.
- ▶ Greater monitoring and reporting could help redress this accountability gap.

On 5 May 2023, the World Health Organization declared an end to the coronavirus as a ‘global health emergency’. Nevertheless, as we move into our second post-pandemic summer, COVID-19 remains omnipresent in the headlines as the public hearings for the UK’s COVID-19 inquiry get underway. This inquiry is set to be one of the biggest and most expensive in UK history. As the inquiry chair Baroness Hallett highlighted in her opening statement, its purpose is to enable the government to ‘learn lessons to inform preparations for future pandemics’.

In her statement, Baroness Hallett underscored the importance of listening to the experiences of those most affected. That listening exercise, now called ‘Every Story Matters’, aims to gather experiences of the pandemic from across the whole of the UK, including from ‘those most affected and from those whose voices are not always heard’.

Listening is, of course, a crucial part of any independent review or public inquiry. The statistics would suggest that the UK is good at creating listening forums: 83 public inquiries have been opened since 1990, five of them in the period since the COVID-19 inquiry was announced in May 2021. However, while in the UK we have a fine tradition of instigating inquiries and listening to evidence, what is less clear is whether the recommendations made by such inquiries are consistently acted upon by those with the power to translate them into public policy and legislation.

Inquiries, reviews & product liability

Inquiries and independent reviews are of particular importance in a product liability context in the UK, where access to justice for

claimants through the judicial system has long been a cause of concern. Campaigners, patients’ rights groups, and their advocates will often have an eye on routes to redress beyond litigation—frequently, because they must do so. Limitation (where medical products, in particular, can give rise to harm with a long latency period), funding considerations, defendant-friendly caselaw and the challenges of evidencing complex technical and medical issues can all conspire to mean that access to justice for those injured by medical devices is extremely challenging.

“ True reform & redress depends on the government of the day committing to action ”

In 2018, the then secretary of state for health, Jeremy Hunt, commissioned an Independent Medicines and Medical Device Safety Review, chaired by Baroness Cumberlege. The upshot was the Cumberlege Report entitled ‘First Do No Harm’, published in 2020. The report explained that litigation had not served those affected by defective products well and proposed that ‘in the future a more equitable way to deliver redress that truly works for patients must be developed’. To that end, the report recommended the creation of a new Independent Redress Agency to ‘administer decisions using a non-adversarial process with determinations based on avoidable harm looking at systemic failings, rather than blaming individuals’. This recommendation was flatly rejected by the government on the basis that ad hoc issue schemes worked more effectively.

This ad hoc approach may work better from the government’s perspective but, as any product liability or public lawyer will

tell you, only very rarely does it work well for claimants. In the context of medical safety issues, many claimants have had to endure decades of litigation, campaigning and lobbying in order to make their voices heard. High-profile scandals have included Thalidomide, Primodos, vaginal mesh and sodium valproate.

Even when litigation succeeds, this may not offer full and comprehensive redress to all those affected. A clear example of this is the infected blood scandal.

Over the course of several decades, those affected have fought for redress for having been given blood products which were infected with hepatitis or HIV. Financial support was provided via schemes such as the Macfarlane Trust or the Skipton Fund. More recently, four regional infected blood support schemes have been established. Despite a group of claimants succeeding in 2001 in the landmark *A v National Blood Authority* [2001] 3 All ER 289 litigation (still the only large-scale group action brought under the Consumer Protection Act 1987 (CPA 1987) which has succeeded at trial), it was clear that many affected individuals still did not have access to redress. The Archer Report (2009) and the Penrose Inquiry (2015) made further progress in grappling with the problem, but neither had the powers of a statutory inquiry. Finally, in September 2018 the Infected Blood Inquiry, established under the Inquiries Act 2005, was commenced, and its work is ongoing today. Sir Brian Langstaff, the inquiry chair, released his second interim report on 5 April 2023 with the recommendation that a compensation scheme be established. In an accompanying statement, Sir Brian commented:

‘It is an unusual step to publish recommendations about redress in advance of detailed findings, but I could not in conscience add to the decades-long delays many of you have already experienced due to failures to recognise the depth of your losses. Those delays have themselves been harmful.’

The government has responded to Sir Brian's recommendations and had, in fact, already commissioned Sir Robert Francis KC to provide independent advice on the framework for compensation and redress. Those affected, having suffered the most horrendous experiences dating back to the 1970s, may justifiably feel, however, that it has taken far too long for their government to act.

Without a central redress agency as recommended by Baroness Cumberlege, we must anticipate that we will continue to see single issue defective product-related inquiries and reviews while those responsible leave it to future generations to try and right the wrongs.

Product liability & the COVID-19 inquiry

Module 4 of the COVID-19 inquiry will focus on vaccines and therapeutics. The module will address issues of recent public concern relating to vaccine safety and the current system for financial support under the payment scheme established by the Vaccine Damage Payments Act 1987 (VDP Act 1987). Product liability issues will be at the heart of this part of the inquiry.

Many of those injured or bereaved through the pandemic will be looking to

the inquiry to listen to their evidence and make recommendations to ensure that lessons are truly learnt. Baroness Hallett has promised to go about her work robustly, efficiently and tenaciously. Her recent skirmish with the Cabinet Office over disclosure of ministerial WhatsApp messages may be seen as reassuring evidence of that commitment. However, if there is one consistent lesson that even a casual survey of inquiries and reviews in the UK provides, it is that no matter how well an inquiry is run, and no matter how urgent the recommendations made are, true reform and redress depends on the government of the day committing to action.

Closing the accountability gap

Two groups with direct experience of engaging in public inquiries, the COVID-19 Bereaved Families for Justice and Grenfell United, have noted this disconnect, identifying what they refer to as a 'shocking accountability gap'.

In this context, the non-governmental organisation INQUEST has recently recommended that a new independent public body should be made responsible for monitoring recommendations arising from inquests, inquiries, official reviews

and investigations into state-related deaths. It would collate recommendations into a national database, analyse responses from public bodies and escalate concerns when progress stalls.

This registration and monitoring function is crucial—and while it will not close the 'shocking accountability gap' by itself, it may make it more difficult for governmental departments to punt inquiry and review recommendations into the political long grass. A particularly effective mechanism might be to introduce a compulsory reporting obligation requiring government departments to provide updates on progress towards the implementation of key recommendations.

As taxpayers, service users, patients and patient advocates, we all stand to gain from introducing greater accountability into our system of inquiry and review. As the COVID-19 inquiry—one which truly affects us all—continues its vital work, there has never been a more urgent time to mind the accountability gap and do what we can to close it.

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