

**WITNESS STATEMENT OF
DEBORAH COLES ON BEHALF OF INQUEST**

I, Deborah Coles of INQUEST, 89-93 Fonthill Road, London, N4 3JH DO SAY AS FOLLOWS:

1. I am the Executive Director of INQUEST and have worked for the charity for 30 years. INQUEST has unique expertise in inquests and public inquiries into state related deaths including disasters. I represent INQUEST on the cross government Ministerial board on deaths in custody and sit on the Independent Advisory Panel on deaths in custody. I was an advisor to reviews conducted by Lord Harris, Baroness Corston and appointed by the Home Office as the special advisor to Dame Elish Angiolini, Chair of the *Independent Review of Deaths and Serious Incidents in Police Custody*. I also advised on the *Review by Bishop James Jones into the Hillsborough disaster* set up by the Prime Minister after the Hillsborough inquests.
2. INQUEST is a charity and non-governmental organisation founded in 1981. It provides an independent, specialist, comprehensive advice service to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public on contentious deaths, their investigations, and the inquest process.
3. INQUEST has contact with many hundreds of relatives of the deceased, who are involved in inquests and inquiries after state related deaths and its caseworkers regularly attend these post death investigative hearings. It also represents the interests of bereaved relatives in policy, parliamentary and campaign work. It co-ordinates the INQUEST Lawyers Group, which is a national network of over 250 lawyers, who provide specialist legal

representation for bereaved families and contribute to policy and legal work much of which has resulted in reform of the post death legal processes.

4. I have unique expertise in, and understanding of, the practicalities, nature and functions of an inquest or an inquiry following a death or multiple deaths, and the consequences of the inquest/ inquiry conclusions, particularly from the perspective of the bereaved family given INQUEST's unique overview of these legal processes.
5. INQUEST has worked with thousands of families after state related deaths, from deaths in custody or detention to public disasters and those where the state had some responsibility for their treatment and care. We have had significant engagement with Ministers, independent investigatory organisations, inspectorates and monitoring boards, regulators, coroners, police forces and others. Some of this work has been to improve the post death processes for bereaved people, to ensure they are treated with dignity and respect and are provided with access to independent advice, support, and information about their rights in legal processes that follow a traumatic bereavement.
6. This statement is derived from INQUEST's direct contact with bereaved, survivors, residents and lawyers and other organisations, and that of my colleagues.

Aftermath

7. INQUEST was initially contacted by the North Kensington Law Centre, members of the local community who knew of our work and lawyers from the INQUEST Lawyers Group. Following this, INQUEST was on the ground with the community and provided continuous support in the aftermath of the fire.

8. INQUEST worked closely with grassroots community organisations such as Grenfell United and Grenfell Legal Support, as well as the North Kensington Law Centre, Kensington & Chelsea Citizens Advice, and the Law Society.
9. It was immediately clear from talking to bereaved and survivors and community groups that there was an uncoordinated emergency response and a distinct lack of communication from the local council, local and national government, and the police. Additionally, there appeared to be a failure to adequately acknowledge the needs of the residents of the walkways and surrounding areas of the Grenfell Tower.
10. In response to the disorganisation, INQUEST's primary aim was to provide practical information and support to the bereaved, survivors and residents and to address the information deficit from the authorities.
11. INQUEST also put out a statement in response to confusion surrounding the legal processes; both the inquest and inquiry process, which I exhibit as DC/1.

Information Sharing

12. In the immediate aftermath, the bereaved, residents and survivors of the fire were not provided with information on how to navigate the aftermath of a catastrophic event.
13. Due to this lack of information and the considerable confusion and uncertainty this caused, and in response to queries raised online, in meetings attended by INQUEST staff and discussions with members of the INQUEST Lawyers Group, INQUEST produced an information leaflet. I exhibit the 'INFORMATION FOR FAMILIES BEREAVED BY THE GRENFELL TOWER FIRE' leaflet as DC/2.
14. The leaflet provided information on reporting missing persons, advice for the bereaved and initial guidance on the criminal investigation, public inquiry, and

inquest processes. It was translated into 21 languages, distributed in person at local community and other meetings, and via local support groups and uploaded onto INQUEST's website.

15. The leaflet ensured that the bereaved, residents and survivors had a greater understanding of the immediate processes relating to their loved ones who were missing or had died in the fire, as well as the legal procedures which would follow the fire. This in our view was vital in enabling and empowering people to make informed choices and have some control over their situation.

16. It was incredibly important to have accessible information at a time where there was a lack of regular updates or accurate information on those who were missing or had died. It was a period of intense speculation and confusion about the number of people dead and missing, which contributed to anxiety amongst the community. The distribution of the leaflet also meant that residents of the Walkways and surrounding areas were informed and supported.

Bereavement

17. The tragedy involved an extraordinary destruction of peoples' homes and private lives in circumstances that were entirely foreseeable and were known to be preventable. This was even more profound for the bereaved who had no bodies left to bury and had the agonising delay in identifying both the dead and remnants of their remains.

18. In DC/2, INQUEST set out the process of reporting a missing person, information regarding identification and access to a deceased relative's body, funeral arrangements, deaths certificates and the role of the coroner.

19. INQUEST sent copies of the INQUEST handbook and posters to the Westminster Coroner's office, to be distributed to the families of those bereaved.

20. INQUEST held a Family Consultation Day in 2019, in which families shared their experiences of the aftermath. I exhibit the aftermath section of the 'Family reflections on Grenfell: No voice left unheard INQUEST report of the Grenfell Family Consultation Day as DC/3. The following positive responses were shared regarding the coroner:

"The coroner was also great; she kept the bodies together and that meant a lot to us. We could tell she was personally affected by what had happened".

"Dr Fiona Wilcox made it easier, she really personalised it. She became part of the family in the way she delivered what she had to deliver, she made it seem as if she felt your pain. She didn't have to do that".

21. The bereaved, survivors and residents fed back in meetings and at the consultation day that there was a lack of effective communication about reporting missing persons, the possibility or likelihood of death of loved ones and what to do next. In DC/3, families described this experience:

"There was no support in the immediate aftermath. It was absolutely crazy. Three days of wandering around hospitals trying to find some answers. Different hospitals wouldn't let us in."

"We were running around hospitals for days. It was only through running into people [other families] in hospitals that we were giving each other information. It was catastrophic to say the least. It was not the way family should have been treated in those circumstances".

"It was four days before we had the FLOs [Family Liaison Officers] come out. We were told our relatives were on a safe list, we thought they were ok and then we were told they were not accounted for".

Adequacy of Response

22. A resounding concern of the affected community is the lack of dignity and respect they have been afforded by local and national government before, during and after the tragedy, such that throughout their voices have simply not been heard. They were victims and needed to be treated humanely.
23. We were informed that there was an inadequate and disorganised response from the authorities. This was both from families who contacted INQUEST and by Grenfell United and families who invited me to speak to their meeting in advance of meeting the Inquiry chair and his team. In my view the bereaved, survivors and residents were not afforded coordinated practical, emotional, psychological, financial and legal support and advice, which made the days and weeks following the fire significantly more difficult at a time of considerable trauma.
24. It was clear that voluntary community organisations and faith groups had stepped in and were providing the most effective support in the absence of a centralised coordinated emergency response hub. The bereaved, survivors and residents were otherwise left to find their own information about their missing loved ones. The lack of any coordinated and effective response to the fire from either local or central Government caused profound anger, anxiety and anguish and exacerbated their trauma, particularly in the days immediately following the fire.
25. In DC/3 families described the assistance they received from voluntary organisations and charities, and how crucial their response was in the absence of local authority support:

"We received no guidance, no support at all. It was a few days before someone got in touch with the direct next of kin in our family. We were very much left to our own devices. In those early hours we [families and the community] began to network, building our own support network initially".

"We got help from Islamic relief and Red Cross. They offered us shelter and support; they asked if anybody needed help. It was really tough for us as it was Ramadan and it was really hot".

"The community centres and faith centres stand out as being helpful. If they weren't around, I don't know what would have happened."

26. I also believe that the mistrust and lack of confidence in local and national government, in circumstances where the relationship between citizens and the state was already strained and, in a neighbourhood, where warnings about fire safety went unheard, has impacted thereafter, and affected engagement with the legal processes that followed. This was further exacerbated by institutional denial and defensiveness.

27. In DC/3 families described the lack of Government support:

"When it happened, the Royal Borough of Kensington and Chelsea and the Government were around but not in force. They didn't understand the scale of it. We have a perception that the Government will always look after us, thought there would have been an organised response, but there wasn't. It was chaotic and people didn't know where to go".

"There was a 0800 number, we rang and left a message and someone got back to us 3 days later. The initial response was disastrous. The Government response was a disaster".

28. Early on, from the profiles and details of those deceased that were placed in the public domain, it became clear that Grenfell Tower housed people from a variety of socio-economic backgrounds, Black and minority ethnic communities and faiths. In my view, institutional racism, discrimination, and inequality played a part in the aftermath, to the extent that the victims did not count, and their lives were not seen as important.

Best Practice

29. State responses to previous disasters like Hillsborough, the Marchioness riverboat, Kings Cross, and many others have revealed the catastrophic impact to people's lives of not providing physical, practical and emotional support to those affected. Disaster Action¹ was a charity rooted in the experiences of those affected by disasters and in trying to get state agencies to learn from the mistakes of the past. They advised on disaster prevention, planning and response and how people's needs in the aftermath of a disaster should be met.

30. In the aftermath of a disaster, it is imperative that there is an organised response and that people's most basic needs are met. As early as possible, it should be made clear, where to go for support and assistance with basic provisions. Communication should be ongoing, inclusive, and easily accessible for those affected.

31. Key to this is the importance of treating people as individuals, with respect and humanity, and promoting and protecting the interests of the bereaved and survivors. Institutional memory is short, and it is unacceptable to see practices in the aftermath of Grenfell that were reminiscent of the poor practices of the past regarding a confused and uncoordinated response and the failure to address the needs of those affected.

¹ <https://www.disasteraction.org.uk/>

32. This was compounded by the very local authority implicated in the disaster and in failing to listen for safety concerns being the local authority on which the bereaved, survivors and residents were having to rely. It is to be hoped that this Inquiry can make recommendations to ensure that any future disaster is met with a humanitarian response which is coordinated and monitored by central government, and which prioritises the needs and interests of the bereaved and survivors above the interests of the state and corporate bodies.

Statement of Truth

I believe that the facts stated in this statement are true.

I am willing for this statement to form part of the evidence before the Inquiry and to be published on the Inquiry's web site.



Signed:

Date: ...6 April 2022.....