

How public inquiries can lead to change



About this report

Public inquiries are a common tool for investigating some of the tragic, complex and controversial issues in society. Government currently has eight live inquiries, looking at events ranging from the catastrophic Grenfell Tower fire to the blood contamination scandal. There have been 68 inquiries since 1990 and they have cost in excess of half a billion pounds. Implementing change and preventing recurrence must be put at the heart of our system of public inquiries. This report looks at how to make that happen.

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Summary

The Government currently has eight public inquiries under way, including: an inquiry into the circumstances of the Grenfell Tower fire in West London, in which 71 people lost their lives, an inquiry into allegations of institutionalised child abuse spanning decades, and an inquiry into blood contamination, which has led to the deaths of an estimated 2,400 people who were infected with hepatitis C and HIV (human immunodeficiency virus). Central and devolved governments have spent at least £638.9 million (m)* on a total of 68 public inquiries since 1990.

There is an expectation that inquiries will answer at least three questions:

- What happened?
- Who is responsible?
- What can we learn from this?

Rightly, much attention is focused on the first two questions. The extent to which inquiries uncover the truth is critical to whether they succeed in restoring public confidence in the institutions of government and to providing victims and their families some sense of having been heard.¹ Naturally, affected parties and the public alike are keen to understand who is at fault, and inquiries can – and often do – highlight where failings have occurred, although they cannot establish criminal or civil liability.² But it is the third question – of preventing recurrence and identifying lessons that can be cast forwards to improve institutions, regulations and behaviours – which is arguably of the most significant public interest and to which we turn in this report.

Many inquiries have delivered valuable legislative and institutional change – from more effective gun control,³ industrial regulation² and CRB checks,³ to the establishment of institutions such as the Rail Accident Investigation Branch.⁴ More broadly, in some cases they have had a profound effect on behaviours and attitudes – perhaps most importantly in the case of the Stephen Lawrence Inquiry, which helped to establish the concept of ‘institutional racism’ within the public consciousness.⁴

But overall, the formal checks and procedures we have in place to ensure that public inquiries lead to change are inadequate. There is no routine procedure for holding the

* Inflation-adjusted in 2017 terms.

** For example, in the case of an outbreak of E. coli O157 in South Wales in 2005, the inquiry set up to investigate it was able to apportion elements of blame for the resulting deaths to regulators, inspectors and other authorities. However, the butcher who allowed meat to become contaminated and then sold it was found guilty in a court of law and sentenced before the commencement of the inquiry itself. See Pennington H (2017) ‘Professor Hugh Pennington: inquiries can blame but they’re not courts’, *The Scotsman*, 25 July, retrieved 5 December 2017, www.scotsman.com/news/opinion/professor-hugh-pennington-inquiries-can-blame-but-they-re-not-courts-1-4512542

*** The Firearms (Amendment) Act 1997 and the Firearms (Amendment) (No. 2) Act 1997 were both passed in response to recommendations made in Lord Cullen’s report on the massacre of 18 people at Dunblane Primary School in March 1996. See Cullen W (1996) *The Public Inquiry into the Shootings at Dunblane Primary School on 13 March 1996*, Scottish Office, retrieved 5 December 2017, <https://www.gov.uk/government/publications/public-inquiry-into-the-shootings-at-dunblane-primary-school>

**** The Rail Accident Investigation Branch was established in the wake of the Southall Rail Accident and the Ladbrooke Grove Rail Inquiries (1997–2000 and 1999–2001 respectively) and the Joint Inquiry into Train Protection Systems (1999–2001).

Government to account for promises made in the aftermath of inquiries,⁵ the implementation of recommendations is patchy,⁶ in some cases repeat incidents have occurred⁷ and there is no system for allowing inquiries to build on the learning of their predecessors.*^{8,9}

Public inquiries investigate events in which people have suffered, or even lost their lives, and where in some cases there is a danger of those events being repeated. They have cost in excess of half a billion pounds since 1990, often take years and involve some of our most senior judges and public officials. Government must give itself the best possible chance of making changes on the basis of the findings of inquiries, and it must be held to account for doing so.

In this report, we set out four key recommendations that we think would support this.

- There is no formal requirement for government to be held to account for the decisions it makes in the aftermath of inquiries. Of the 68 inquiries that have taken place since 1990, only six have received a full follow-up by a select committee to ensure that government has acted. Even in cases where government decides not to implement recommendations, there should be a set process for having it explain why. Parliament can and should play a more significant role in holding ministers to account. To facilitate this, **the Liaison Committee should consider adding an eleventh core task to the guidance that steers select committee work:¹⁰ scrutinising the implementation of inquiry findings.** This scrutiny should be based on a comprehensive and timely government response to inquiry recommendations after the publication of an inquiry report. Departments should update the relevant select committee on implementation progress on an annual basis for at least five years following an inquiry report. In instances where the information provided is unsatisfactory, select committees should move to hold full hearings as soon as possible. Where full hearings are necessary, the approach of the Health Select Committee to the Mid Staffordshire NHS Foundation Trust Public Inquiry provides an excellent model.
- Since 1990, nine inquiries have taken five years or more from the point of inquiry announcement to produce their final report.^{**} The average inquiry takes two and a half years to publish its final report. In these years between incident and report, there is a danger of recurrent or similar incidents taking place. There is also the risk that systems and institutions move on to such an extent that recommendations – when they do arrive – are rendered redundant. Learning from the Air Accident Investigation Branch, **interim reports should be published as rapidly as possible, setting out any immediate changes that need to be made to prevent recurrence.** In the case of the Shoreham Airshow disaster in August 2015, the first report was released only 13 days later.¹¹ This kind of speed might be unrealistic for public inquiries, but where quick changes might be necessary, interim reports should be published within a matter of months rather than years.

* We carried out interviews for this research – see Appendix 1 for a detailed explanation of our methodology – and this was a point made repeatedly by interviewees.

** These are the Mirror Group Newspapers plc Inquiry (1992–2001), the Saville Inquiry (1998–2010), the FV Gaul Inquiry (1999–04), the Rosemary Nelson Inquiry (2004–11), the Penrose Inquiry (2008–15), the Vale of Leven Inquiry (2009–14), the Al-Sweady Inquiry (2009–14), the Chilcot Inquiry (2009–16) and the Robert Hamill Inquiry, which was initiated in 2004, published an interim report in 2011, but has had its final report embargoed indefinitely while criminal proceedings are conducted.

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- To develop robust, implementable recommendations, expertise on the issues at hand is needed – for instance, specialist knowledge of the intricacies of child heart surgery, or of fire safety during building construction, or an understanding of the information-sharing practices of different public services. Additionally, knowledge of how to construct policy recommendations in a form that is likely to have traction in government is an aid to effectiveness. It is not realistic to expect inquiry chairs to possess all these skills or knowledge. Therefore, **inquiries should adopt a seminar process to involve expert witnesses when developing recommendations**, as happened, for example, during the Bristol Royal Infirmary Inquiry and the Mid Staffordshire NHS Foundation Trust Inquiry.
 - Those running inquiries often rely on informal networks for guidance – there is no detailed formal guidance or support for them, despite regular calls for it to be created. **Government should implement the repeated recommendation of Parliament to create a permanent inquiries unit within the Cabinet Office**. Its first task should be the production of more detailed – and ideally public – guidance on running inquiries. Its second task should be to act as the repository for lessons learned from previous inquiries and to work with inquiry secretariats to ensure that this duty can be discharged.

1. Introduction

Inquiries are now a permanent fixture in public life. Since 1990, central and devolved governments have spent at least £638.9 million (m)* on public inquiries and this figure is rising.** There are currently eight public inquiries under way;*** the number peaked in late 2010 under the Coalition Government when there were 15 inquiries running concurrently. Inquiries have become the main vehicle for investigating some of the most tragic, complex and controversial issues in society: from one-off events such as the Grenfell Tower fire, to broader issues of serious public concern, as in the case of the Independent Inquiry into Child Sexual Abuse. At the same time, the use of other forms of investigation, including Royal Commissions****¹ and parliamentary commissions of inquiry, has declined.

We have identified 68 public inquiries that have been active or established between 1990 and 2017.***** These cover a wide range of different issues (see Figure 1). The main commonality between them is the existence of sufficient public concern to drive ministers to action. This disquiet usually revolves around allegations of institutional failure that are not addressed by parliamentary or judicial processes, although the exact nature of this failure is specific to each inquiry.

Public inquiries are often treated as the 'gold standard' of investigations, reserved for the most serious of issues.² This status creates high expectations of inquiries, both for those affected and for the wider public.

The first expectation is that an inquiry will establish the facts. As the public reaction to inquiries such as the Bloody Sunday Inquiry has shown, the extent to which they are perceived to have uncovered the truth is critical to whether they succeed in restoring public confidence in the institutions of government.³ This process can also help families and victims to feel that their concerns have been heard.

* Inflation-adjusted in 2017 terms.

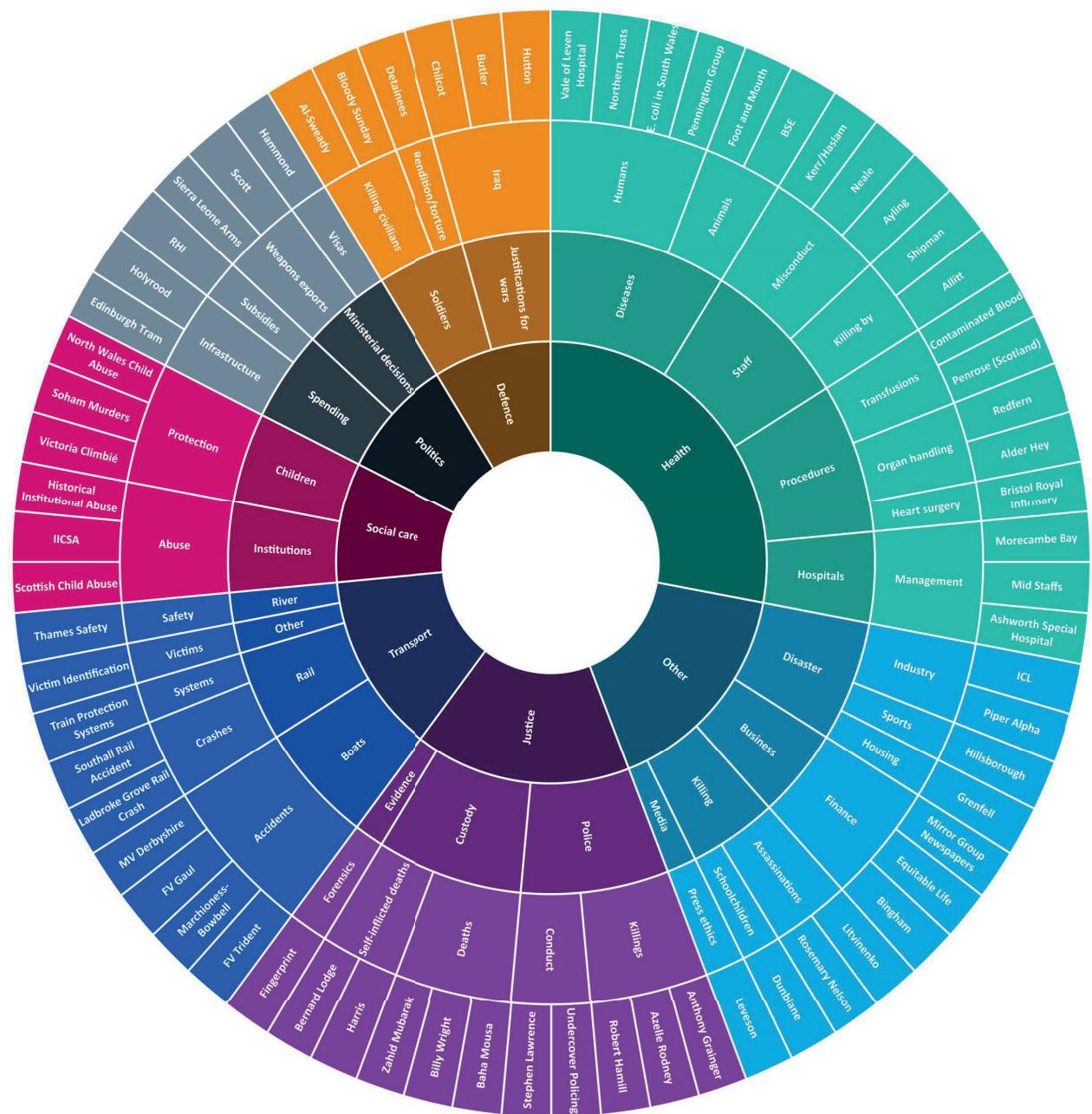
** Thirty inquiries have been called or converted from another form of investigation since 2005, eight of which are ongoing. Of the 30 inquiries, 24 have reported final or interim costs that we were able to identify, totalling at least £263.2m (2017 inflation-adjusted values). Seven of these inquiries were convened and funded by devolved administrations, costing at least £54m (2017 inflation-adjusted values). In total, we were able to identify expenses for 43 inquiries since 1990, which have the combined inflation-adjusted cost of £638.9m; this includes the estimated £201.6m spent on the Saville Inquiry (£191.5m reported in 2010).

*** As of December 2017, these are: the Anthony Grainger Inquiry, the Blood Contamination Inquiry, the Edinburgh Tram Inquiry, the Grenfell Tower Inquiry, the Independent Inquiry into Child Sexual Abuse, the Renewable Heat Incentive Inquiry, the Scottish Child Abuse Inquiry and the Undercover Policing Inquiry.

**** The last Royal Commission was in 2000, on the reform of the House of Lords. Only two others were initiated in the preceding 23 years.

***** Please refer to Appendix 1 for a detailed explanation of our methodology and to Appendix 2 for a complete list of the public inquiries we considered in our analysis.

Figure 1: Classification of 68 public inquiries, 1990 to 2017



Notes: BSE = bovine spongiform encephalopathy, IICSA = Independent Inquiry into Child Sexual Abuse and RHI = Renewable Heat Incentive.

Source: Institute for Government analysis

The second expectation is that an inquiry will establish who is to blame for the events that have occurred. Inquiries cannot determine criminal or civil liability,⁴ but they can – and often do – highlight where failings have occurred.*

But it is the third expectation that is arguably the most important: inquiries should also aim to change the systems that gave rise to the tragedies in the first place and to prevent recurrence. This objective – to be forward-looking, to improve government and public services, and to prevent the same mistakes from being made again – is the most important contribution that an inquiry can make to the wider public interest. Government has itself argued that this is the key purpose of an inquiry.^{5,6}

Despite the gravity of the issues that inquiries address, the public expectation that rightly surrounds them, their cost and the frequency with which they are used, there are few sources of guidance on how to structure, run and follow up on an inquiry effectively.** The central issue of the lasting change that inquiries achieve has received scant attention. Many inquiries have delivered valuable legislative and institutional change – from more effective gun control*** and CRB checks,⁷ to the establishment of institutions such as the Rail Accident Investigation Branch.**** They can also drive cultural change; in some cases they have had a profound effect on behaviours and attitudes.⁸ The most remarkable example of this is the way the Macpherson report – which investigated the death of Stephen Lawrence – helped to establish the concept of 'institutional racism' within the public consciousness.⁹ But overall, the amount of change delivered as a result of inquiries is variable^{10,11,12} and in some cases repeat incidents have occurred, which should have been avoided.^{13,14} There is no firm procedure for holding the Government to account for promises made in the aftermath of inquiries,¹⁵ and the Cabinet Office system intended to allow inquiries to learn from their predecessors is not being used.*****

In this report we look at how to change this. From the establishment of an inquiry to its aftermath, we examine how inquiries can best assure that they develop powerful, timely recommendations for change; and how government can be held to account for implementing them.

Notes:

* For example, in the case of an outbreak of E. coli O157 in South Wales in 2005, the inquiry into it was able to apportion elements of blame for the resulting deaths to regulators, inspectors and other authorities. However, the butcher who allowed meat to become contaminated and then sold it was found guilty in a court of law and sentenced before the commencement of the inquiry itself. See Pennington H (2017) 'Professor Hugh Pennington: inquiries can blame but they're not courts', *The Scotsman*, 25 July, retrieved 5 December 2017, www.scotsman.com/news/opinion/professor-hugh-pennington-inquiries-can-blame-but-they-re-not-courts-1-4512542

** As Professor Adam Tomkins MSP put it during oral evidence to the House of Lords Select Committee on the Inquiries Act 2005: 'Public inquiries are a component of our system of administrative justice, but there is no system of public inquiries.' See House of Lords Select Committee on the Inquiries Act 2005 (2014) *Written and corrected oral evidence*, p424 The Stationery Office.

*** The Firearms (Amendment) Act 1997 and the Firearms (Amendment) (No. 2) Act 1997 were both passed in response to recommendations made in Lord Cullen's report on the massacre of 18 people at Dunblane Primary School in March 1996. See Cullen W (1996) *The Public Inquiry into the Shootings at Dunblane Primary School on 13 March 1996*, Scottish Office, retrieved 5 December 2017, <https://www.gov.uk/government/publications/public-inquiry-into-the-shootings-at-dunblane-primary-school>

**** The Rail Accident Investigation Branch was established in the wake of the Southall Rail Accident and the Ladbroke Grove Rail Inquiries (1997–2000 and 1999–2001 respectively) and the Joint Inquiry into Train Protection Systems (1999–2001).

***** A point made repeatedly during our research and substantiated in: House of Lords Select Committee on the Inquiries Act 2005 (2014) *The Inquiries Act 2005: Post-legislative scrutiny*, The Stationery Office.

2. Establishing an inquiry

Impact does not begin at the end of an inquiry, but at the start. When establishing an inquiry, a number of key decisions are made by the initiating minister:

- whether to establish an inquiry or use a different type of investigation
- what the intended purpose of the inquiry is
- who should be appointed to chair the inquiry, and whether they require the support of a panel or technical assessors
- setting the terms of reference, usually in consultation with the chair, with the devolved governments wherever matters cover areas of their interest or competence, and increasingly with victims and the wider public
- the timing of the inquiry.¹

Decisions on these critical questions are sometimes made hurriedly, in the face of significant public and political pressure.* But these decisions are central to an inquiry's effectiveness: they will have implications for its length, its costs and public expectations. Critically, they will augment or diminish the chances of achieving change on the basis of inquiry findings.

Inquiries are not the only way to achieve change

Since 2000, there have never been fewer than three concurrent inquiries running in any month, and at the high point in 2010 there were as many as 15 (see Figure 2). The rise of the public inquiry has been accompanied by a long-term shift away from

Figure 2: Number of concurrent public inquiries monthly, 1998 to 2017



Source: Institute for Government analysis

* The Hutton and Grenfell Inquiries were both established the day following the events in question. Similarly, the inquiry into the Dunblane massacre was established within eight days of the massacre; and in the case of Anthony Grainger, an inquest was convened two days after his death and a separate inquiry was ordered within two weeks of the event.

other forms of investigation, particularly as Royal Commissions have fallen into disuse.² During our research, we heard that inquiries have come to be seen as the 'gold standard' for an independent investigation into a major disaster, accident or other event involving significant damage or loss of life.

Convening an inquiry is understandably tempting. It offers ministers the means quickly to relieve political pressure in difficult circumstances^{*} and the Inquiries Act 2005 provides ministers with the latitude to set them up under a broad set of circumstances.^{**} So far, the decision to establish an inquiry under the Act has never been subject to a successful judicial review.³ But inquiries are not always the best method for examining a tragedy, disaster or scandal. In some cases, an inquest or other form of investigation might achieve the necessary goals more quickly and cheaply than an inquiry can do.⁴ The alternatives – inquests, independent panels and Royal Commissions – should be borne in mind by ministers before convening an inquiry.

Inquests

Inquests are legally mandated, coroner-led investigations into the unnatural death or death in custody of an individual or individuals to establish how, where and why they died.^{***} They culminate in the coroner recording a conclusion about the cause(s) of death. Inquests are not about apportioning blame: they establish what happened; the question of who should be held responsible remains a matter for criminal and civil courts. When the purpose of an investigation is to establish the cause(s) of death, inquests usually represent a more cost-effective, faster and more streamlined approach than inquiries. The average length of time for an inquest to be processed was 18 weeks in 2016⁵ and coroners are required to report any inquest that lasts longer than a year to the Chief Coroner, and subsequently report when the investigation is concluded.⁶ There are set procedures in place for gathering lessons: coroners publish recommendations based on their investigations via 'Reports to Prevent Future Deaths'.⁷ They have a statutory duty to make these recommendations wherever they identify a concern about the nature of a death.

However, inquests have a narrower remit to operate than inquiries. They are limited in their ability to investigate beyond the immediate cause(s) of the death and have restrictions on handling sensitive materials or holding closed hearings. This was one of the reasons why the inquests into the deaths of Azelle Rodney, Alexander Litvinenko and Anthony Grainger were converted from inquests to statutory inquiries.⁸ If public concern extends to wider issues, or the changes needed to prevent recurrence require looking beyond the immediate death to broader systems and institutions, then public inquiries may still be the most appropriate option.

* 'Most inquiries are... "quick political fixes" in response to urgent pressures, like the Hutton report after the death of Dr David Kelly or the Leveson inquiry after the revelations about the hacking of Milly Dowler's phone.' See Riddell P (2016) 'The role of public inquiries', blog, Institute for Government, 26 July, retrieved 5 December 2017, www.instituteforgovernment.org.uk/blog/role-public-inquiries

** The Inquiries Act 2005 states that there is cause for an inquiry when 'particular events have caused, or are capable of causing, public concern, or there is public concern that particular events may have occurred.' See Inquiries Act 2005, s 1(1), retrieved 5 December 2017, www.legislation.gov.uk/ukpga/2005/12/contents

*** The right to life enshrined in Article 2 of the European Convention on Human Rights 1953 has been interpreted as placing a duty on nations to properly investigate a death that is either violent or unnatural, where the cause of death is unknown or where the death occurred in state custody or detention. See Chief Coroner (2013) *The Chief Coroner's Guide to the Coroners and Justice Act 2009*, Chief Coroner, p. 8.

Independent panels

Another alternative is the emerging model of the independent panel. There have been independent panels on a range of issues, the best known of which is the Hillsborough Independent Panel. This was convened in the wake of an inquest, an inquiry and an independent non-statutory review, all of which failed to satisfy the expectations and concerns of the victims, their families and the wider public.* Other independent panels have considered the riots that took place in towns and cities across England in August 2011 and concerns about the care provided at the Gosport War Memorial Hospital.

Unlike an inquiry, panels usually do not hold oral hearings or have the power to compel testimony or the release of documents. Instead, their role focuses on gathering information by negotiating the disclosure of documents to contribute to the public understanding of the issue in hand. In the case of the Hillsborough tragedy, the Independent Panel was able to do this successfully, gathering information – from central government, local government, other public agencies and some private bodies – that related directly to events surrounding the tragedy and its aftermath. In total, some 450,000 pages of material were disclosed.⁹ Initially, the Panel made this information available to the Hillsborough families and affected parties before drafting a report setting out what it had learned and publishing most of the gathered material as a permanent archive. A similar approach is being used by the Gosport Independent Panel.¹⁰

When the Hillsborough Independent Panel reported in September 2012,¹¹ it was credited by victims and their families as having finally got to the truth of the disaster. It led to apologies from the-then Prime Minister David Cameron, from the *Sun* newspaper and from the Chief Constable of South Yorkshire Police. As a process for achieving truth and some measure of closure, the Panel appears to have been effective. The panel format might be an appropriate alternative to an inquiry when the main goal is to establish an historical account of what happened, although the absence of legal powers to compel co-operation should be noted.

Royal Commissions

A Royal Commission is an ad-hoc advisory committee appointed by the Government (in the name of the Crown) for a specific investigatory and/or advisory purpose. During the past 200 years, they were most in vogue during the 19th century: some 388 commissions were established between 1830 and 1900 (more than five a year on average).¹² Royal Commissions have fallen into disuse more recently in the UK, but are still used in Australia, Canada and New Zealand. The last Royal Commission concluded in 2000, looking at House of Lords reform.¹³ Before that there had only been two other Royal Commissions since the 1970s.¹⁴ Although there have been successes – the Royal Commission on Criminal Procedure directly influenced legislation governing police powers in the Police and Criminal Evidence Act 1984 and the establishment of an independent Crown Prosecution Service in the Prosecution of Offences Act 1985 – the overall lack of influence that Royal Commissions appear to have wielded (and the time

* Following the Hillsborough disaster in April 1989, there was a coroner's inquest (1989–91), an initial public inquiry (the Taylor Inquiry, 1989–90), a further independent investigation – see Stuart-Smith Rt Hon Lord Justice (1998) *Scrutiny of Evidence Relating to the Hillsborough Football Stadium Disaster*, The Stationery Office – then the establishment of the Hillsborough Independent Panel (2009–12) and a second round of coroner's inquests (2012–16).

they take to report) is one of the reasons why they have been shelved in favour of other forms of inquiry. There is still a stalemate on House of Lords reform, for instance.

However, one of the participants in our research suggested that Royal Commissions might have an advantage over inquiries in matters of broader policy change. Inquiries tend to be rooted in specific incidents, which might not be the most appropriate basis for considering wider policy change because the circumstances do not always generalise well. For example, an inquiry into one specific fatal police shooting might not be the best way to investigate policy options for police use of weapons more broadly.

In theory, Royal Commissions have the advantage of considering change beyond a single, potentially limiting incident. They are there to consider intractable policy challenges. For this reason, a Royal Commission or similar might be an appropriate vehicle to consider the wider issues of social housing policy highlighted by the circumstances of the Grenfell Tower fire. Table 1 looks at the different types of formal independent investigation and how they compare on 13 key characteristics.

Notes for Table 1 (see following page)

- i The basis for holding a statutory inquiry is defined by Article 1, section 1 of the Inquiries Act 2005, which states that a minister can establish an inquiry whenever 'particular events have caused, or are capable of causing, public concern, or there is public concern that particular events may have occurred'. Non-statutory inquiries are not bound to follow the Act in how they operate, but would be established on the basis of a similar logic.
- ii The right to life enshrined in Article 2 of the European Convention on Human Rights 1953 has been interpreted as placing a duty on nations to properly investigate a death that is either violent or unnatural, where the cause of death is unknown or where the death occurred in state custody or detention. See Chief Coroner (2013) *The Chief Coroner's Guide to the Coroners and Justice Act 2009*, Chief Coroner, p. 8.
- iii For the 60 inquiries that have completed since 1990, non-statutory inquiries took between one and seven years, with a median length of 1.2 years; statutory inquiries took between one and twelve years, with a median length of three years. Of these inquiries 90% took less than six years.
- iv Any inquest that takes longer than a year must be reported to the Chief Coroner with an explanation as to why, and must make a similar report when it concludes. See Coroners and Justice Act 2009, s 16(1).
- v Royal Commissions vary greatly in length. The most recent (the Wakeham Commission) existed for little more than a year. In contrast, the Royal Commission on Environmental Pollution ran for 41 years, from 1970 to 2011, publishing 29 major reports; this was a standing commission that was classified as a non-departmental public body under the sponsorship of the Department for Environment, Food and Rural Affairs (Defra).
- vi Maxwellisation is the process by which an inquiry sends out pre-publication notifications to anyone who receives criticism in its report(s). These official letters are commonly known as Salmon Letters, after Cyril Salmon, Baron Salmon, who originated the principle as part of his Royal Commission on Tribunals of Inquiry (1966).
- vii Schedule 5 of the Coroners and Justice Act 2009 details the powers of coroners. Paragraph 7 states that 'the coroner must report' things that may cause future deaths and actions that could be taken to prevent this from happening.
- viii 'These include receiving disclosure of documentation, being represented and making legal submissions, suggesting questions and receiving advance notice of the inquiry's report.' See Independent Inquiry into Child Sexual Abuse (2017) *Core Participant Status – Frequently Asked Questions*, retrieved 5 December 2017, www.iicsa.org.uk/key-documents/303/view/core-participant-status-faqs_2%20.pdf

Table 1: Comparison of different types of formal independent investigation

	Statutory inquiry	Non-statutory inquiry	Inquest	Independent panel	Royal Commission
Establishment	By a minister, whenever particular events cause sufficient 'public concern' ⁱ	By a coroner, whenever a death occurs under specific circumstances ⁱⁱ	By a minister	By means of a royal warrant at the request of a secretary of state ¹⁵	
Terms of reference	Terms of reference set by a minister	No specific terms of reference	Terms of reference set by a minister		
Determination of guilt	Cannot determine civil or criminal liability				
Public or private	Public to the greatest extent possible, with allowances for some private evidence ¹⁶	Presumed to be public but can sit partially or wholly in private	Public, with an option to hear some evidence in private	Public	Can be public or private
Composition	Chair-led with the option to include panellists ¹⁷		Coroner-led	A chair-led panel, of typically 4 to 12 people	A large, chair-led panel, of typically 10 to 16 people
Typical duration	1 to 6 years ⁱⁱⁱ		Less than a year ^{iv}	1 to 3 years	Years to decades ^v
Subpoena power	Can compel testimony and the production of documents under threat of criminal sanction	No power to compel witnesses or order the production of documents	Can compel testimony and the production of documents under threat of criminal sanction	No power to compel witnesses or order the production of documents	
Taking evidence	Can take evidence under oath ¹⁸	Cannot take evidence under oath	Can take evidence under oath	Cannot take evidence under oath	
Maxwellisation^{vi}	Maxwellisation must take place by means of 'Salmon Letters' ¹⁹	Maxwellisation generally expected	No specific Maxwellisation process		
Recommendations	In most cases the terms of reference will require the delivery of recommendations for change		Duty to recommend actions as part of 'Reports to Prevent Future Deaths' ^{vii}	In some cases the terms of reference may require the delivery of recommendations for change	
Public access to documents	Duty to ensure public access to documents ²⁰	No specific duty to release documents	Duty to disclose most relevant documents from an inquest when requested ²¹	One of the main purposes of independent panels is usually disclosure of documents	May disclose documents if required to do so by terms of reference
Core participants	'Core participant status' available for individuals, organisations and institutions with an interest in the work of the inquiry – this status grants certain special rights ^{viii}		No special 'core participant status' for parties affected by or involved in the issue of interest		

The terms of reference set out the purpose of an inquiry

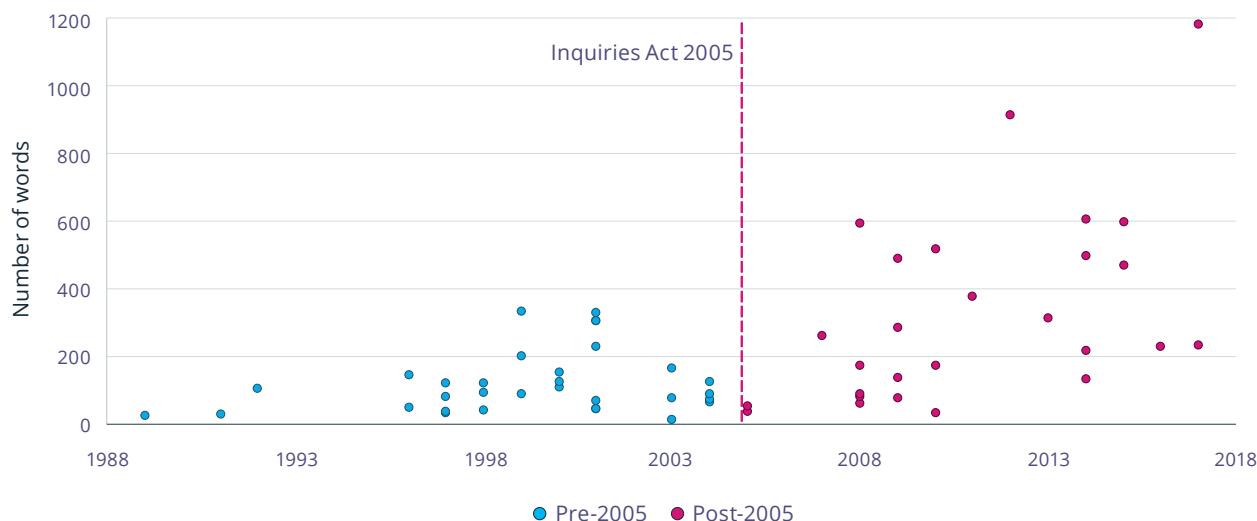
To be effective and deliver change, inquiries need a clear sense of purpose. The House of Lords Select Committee on the Inquiries Act 2005 has stated that the purpose of inquiries is to 'establish disputed facts, determine accountability, restore public confidence and... prevent recurrence of events and taking forwards public policy'.²²

Jason Beer QC adds establishing blame, providing catharsis and meeting human rights obligations to that list.²³ But inquiries rarely address all these aims. Participants in our research suggested that, for instance, the inquiries into the murder of Rosemary Nelson, historical incidents of child abuse, and infections resulting from contaminated blood, were focused mainly on establishing the facts and providing some resolution to those directly affected. Other inquiries were tasked more explicitly with making recommendations for change, for example the Mid Staffordshire NHS Foundation Trust Inquiry,²⁴ the Fingerprint Inquiry²⁵ and the Shipman Inquiry.²⁶

The terms of reference for an inquiry usually offer the clearest exposition of its aims. Decisions on the wording of the terms of reference influence how the inquiry is run, how long it will take, how much it will cost and how it can effect change.²⁷ As such, being clear and direct in the terms of reference about which of the many potential purposes of inquiries is being pursued is critical. This will ensure that the inquiry is run in a way that supports these aims and importantly will help to avoid disappointment or disillusionment at the end of an inquiry.

Over time, inquiry terms of reference have been becoming longer (see Figure 3). This shift reflects a growing focus on detailed and specific questions within terms of reference, instead of the vague instructions to 'investigate such and such event' that had been common previously. The Saville Inquiry into the events of Bloody Sunday – which was roundly criticised for its length (12-and-a-half years) and costs (£191.5m) – had particularly loose and wide-ranging terms of reference, albeit focused on the events of one night.²⁸ Modern terms of reference are also – where appropriate – better at setting out the need for recommendations as a core part of the inquiry.

Figure 3: Word length of terms of reference for public inquiries, 1990 to 2017



Source: Institute for Government analysis

Since a series of high-profile inquiries failed to adequately involve victims and their families – perhaps most famously the first Bloody Sunday Inquiry – the communities directly affected by tragedies are now playing a larger role in developing the terms of reference. At the outset of the Grenfell Tower Inquiry, a public consultation was run on the draft terms of reference and a series of meetings took place with survivors and their families to take in their views.²⁹ The idea of such consultation is to ensure that the expectations of different groups – including affected parties – are acknowledged from the outset, and to help build trust in the inquiry.

Public inquiries rarely satisfy everyone

But balancing competing expectations is not always possible.

One of the most common sources of disagreement is about the breadth of the terms of reference. Citizens – particularly directly affected parties – sometimes argue for broad terms of reference. This happened during the establishment of the Grenfell Tower Inquiry: the final terms of reference include looking at the causes of the fire itself, the history of the building and the relationship between residents and the local authority. However, they do not extend to looking at social housing policy more broadly or the Government's response to the disaster, despite calls for them to do so.

The desire for a comprehensive account, not just of an incident but also of the broader circumstances in which it occurred, is understandable. But there are good reasons to resist attempts to have inquiries range over too much ground. With inquiries such as Saville, the broader and looser terms of reference meant that the inquiry lacked focus and partly contributed to its length and cost. It has also been argued that wide-ranging inquiries are less likely to deliver against their grand ambitions and invariably fail to satisfy the victims, survivors, families and the public.³⁰

Wide-ranging remits can also compromise the 'primary purpose of an inquiry'³¹ which speaks most to the public interest: the opportunity to learn from what went wrong and prevent recurrence. Lengthy, broad and expensive inquiries can delay or constrain change. In the case of the Chilcot Inquiry, for instance, the remit was so wide that the inquiry took seven years and the report came so long after the events being examined that the window of opportunity for change had closed; systems and institutions had already moved on.³² If very public mistakes have been made or there is a danger of recurrence, then lessons need to be drawn as soon as possible. Applying a narrower focus can ensure that inquiries deliver more efficiently, and may therefore be able to influence change more effectively.

There is a preference for judicial chairs

The chair has a privileged and outsized role in any inquiry. They set the tone and have the final say on all aspects of an inquiry's work. This responsibility often becomes tied up with their individual reputation. Many inquiries come to be known by the name of the chair, to the point where this can eclipse the individual behind the name.³³ Each inquiry chair is granted a unique moral authority to investigate a matter and this authority is a rare resource that – when used well – will dramatically enhance the effectiveness of the inquiry. However, this comes at a cost; even short inquiries consume a significant amount of time and energy, and the chair must agree to put all their other work on hold for at least a matter of months, often years, in order to perform a public service.

The current process for selecting and appointing chairs is nearly as ad hoc as the process of establishing inquiries themselves. Previous inquiry chairs describe an abrupt and hurried process:

"As far as appointment is concerned, like most chairmen, I had the experience of being phoned up out of the blue and asked to decide within an hour whether I would like to chair the inquiry because the minister was in a hurry to make an announcement. I am frequently asked, probably with some surprise, 'Why were you chosen?' I have absolutely no idea, or about the process."

Sir Robert Francis QC³⁴

"My experience was even more dramatic from that, in so far as I was phoned at about 8.30pm to be told that the Secretary of State was delighted that I had agreed to take on this inquiry, which I might say left me with little room to negotiate."

Professor Sir Ian Kennedy³⁵

Under the terms of the Inquiries Act 2005, appointments are solely at the discretion of the responsible minister.³⁶ They are required to consult whoever they want to appoint, but otherwise there are few rules and even fewer guidelines regarding appointments. The only statutory requirement relates to judicial appointments; should a minister want to invite a judge to sit as a chair or a panellist, they must consult with the responsible senior judge or Lord Chief Justice.³⁷

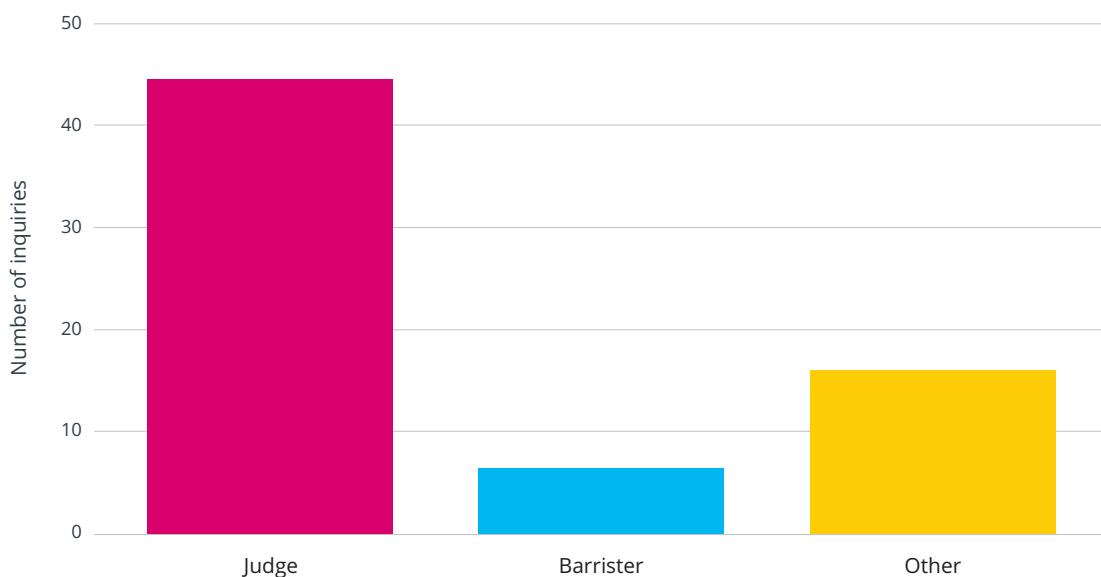
Judges have been the preferred choice to chair most public inquiries since 1990 (see Figure 4). Out of the 68 public inquiries run between 1990 and 2017, 44 had/have judicial chairs.* There are many reasons why judges are such a popular choice, with several commonly cited strengths including:

- political independence
- experience of running hearings
- the ability to analyse information and uncover facts
- the benefit of legal experience in instances when an inquiry is running concurrently with criminal proceedings
- an understanding of legal and procedural complexity.³⁸

The point on political independence is particularly important. Many inquiries deal with failures of government and its institutions, and protecting the independence of inquiries is a priority.³⁹ Chairs must be independent from the issue to support the confidence of the victims and their families and groups. By virtue of their training and their judicial oath, judges are bound to be independent of both the issue and wider politics. Failure to command the trust of the victims saw the Independent Inquiry into

* Of the 24 inquiries with non-judicial chairs, six were chaired by senior barristers: Sir Roger Thomas QC (the Mirror Group Newspapers plc Inquiry, 1992–2001), Michael Redfern QC (the Royal Liverpool Children's Inquiry, 1999–2001 and the Redfern Inquiry, 2007–10), Sir Anthony Hammond QC (the Hammond Inquiry, 2001), Sir Stephen Young QC (the FV Trident Inquiry, 2009–11) and Robert Francis QC (the Mid Staffordshire NHS Foundation Trust Inquiry, 2010–13).

Figure 4: Number of inquiries by professional background of their chairs, 1990 to 2017



Source: Institute for Government analysis

Child Sexual Abuse lose three chairs.* Concerns over the Department of Health conducting the inquiry into the contaminated blood scandal led to the investigation being converted to a statutory inquiry with an independent chair, under the sponsorship of the Cabinet Office in 2017.⁴⁰

But approaching inquiries like court cases can constrain change

There are some downsides to appointing judicial chairs though, and these often correspond to the strengths of their non-judicial alternatives. By nature of their training and experience, judges tend to see the end of an inquiry as a hard point of separation, after which their involvement ceases.⁴¹ As several judges have noted:

Unless an inquiry directly concerns the administration of justice, or where there has been prior agreement about this... a judge should not be asked to comment on the recommendations in his report or to take part in its implementation.

Lord Justice Beatson⁴²

"Once the inquiry chairman has reported, that is the end of it as far as the chairman goes. His job is done, and I would not wish to be involved in any follow-up. The implementation of recommendations is an entirely different exercise. That is for the politicians and the Executive to do."

Lord Gill⁴³

* The inquiry was announced on 7 July 2014. Baroness Butler-Sloss was the nominal chair from 8 to 14 July 2014, Fiona Woolf from 5 September to 31 October 2014, Dame Goddard from 4 February 2015 to 4 August 2016 and then Professor Alexis Jay from 11 August 2016.

A judge's desire to cease involvement with an inquiry after handing down their findings is understandable – their oaths preclude them from getting involved in politics, and their trial-based experience means that they are used to a hard endpoint to their involvement when a process has its formal conclusion. However, such a wall between an inquiry and its aftermath entails the loss of the chair's unique standing and moral authority, which often make them one of the most effective advocates for their recommendations.

Non-judicial chairs appear to be more willing to countenance continued involvement. Baron Laming, a former social worker who chaired the inquiry into the death of Victoria Climbié and the Review of Child Protection in the wake of the Baby P case, developed detailed implementation plans as part of his roles.⁴⁴ Lord Bichard, who chaired the Soham Inquiry, went as far as informally reconvening the inquiry six months after it reported, to monitor the progress of his recommendations.⁴⁵

Another potential advantage of non-judicial chairs is their ability to incorporate specialist knowledge and expertise within the role of the chair, such as an understanding of the nuances of particular scientific or social issues of relevance to the inquiry, or experience of policy making.⁴⁶ While judges excel at fact-finding, their training does not necessarily equip them with policy-making skills. When an inquiry argues for changes to policy, a judge may not be best placed to form effective recommendations without additional support. While policy making or expert knowledge can be incorporated into judge-led inquiries through the inclusion of experts as members of the chair's panel, or as technical assessors, there may be benefits to having a chair who is a subject-matter expert.

3. Running an inquiry

Once the team has been assembled, the real work on an inquiry begins: gathering evidence, testing recommendations and producing reports. The way this work is structured, the use of specific expertise and capability, and the pace of reporting, all have a significant impact on the efficiency and effectiveness of an inquiry – and ultimately, whether or not it is able to produce a timely, powerful set of recommendations capable of driving change.

Inquiries have to learn as they go

Running an inquiry is a daunting process. Former chairs recall phones ringing in the dark, rushed decisions and starting from scratch on issues of national importance.¹ During our research, past inquiry secretaries recounted walking the halls of Whitehall, seeking out fellow civil servants with experience of running a secretariat; or sitting in the gallery of an ongoing inquiry, hoping to learn through observation. There is no well-established guidance for the process of running an inquiry, gathering evidence and producing reports. Instead, the form of an inquiry is largely dictated by the chair with support from the secretariat. Some flexibility makes sense; each public inquiry is different:

A major part of the challenge in revising Public Inquiry design is the widespread acknowledgment that the process has to be flexible, due to the variety and range of topics which Public Inquiries are required to address – from the actions of Harold Shipman in murdering his patients, to the management of foot and mouth outbreaks in agriculture.

Dr Karl Mackie²

But all inquiries face common decisions, which will affect their ability to create the momentum for change. The approach taken to time management, how the inquiry is structured, the pace and scope of its outputs, and its use of recommendations, will all contribute to the outcome of an inquiry.

What little guidance on inquiries that does exist almost exclusively pertains to the earliest stages of inquiries.³ There is little written in accessible forms to guide how inquiries could be run. Even what is available can be difficult to access:

"One of the extraordinary things I have discovered, thanks to Lord Woolf's review, was that there was some Cabinet Office guidance about the running of public inquiries that is restricted, and therefore I presume that was the reason no one offered to show it to me."

Sir Robert Francis QC⁴

In the guidance available from the Cabinet Office, writing a ‘lessons learned’ paper is the responsibility of the inquiry secretary.⁵ This paper is intended to focus on the process of the inquiry and what has been learned, with the intention of informing future inquiries. However, when the House of Lords Select Committee on the Inquiries Act 2005 tried to find copies of these reports, it was ‘astonished to be told that the Cabinet Office held only one, for the Baha Mousa Inquiry’.⁶ The Bernard Lodge Inquiry included comments that amounted to a set of lessons in the text of its main report, under the heading ‘Lessons about inquiry procedure’.⁷ But in general, this material is extremely hard to locate, if it exists at all.

The lack of guidance creates inefficiencies in the process of setting up an inquiry, and means that secretariats are not always able to access the full range of good practice. Instead, they are heavily dependent on individual experience and informal networks for advice. Due to staff turnover, finding this cannot be guaranteed.⁸ Secretaries to inquiries – who are usually experienced senior civil servants – have sometimes played this role more than once and so know the ropes.* But this is far from always the case and, as the House of Lords Select Committee on the Inquiries Act 2005 has pointed out, it is precisely those experienced secretaries who have emphasised how valuable it would be to have full and detailed guidance on setting up and running an inquiry.⁹

Inquiries take an average of two-and-a-half years to report

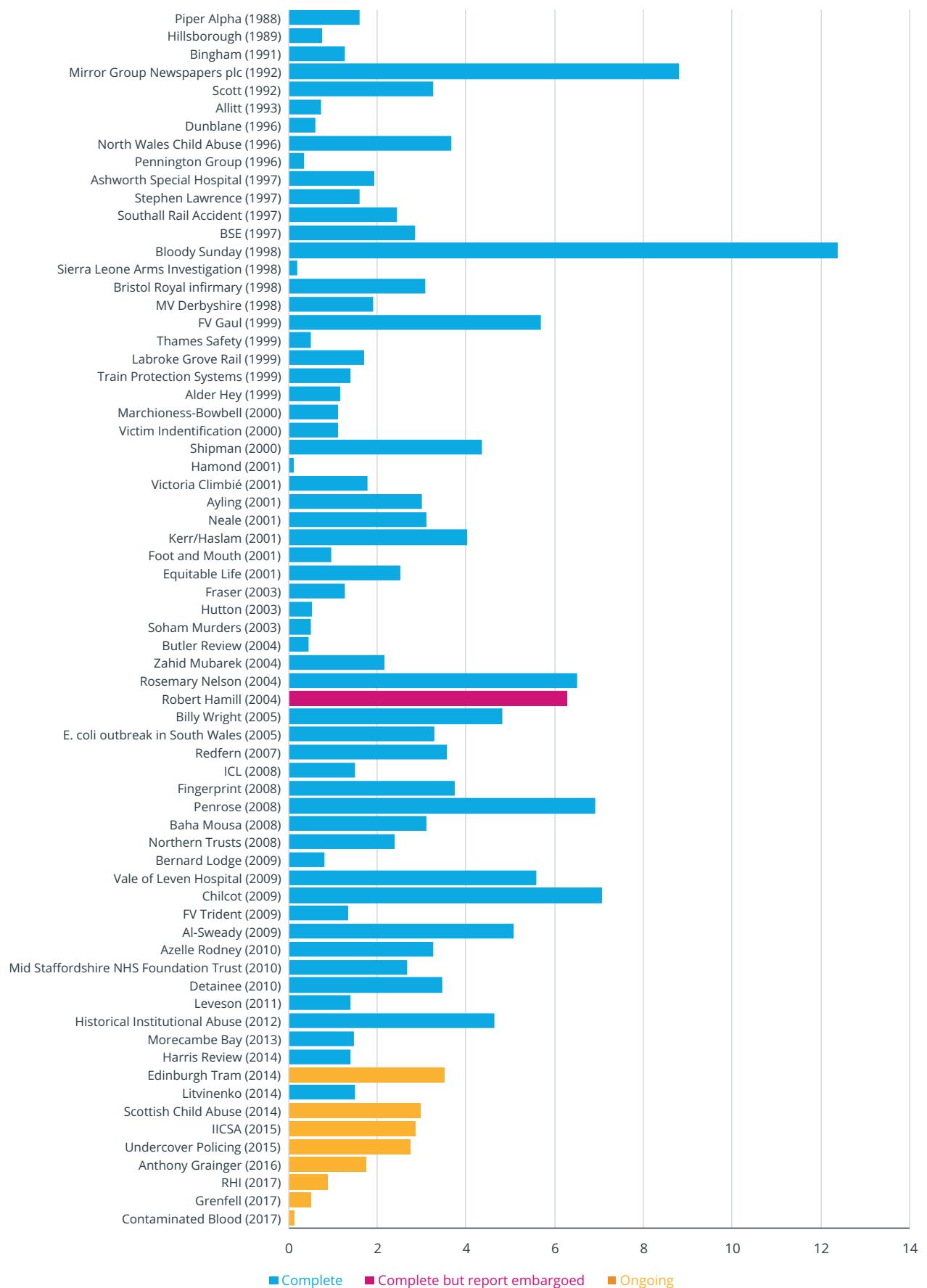
Inquiries are slow-moving beasts even when run well (see Figure 5). Since 1990, they have taken an average of two-and-a-half years to report and nine have taken five years or more to produce their final reports.^{**} As Mr Justice Scott Baker observed, ‘the plain fact is that inquiries held in public do tend to develop a life of their own, however efficiently or carefully they are managed’.¹⁰ This is expensive. And it delays closure and catharsis for the victims involved. But the greatest risk, as was famously the case with the Chilcot Inquiry, is that by the time they conclude, they are too late to be useful and practice has already moved on. This danger is heightened when the nature of an inquiry is historical. The Bristol Royal Infirmary Inquiry, which reported in 2002, was examining events that took place as far back as the 1980s and early 1990s. The current Independent Inquiry into Child Sexual Abuse is looking back over many decades.

One way to mitigate the risk of anachronism is to run more efficient inquiries. It might be possible to incentivise shorter timeframes through a compulsion for chairs to report to government when they run beyond a certain deadline (this is the model used by inquests). However, assuming that sometimes the only way to get to the truth is by working through all the historical evidence step by step, there are other opportunities to ensure that change is effected in a timely fashion, as we explore below.

* At least seven secretaries have been appointed with prior experience of being an inquiry secretary. In the case of Lee Hughes CBE, he served as secretary to at least four inquiries (Hutton, Baha Mousa, Al-Sweady and Litvinenko).

** These are the Mirror Group Newspapers plc Inquiry (1992–2001), the Saville Inquiry (1998–2010), the FV Gaul Inquiry (1999–2004), the Rosemary Nelson Inquiry (2004–11), the Penrose Inquiry (2008–15), the Vale of Leven Inquiry (2009–14), the Al-Sweady Inquiry (2009–14), the Chilcot Inquiry (2009–16) and the Robert Hamill Inquiry, which was initiated in 2004, published an interim report in 2011, but has had its final report embargoed indefinitely while criminal proceedings are conducted.

Figure 5: The duration of public inquiries active in the period 1990 to 2017



Source: Institute for Government analysis

Concurrent police investigations and court proceedings will extend the timeline

One of the most common reasons for delays is concurrent investigations by the police. The existence of these, and the criminal and civil trials that may follow, will always complicate and slow the progress of any inquiry. Lord Leveson attempted to manage this complication by splitting his inquiry into the British press into two parts – a practice that has been used by various inquiries since the 1980s. The first part of the inquiry addressed:

The culture, practices and ethics of the press... contacts between the press and politicians and the press and the police... the extent to which the current regulatory regime has failed and whether there has been a failure to act upon any previous warnings about media misconduct.¹¹

This part delivered a report in 16 months, only four months later than originally proposed.¹² The second part was intended to resume 'follow[ing] the conclusion of any criminal prosecutions'.¹³ However, it was never initiated, for reasons including the length and complexity of the criminal proceedings and changing political sentiment. The Conservative Party since committed to dropping the second part of the inquiry as part of its 2017 general election manifesto, explicitly citing the lengthy criminal proceedings.¹⁴ The Detainee Inquiry faced similar challenges, with fresh police investigations leading to the inquiry being wound up early:¹⁵ '... the problem we had in the Detainee inquiry. As long as the police are investigating something, you cannot tackle that and people cannot give you evidence for perfectly good reasons of justice'.¹⁶

Some inquiries go as far as they can and then wait for the conclusion of criminal proceedings before publishing. For example, the Robert Hamill Inquiry's final report is still awaiting publication as legal proceedings are ongoing.¹⁷ Most recently, the Grenfell Tower Inquiry has announced that its interim report – due by Easter 2018 – will be delayed because of the ongoing police investigation and the danger of compromising prosecutions.¹⁸ Given the difficulty of running an inquiry alongside police and criminal proceedings, consideration should be given to beginning inquiries once police and legal proceedings have been completed.

Learning from the aircraft industry – the use of interim reports

One means of getting to conclusions and recommendations quickly is the use of interim reports, rather than relying on a single comprehensive account at the conclusion of the inquiry. Interim reports are an under-utilised approach that can help inquiries deliver more rapidly on the key aim of preventing recurrence.¹⁹ There can be downsides to interim reports – not least that they usually base their conclusions on limited information, given the shorter timescales. But there are many inquiries where a range of issues can be satisfactorily addressed before the final conclusion of the investigation. For example, in cases of industrial accidents or regulatory failure, some necessary changes may be well understood early on in the process.²⁰ In these cases, there is little value in holding back useful findings and recommendations until the culmination of all the other investigations; an interim report will allow for earlier, immediate action.

This approach is similar to that used by the Air Accident Investigation Branch when a plane crashes: first, technical issues are examined as quickly as possible to provide recommendations on the grounding of other aircraft. Short initial reports are usually produced very quickly following major events. For instance, in the case of the Shoreham Airshow disaster in August 2015, the first report was released only 13 days later.²¹ A detailed exploration of the entire incident and liability will come later.²²

There are also cases where elements of an inquiry can be split apart and run in parallel to increase efficiency, an approach known as 'modularisation'. The Bahá Mousá Inquiry was split into four parallel modules, covering several different aspects, so that they could be explored concurrently:

- a reconstruction of the events leading up to Bahá Mousá's death
- the structure of the UK military
- the protocols and rules relating to prisoner detention
- a series of recommendations.²³

This approach also supported the logic and structure of the recommendations themselves, contributing to the case for change.²⁴

The Independent Inquiry into Child Sexual Abuse – which has been described as 'the largest and most ambitious inquiry ever established'²⁵ – is split into over a dozen modules, dealing with different times and locations. While there is a thematic link between all the investigations within the inquiry, the actual events are independent to a degree, which allows them to be examined in parallel.

Using the evidence-gathering process to test recommendations

As we have outlined previously, one of the challenges for inquiries is developing a powerful, workable set of recommendations when the chairs (usually judges) do not have a background in policy development. To mitigate this, inquiry chairs have sometimes sought input on specific questions about policy and recommendation development from experts, who may lie outside the existing witness pool for the inquiry.

Seminars are an approach that several inquiries have adopted, with broadly positive results. For instance, the Mid Staffordshire NHS Foundation Trust Inquiry held seminars after the oral evidence was complete, with a specific focus on developing recommendations. The inquiry team held seven seminars around England. These were open and public, independently facilitated and included a mixture of experts and core participants. The topics included "health care regulation, the role of NHS boards and nursing".²⁶ "They were very helpful to the chairman and the inquiry team. ... It is partly about it being on the public record, and there is a slightly different, less formal feel. ... It was a very rich part of the inquiry process."²⁷ Dr Judith Smith, an assessor and expert witness to the Mid Staffordshire Inquiry, has said that the seminars were "a particularly helpful and fruitful part of my work as an expert".²⁸

The Bahá Mousa Inquiry made use of seminars, in particular to consider and refine its recommendations.²⁹ The Bristol Royal Infirmary Inquiry also used seminars – in this case to understand the current policy landscape (given that the health care system had moved on since the 1980s and early 1990s, the period on which the inquiry focused) in order to develop relevant, contemporary recommendations.³⁰

The use of seminars is an authoritative way to develop recommendations with traction. They act as a supplement to the evidence-gathering process and allow inquiries to build in up-to-date, expert capability.

4. After an inquiry

Since 1990, the UK Government and the devolved administrations have received 60 inquiry reports,^{*} which feature 2,625 recommendations for change.^{**} The Mid Staffordshire NHS Foundation Trust Inquiry alone produced 290 recommendations.¹

But these are merely suggestions for change; implementation is usually the responsibility of the central or devolved governments. This includes ensuring that recommendations directed at private entities, such as particular industries or service providers, are implemented. Typically, the Secretary of State for the relevant department – or sometimes the Prime Minister – will provide an immediate response to an inquiry report, setting out how government plans to take the recommendations forward. For instance, David Cameron responded to both the Leveson report² and the Chilcot report³ on the days they were published. In some cases, government goes further and also provides a comprehensive response to inquiry reports, setting out its reasons for accepting or rejecting recommendations. This happened in the cases of the Mid Staffordshire NHS Foundation Trust Inquiry and the Harris Review into self-inflicted deaths in custody. This should happen for every inquiry.

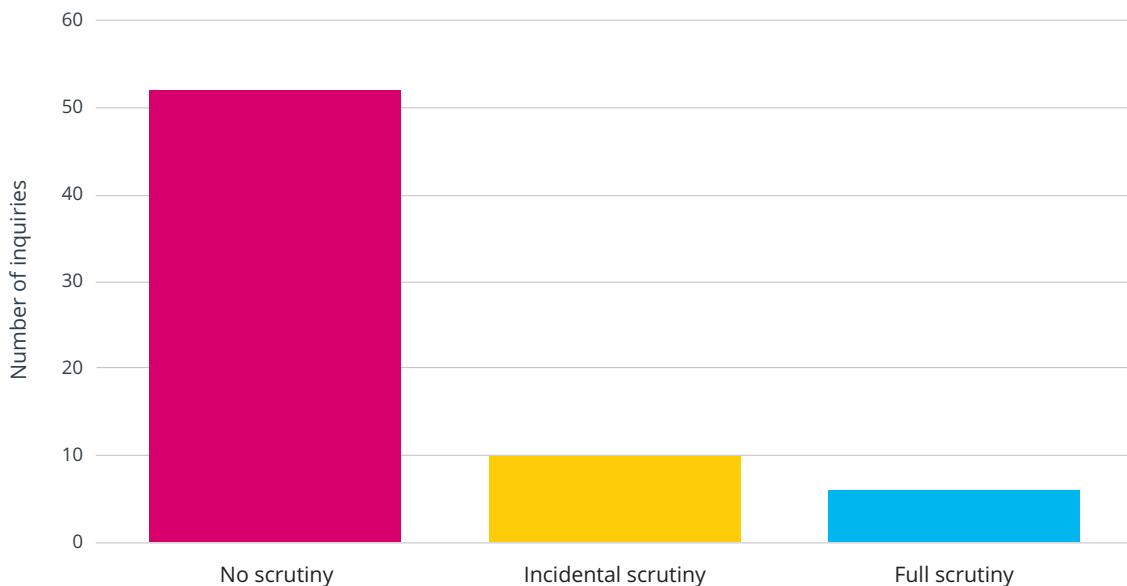
Beyond this initial response, there is little firm procedure for holding government to account for any promises made in the aftermath of inquiries. The Inquiries Act 2005 does not make any provision for the implementation of inquiry recommendations and recommendations are non-binding. As one law firm has put it: '[O]ther than facing potential public criticism, there is no recourse if Government fail to implement recommendations or fail to explain their reasons for non-implementation.'⁴

Follow-up does happen – but it is ad hoc. The conclusions and recommendations of the Mid Staffordshire NHS Foundation Trust Inquiry received significant, high-quality scrutiny: the Health Select Committee ran an in-depth analysis of the Government's response.⁵ This included oral evidence from the chair of the inquiry, Sir Robert Francis QC; the chair, medical director and director of nursing of the NHS; and the Secretary of State for Health. Other select committees have undertaken similar scrutiny. These include the Public Administration and Constitutional Affairs Committee's examination of the Government's response to the recommendations of the Chilcot Inquiry⁶ and the Home Affairs Select Committee's 10-year retrospective on the implementation of the Macpherson report on the death of Stephen Lawrence, and its legacy.⁷ But overall, the

* In total, 68 inquiries have been established since 1990. This figure excludes the eight ongoing inquiries.

** Not all inquiries publish recommendations. Defence-related inquiries are particularly notable for avoiding recommendations, for example the Chilcot, Detainees and Hutton Inquiries. For 53 inquiries where we could identify a set of recommendations, two inquiries made only a single recommendation (the Litvinenko and Penrose Inquiries). The other 51 inquiries made 2,623 recommendations, including the 290 recommendations made by Sir Robert Francis QC in the Mid Staffordshire NHS Foundation Trust report. Inquiries exclusively convened under the Inquiries Act 2005 have made at least 679 recommendations.

Figure 6: Number of inquiries receiving select committee scrutiny, 1990 to 2017



Source: Institute for Government analysis

number of inquiries that have received some form of follow-up is disappointing (see Figure 6). Of the 68 inquiries that have taken place since 1990, only six have received a full follow-up by a select committee to ensure that government has acted.*

But there is no established expectation of or routine procedure for this type of scrutiny. Perhaps partly as a result of this, some inquiries, like the Leveson Inquiry, see their recommendations quietly shelved. Others see their recommendations implemented, only to be undone as political attitudes shift. This was the case with the National Safeguarding Delivery Unit, the headline recommendation of Lord Laming's report following the inquiry into the death of Baby P.⁸ Established in July 2009, it was disbanded in June 2010 following a change of government.⁹ Most commonly, inquiries see a mixed response: some recommendations are adopted, some are rejected and others are partially implemented. The Shipman Inquiry is a clear example of this.¹⁰ There might be good reasons for failing to adopt some recommendations, but a failure to implement must be picked up and government must be called up to explain its decision making.

Given the seriousness of the subjects being addressed by inquiries and the huge sums of public money invested in them,** the inadequacy of monitoring and accountability mechanisms in the aftermath of inquiries is striking and a cause for concern.

* The Scott Inquiry (1992–1996), the Stephen Lawrence Inquiry (1997–1999), the Victoria Climbié Inquiry (2001–2003), the Chilcot Inquiry (2009–2016), the Mid Staffordshire NHS Foundation Trust Inquiry (2010–2013) and the Leveson Inquiry (2011–2012).

** Since 1990, central and devolved governments have spent at least £638.9m (2017 inflation-adjusted value) on public inquiries.

Is it really over when it's over?

Much of the most important work of inquiries is only just beginning when an inquiry report is published. As former inquiry chairs have put it:

"Implementation is – of course – everything."

Sir Robert Francis QC¹¹

"The main reason for most inquiries is to find out how we can avoid something like that happening again and what changes to systems, training and procedures would help to avoid that happening. Therefore, I think [inquiries are] absolutely about action."

Lord Michael Bichard¹²

But for an inquiry team – the chair, the secretariat and often an expert panel – their work is over. By law, once the chair has informed the sponsoring minister that the terms of reference have been fulfilled, the inquiry ends.¹³ Some participants in our research suggested that this 'hard line' between the inquiry and the aftermath was an important feature of the process: the baton is handed from the inquiry to the ministers who must choose whether and how to implement the changes it has recommended.

However, some inquiry teams choose to stay involved even after they have reported. Perhaps most famously, Lord Bichard decided – largely of his own volition – to revisit his Soham Inquiry six months after reporting, to investigate the state of implementation.¹⁴ Other chairs – such as Sir Robert Francis QC, Dame Janet Smith,* Baron Laming** and Sir Desmond Fennell QC*** – also maintained an active interest in their work after the formal conclusion of their inquiries.¹⁵ Inquiry chairs are uniquely powerful advocates in this regard. Not only do they have an unparalleled knowledge of the topic of the inquiry, they are also the lone arbiters of the moral authority vested in the inquiry by the public concern that drove its initial inception. This grants them a strong voice in the months and years following the inquiry.

In other cases, chairs have adjourned their inquiries, rather than completing the terms of reference, enabling them to have an ongoing, authoritative voice on the implementation of recommendations.¹⁶ Some chairs have specifically looked at the question of implementation in an attempt to prevent political backsliding. Robert Francis recommended that organisations to whom the recommendations of the Mid Staffordshire NHS Foundation Trust Inquiry were relevant should indicate to what extent they intended to implement the recommendations and publish annual progress reports.¹⁷

* The Shipman Inquiry (2000–05).

** The Victoria Climbié Inquiry (2001–03).

*** The King's Cross Fire Inquiry (1988). This was conducted before Desmond Fennell's appointment as a High Court judge.

What is required is a means by which it is clear not only which of the recommendations has been accepted, by whom, and what progress is being made with implementation, but above all how the spirit behind the recommendations is being applied. All organisations that are or should be involved in implementation should account for their decisions and actions in this regard.¹⁸

Sir Robert Francis QC

Robert Francis also invited the Health Select Committee to review whether implementation was happening. A report looking at this question was published in 2013.¹⁹ The Department of Health also initiated an independent review into the culture of reporting within the NHS; this followed on from some of the recommendations made by the Mid Staffordshire Inquiry and was also chaired by Robert Francis.²⁰

This kind of activity is to be welcomed – all avenues for promoting change should be exploited. However, on balance it is unrealistic to argue for any formal change in the role of the chair to encompass follow-up. Chairs – particularly judicial chairs – are unlikely to have the time to do regular follow-up on the progress of change. Additionally, the skills needed to scrutinise policy change are not always similar to those required for running an inquiry. But most importantly, 'one has to allow some clear water between the outcome of the inquiry and the possible implementation of its recommendations'.²¹ The responsibility for making change on the back of an inquiry rests with the Government. It must decide what to implement and what not to implement, and it must be held accountable for these decisions. It is to this requirement that we turn next.

Who is holding government to account?

There are few mechanisms for holding government to account for what it does with the outputs of inquiries beyond an initial response statement. In some cases, select committees have followed up on inquiries to attend to the state of recommendations. But often, government receives little formal scrutiny beyond this and is not regularly held to account in the years after an inquiry during which implementation is – in theory – taking place. This is despite the seriousness of the issues that inquiries address – major child protection failures, serious transport disasters, significant health care failures and institutional abuse – and the hundreds of millions of pounds of public money spent on inquiries.

Government should not be obliged to implement all inquiry recommendations. In some instances, it will have understandable grounds for objection or concern. In the case of the Shipman Inquiry, some recommendations regarding the prescription of opiates were deemed too severe and in practice would have excessively limited access to pain relief for patients in need.²²

However, even in cases where government decides not to implement change, a process of government being called to explain its decisions is appropriate – not least so that members of the public who have been directly involved in an inquiry understand why change has not been taken forward. As advocacy group Liberty has put it, those responsible for implementation should be 'effectively tested and

questioned and asked to explain why they have or have not implemented certain recommendations'.²³

During our research we heard repeated, powerful arguments for an enhanced role for select committees in undertaking this scrutiny of government. Their routine involvement would provide an opportunity to monitor the state of the implementation of recommendations. Where implementation has not happened, rather than forcing government to adopt inquiry recommendations it might rightly deem unsuitable, select committees could ensure that ministers provide reasons for a departure from the findings they had invested significant public resources to reach. At the very least, such a process would support greater accountability and deliberation beyond the lifespan of an inquiry.²⁴

There are a number of ways in which select committees could perform this function. One option would be to place additional responsibilities on the chair of an inquiry – for instance mandating them to write to the clerk of a select committee to request scrutiny activities in instances where they were concerned about the likelihood of implementation. This would have the benefit of reducing the burden on select committees by limiting their involvement to instances where there was cause for concern. However, given the earlier points made about the likelihood of the continued involvement of a chair, this process would be unlikely to create the routine monitoring, accountability and debate required. An alternative option would involve the House of Lords, which has some precedent for creating ad-hoc committees to look at specific issues in more detail.* However, again, this would not create a permanent, standing process for accountability or pressure for change.

Select committees should be a formal point of scrutiny and accountability for inquiry findings

This brings us to the work of House of Commons select committees. It is here that there is most potential for action. There is already precedent for departmental select committees following up on the aftermath of inquiries. But rather than this occurring on an ad-hoc basis, it should be a core part of select committee work.

Currently the work of select committees is defined by 10 advisory 'core tasks'.**²⁵ We suggest adding an 11th task: scrutinising the implementation of inquiry findings. Given the number of inquiries that government pursues, the burden of running regular sessions on every inquiry might be overwhelming. Therefore, government departments responsible for implementing inquiry recommendations should update the relevant department select committee on progress. In instances where the information provided is unsatisfactory, select committees should move to hold full hearings. Updates should be required for at least five years after inquiries have reported, or until the committee is satisfied that recommendations have been implemented or sound reasons have been provided for deciding not to implement

* Some recent ad-hoc House of Lords select committees have looked at stem cell research (2001–02), religious offences (2002), assisted dying (2004–05), UK economic regulators (2006–07), the Barnett formula (2008–09), adoption legislation (2012–13), the Inquiries Act 2005 (2012–15), extradition law (2014–15) and affordable child care (2015).

** It should be noted that the 10 core tasks are advisory guidance developed by the Liaison Committee.

them. Where recommendations cover the work of multiple departments and public bodies, it would not be unusual for one committee to put questions out to institutions under the oversight of another committee, either with the permission of the other committee chair, or as part of a joint effort.

We are aware that this is not the first report to make recommendations about the need for additional scrutiny from select committees.^{26,27,28,29} But so far, insufficient action has been taken. Given the frequency, significance and cost of public inquiries, there is no good reason for the absence of formal accountability mechanisms. Ministers should account for what they do with the results of inquiries. For inquiries that are there to bring about change, a proper means of ensuring accountability could monitor whether this change had been achieved and might provide an additional incentive for government to act. For inquiries that have as their primary goal the restoration of public trust, transparently setting out what has been achieved can only support this.

5. Conclusion and recommendations

The Government currently has eight public inquiries under way, dealing with topics including: the Grenfell Tower fire, in which 71 people lost their lives, the Independent Inquiry into Child Sexual Abuse examining allegations of institutionalised child abuse spanning decades, and the newly announced inquiry into blood contamination, which has led to the deaths of an estimated 2,400 people who were infected with hepatitis C and HIV.

In all cases, serious institutional failures have contributed to suffering and loss of life and have led to sufficient injury to public confidence in the Government that an independent body has been charged with investigating.

During the process of examination, inquiries usually aim to answer at least two questions: What happened? And how can we learn from this to prevent future disasters? There is often a public expectation that a third question will also be answered: who is responsible? All three questions are critically important, but it is the second question that we think speaks most clearly to the immediate *public* interest.

Despite this, is it arguably here that our institutions and processes are at their weakest. There is no firm procedure for holding the Government to account for promises made in the aftermath of inquiries,¹ the implementation of recommendations is patchy,^{2,3,4} in some cases repeat incidents have occurred⁵ and there is no system for allowing inquiries to build on the learning of their predecessors.^{* 6,7}

This is not the same as arguing that inquiries have not delivered change. Many inquiries have achieved significant lasting changes, including:

- an overhaul of laws controlling the ownership of handguns^{**}
- improved safety regulations for offshore platforms⁸
- more effective oversight of doctors and other health professionals⁹
- the creation of new and effective institutions, such as the Rail Accident Investigation Branch, which works to improve rail safety.¹⁰

But change must become routine and the public must receive assurances that

* A point made repeatedly in the interviews we carried out for this research.

** The Firearms (Amendment) Act 1997 and Firearms (Amendment) (No. 2) Act 1997 were both passed in response to recommendations made in Lord Cullen's report on the massacre at Dunblane Primary School. See Cullen W (1996) *The Public Inquiry into the Shootings at Dunblane Primary School on 13 March 1996*, Scottish Office, retrieved 5 December 2017, <https://www.gov.uk/government/publications/public-inquiry-into-the-shootings-at-dunblane-primary-school>

inquiries are being taken seriously every time. Implementing change and preventing recurrence must be put at the heart of our system of public inquiries.

In this report, we have looked at how this could happen at every stage of an inquiry – from establishment to the aftermath. In some places we have outlined the debates on contentious issues with no easy answers, such as the merits and demerits of using judicial chairs or the potential of introducing time limits for inquiries, akin to the rules for inquests. But four issues stand out to us as being the clearest opportunities to strengthen the ability of inquiries to effect change – or at least for the public to gain an explanation where change has not happened through robust accountability arrangements.

- Government receives little formal scrutiny in the aftermath of inquiries. Even in cases where government decides not to implement recommendations, there should be a set process for explaining why. Parliament can and should play a more significant role in holding ministers to account. To facilitate this, **the Liaison Committee should consider adding an eleventh core task to the guidance that steers select committee work:**¹⁰ **scrutinising the implementation of inquiry findings.** This scrutiny should be based on a comprehensive and timely government response to inquiry recommendations after the publication of an inquiry report. Given the number of inquiries that government pursues, and the breadth of committees' other responsibilities, the burden of running regular sessions on every inquiry might be overwhelming. But departments should update the relevant select committee on implementation progress on an annual basis for at least five years following an inquiry report.* In instances where the information provided is unsatisfactory, select committees should move to hold full hearings. Where full hearings are necessary, the approach of the Health Select Committee to the Mid Staffordshire NHS Foundation Trust Inquiry provides an excellent model.
- Since 1990, nine inquiries have taken five years or more from the point of inquiry announcement to produce their final reports.** The average inquiry takes two and a half years to publish its final report. In the space between an incident occurring and an inquiry reporting, there is the danger of similar incidents taking place, or for systems and institutions to move on to such an extent that recommendations are rendered redundant. Borrowing from the Air Accident Investigation Branch approach when a plane crashes, **interim reports should be published as rapidly as possible, setting out any immediate necessary changes.** In the case of the Shoreham Airshow disaster in August 2015, the first report was released only 13 days later.¹¹ This kind of speed might be unrealistic for public inquiries, but where quick changes might be necessary, interim reports should be published within a matter of months.

* Select committees might need additional resources to assess government updates on implementation and to support the holding of full hearings where necessary. This might require an uplift in the Administration Estimate of the House of Commons.

** These are the Mirror Group Newspapers plc Inquiry (1992–2001), the Saville Inquiry (1998–2010), the FV Gaul Inquiry (1999–2004), the Rosemary Nelson Inquiry (2004–11), the Penrose Inquiry (2008–15), the Vale of Leven Inquiry (2009–14), the Al-Sweady Inquiry (2009–14), the Chilcot Inquiry (2009–16) and the Robert Hamill Inquiry, which was initiated in 2004, published an interim report in 2011, but has had its final report embargoed indefinitely while criminal proceedings are conducted.

- Developing detailed recommendations for change requires a number of different skillsets that it is unrealistic to expect chairs to possess. Expertise on the issues at hand is needed; for instance, specialist knowledge on the intricacies of child heart surgery or on fire safety during building construction, or an understanding of the information-sharing practices of different public services. Additionally, some knowledge of how to construct policy recommendations in a form that is likely to have traction in government will be an aid to effectiveness. **To ensure that recommendations are constructed as effectively as possible and with the greatest chance of implementation, inquiries should adopt a seminar process to involve expert witnesses** when constructing recommendations, as happened during the Bristol Royal Infirmary Inquiry and the Mid Staffordshire NHS Foundation Trust Inquiry.
- Inquiries investigate some of the most serious crises in society. Governments have spent hundreds of millions of pounds of public money on inquiries and the inquiries have taken years out of the schedules of some of our most senior judges and civil servants to run them. But those running inquiries often rely on informal networks for guidance – there is no detailed formal guidance or support for them, despite regular calls for it to be created. **Government should implement the repeated recommendation of Parliament to create a permanent inquiries unit within the Cabinet Office.** Its first task should be the production of more detailed guidance on running inquiries. Its second task should be to act as the repository for lessons learned from previous inquiries and to work with inquiry secretariats to ensure that this duty can be discharged. As much of this information as possible should be made public.

Appendix 1: Methodology, definitions and data criteria

This report was produced on the basis of a detailed literature review of academic and grey literature on public inquiries and other forms of independent investigations (for example, inquests and independent panels); in-depth interviews with 15 individuals from government, the legal profession, Parliament and victims' groups; and a roundtable, which brought together former inquiry chairs, secretaries and counsel.

Due to the ad-hoc nature of inquiries, it is challenging to define a single criterion that definitively separates 'public inquiries' from all other forms of review or investigation. There is no comprehensive list of inquiries and the notable lists that have been published contradict each other in places.*

For the purposes of this research, we identified three features that define an inquiry as a 'public inquiry', which are broadly in line with criteria used several times by Parliament:^{1,2}

- The inquiry has been convened due to an event that has caused public concern, or circumstances that could give rise to public concern.³
- The inquiry has been convened by a minister or the Prime Minister.^{**}
- The inquiry has been funded with public money, but has been run independent of government.

These criteria exclude various private independent inquiries,^{***} planning inquiries, air accident investigations, investigations into 'serious incidents' in the NHS and investigations run by individual government departments.

We used these criteria to define a set of 68 public inquiries that have taken place between January 1990 and the present day.^{****} This set of 68 inquiries is the dataset for this report. A full list of these inquiries can be found in Appendix 2.

* In particular, Annex 1 of the Public Administration Select Committee's 2004 report *Government by Inquiry*, and Appendix 4 of the House of Lords Select Committee on the Inquiries Act 2005's 2014 report *The Inquiries Act 2005: Post-legislative scrutiny*.

** The only slight exceptions are the Joint Inquiry into Train Protection Systems, the Ladbroke Grove Rail Inquiry and the Southall Rail Inquiry. These were convened by the Health and Safety Commission, with the support of the Deputy Prime Minister.

*** For example, the Independent Public Inquiry into Contaminated Blood and Blood Products led by Lord Archer of Sandwell (2007–).

**** January 1990 is an appropriate cut-off for three main reasons. First, 1990 represents a natural break in the chain of inquiries, being the most recent period where there were no public inquiries running. Second, while the Inquiries Act 2005 represents a significant turning-point in the evolution of the public inquiry, many post-2005 inquiries cannot be fully understood without the context of earlier inquiries, including several significant public inquiries held during the 1990s. Third, good data on or pertaining to inquiries – such as digital versions of inquiry reports, and other analyses of their impacts – is substantially harder to access before 1990. Please note that our analysis includes the Taylor Inquiry (reported on 18 January 1990) and the Piper Alpha Inquiry (reported on 15 February 1990).

The following definitions also apply:

- The length of an inquiry is determined as the time taken between the date of the announcement of the inquiry and the date of the publication of a final report.
- For the purposes of comparisons between sponsor departments, the following former departments are classified under their contemporary versions:
 - Department of Energy (DoE)* and Department of Trade and Industry (DTI):**
Department for Business, Energy and Industrial Strategy (BEIS)
 - Ministry of Agriculture, Fisheries and Food (MAFF):*** Department for Environment, Food and Rural Affairs (Defra)
 - Department for Transport, Local Government and the Regions (DTLR):****
Department for Transport (DfT)
 - Department for Constitutional Affairs (DCA):***** Ministry of Justice (MoJ).

* The Piper Alpha Inquiry (1988–90).

** The Mirror Group Newspapers plc Inquiry (1992–2001) and the Redfern Inquiry (2007–10).

*** The BSE Inquiry (1997–2000).

**** The Marchioness–Bowbell Inquiry (2000–01) and the FV Trident Inquiry (2009–11).

***** The Hutton Inquiry (2003–04).

Appendix 2: List of 68 public inquiries, 1990 to 2017

Table A2: List of 68 public inquiries, 1990 to 2017

Inquiry	Dates	Chair(s)	Legislative basis	Purpose
Piper Alpha Inquiry	July 1988 to February 1990	Lord William Cullen	Offshore Installations (Public Inquiries) Regulations 1974	To investigate the causes of the fire which killed 167 people on the Piper Alpha oil platform in July 1988
Hillsborough Inquiry (The Taylor Inquiry)	April 1989 to January 1990	Lord Peter Taylor	Non-statutory	To investigate events relating to the deaths of 96 people at Hillsborough Football Stadium in April 1989
Bingham Inquiry	July 1991 to October 1992	Lord Thomas Bingham	Non-statutory	To investigate the circumstances surrounding the collapse of the Bank of Credit and Commerce International
Mirror Group Newspapers plc Inquiry	June 1992 to March 2001	Sir Roger Thomas, Raymond Turner	Sections 432(2) and 442 of the Companies Act 1985	To investigate the financial affairs of the Mirror Group Newspapers, particularly the alleged abuse of its pension funds
Scott Inquiry	November 1992 to February 1996	Sir Richard Scott	Non-statutory	To investigate the role of ministers and Parliament in the approval of arms exports to Iraq during the 1980s
Allitt Inquiry	May 1993 to February 1994	Sir Cecil Clothier	Section 2 of the National Health Service Act 1977	To investigate deliberate deaths and injuries of 13 children caused by a nurse, Beverley Allitt
Dunblane Inquiry	March 1996 to October 1996	Lord William Cullen	Tribunals of Inquiry (Evidence) Act 1921	To investigate the circumstances leading to the fatal shootings of 18 people at Dunblane Primary School in March 1996
North Wales Child Abuse Inquiry	June 1996 to February 2000	Sir Ronald Waterhouse	Tribunals of Inquiry (Evidence) Act 1921	To investigate several hundred cases of child sexual abuse in Welsh care homes between 1974 and 1990

Inquiry	Dates	Chair(s)	Legislative basis	Purpose
Pennington Group Inquiry	November 1996 to April 1997	Professor Hugh Pennington	Non-statutory	To investigate the causes of a 1996 outbreak of E. coli in Scotland, due to contaminated food
Ashworth Special Hospital Inquiry (The Fallon Inquiry)	February 1997 to January 1999	Sir Peter Fallon	Section 84 of the National Health Service Act 1977	To investigate the policies, clinical care and procedures of a mental health unit accused of widespread abuses
Stephen Lawrence Inquiry	July 1997 to February 1999	Sir William Macpherson	Section 49 of the Police Act 1996	To investigate the circumstances surrounding the death of Stephen Lawrence and the police response
Southall Rail Accident Inquiry	September 1997 to February 2000	Professor John Uff	Section 14(2)(b) of the Health and Safety at Work Act 1974	To investigate the causes of the Southall rail crash in September 1997
BSE Inquiry	December 1997 to October 2000	Lord Nicholas Phillips	Non-statutory	To establish the history of BSE and its emergence in the UK, and to assess the adequacy of the UK's response to it
Bloody Sunday Inquiry (The Saville Inquiry)	January 1998 to June 2010	Lord Mark Saville	Tribunals of Inquiry (Evidence) Act 1921	To investigate the deaths of civilians killed by British soldiers in Northern Ireland in January 1972
Sierra Leone Arms Investigation	May 1998 to July 1998	Sir Thomas Legg, Sir Robin Ibbs	Non-statutory	To investigate the extent of ministerial involvement in the sale of arms to Sierra Leone by UK companies
Bristol Royal Infirmary Inquiry (The Kennedy Inquiry)	June 1998 to July 2001	Professor Ian Kennedy	Section 84 of the National Health Service Act 1977	To investigate the management of the care of children receiving cardiac surgery at Bristol Royal Infirmary
MV Derbyshire Inquiry	December 1998 to November 2000	Sir Anthony Colman	Section 269 of the Merchant Shipping Act 1995	To establish what caused the MV <i>Derbyshire</i> to sink in the Pacific in September 1980 with a loss of 44 lives

Inquiry	Dates	Chair(s)	Legislative basis	Purpose
FV Gaul Inquiry	April 1999 to December 2004	Sir David Steel	Section 269 of the Merchant Shipping Act 1995	To establish what caused the <i>FV Gaul</i> to sink in January 1974 with a loss of 36 lives
Thames Safety Inquiry	August 1999 to February 2000	Lord Anthony Clarke	Non-statutory	To examine those responsible for safety on the River Thames in light of the <i>Marchioness–Bowbelle</i> disaster
Ladbroke Grove Rail Inquiry	October 1999 to June 2001	Lord William Cullen	Section 14(2)(b) of the Health and Safety at Work Act 1974	To investigate the causes of the railway crash near Paddington Station in October 1999
Joint Inquiry into Train Protection Systems	November 1999 to March 2001	Professor John Uff, Lord William Cullen	Section 14(2)(b) of the Health and Safety at Work Act 1974	To consider the lessons learned about rail safety from the Ladbroke Grove and Southall Rail Inquiries, and other events
Royal Liverpool Children's Inquiry (The Alder Hey Inquiry)	December 1999 to January 2001	Michael Redfern	Section 2 of the National Health Service Act 1977	To investigate the history of post-mortems at Alder Hey, in particular the handling of human tissue and organs
Marchioness–Bowbell Inquiry	February 2000 to March 2001	Lord Anthony Clarke	Non-statutory	To investigate the circumstances of the collision between the pleasure steamer <i>Marchioness</i> and the dredger <i>Bowbelle</i>
Victim Identification Inquiry	February 2000 to March 2001	Lord Anthony Clarke	Non-statutory	To examine the procedures for establishing the identities of victims following transport accidents
Shipman Inquiry	September 2000 to January 2005	Dame Janet Smith	Tribunals of Inquiry (Evidence) Act 1921	To examine the actions of responsible organisations and individuals in the case of the murders by Dr Harold Shipman
Hammond Inquiry	January 2001 to March 2001	Sir Anthony Hammond	Non-statutory	To investigate whether ministers acted appropriately in the matter of granting a visa to Mr SP Hinduja

Inquiry	Dates	Chair(s)	Legislative basis	Purpose
Victoria Climbié Inquiry (The Laming Inquiry)	April 2001 to January 2003	Lord William Laming	Established with powers from three separate Acts*	To investigate the circumstances that led to the death of Victoria Climbié and the context of failures by public services
Ayling Inquiry (Part of the 'Three Inquiries')	July 2001 to July 2004	Dame Anna Pauffley	Section 2 of the National Health Service Act 1977	To investigate the procedures for patients to raise concerns or file complaints about doctors between 1985 and 2000. To assess the effectiveness of these and other safeguarding measures in light of the abuses perpetrated by Drs Clifford Ayling, Richard Neale, William Kerr and Michael Haslam. To evaluate the actions taken by authorities, regulators and other responsible organisations and individuals in response to these abuses
Neal Inquiry (Part of the 'Three Inquiries')	July 2001 to August 2004	Suzan Matthews	Section 2 of the National Health Service Act 1977	
Kerr/Haslam Inquiry (Part of the 'Three Inquiries')	July 2001 to July 2005	Nigel Pleming	Section 2 of the National Health Service Act 1977	
Foot and Mouth Inquiry	August 2001 to July 2002	Dr Iain Anderson	Non-statutory	To examine the causes of the 2001 foot and mouth disease outbreak and the effectiveness of the responses made
Equitable Life Inquiry	August 2001 to March 2004	Lord George Penrose	Non-statutory	To investigate the circumstances that led to a financial crisis at the Equitable Life Assurance Society
Holyrood Inquiry (The Fraser Inquiry)	June 2003 to September 2004	Lord Peter Fraser	Non-statutory	To investigate decisions made relating to the construction costs of the new Scottish Parliament building
Hutton Inquiry	July 2003 to January 2004	Lord Brian Hutton	Non-statutory	To investigate the circumstances that led to the death of Dr David Kelly
Soham Murders Inquiry (The Bichard Inquiry)	December 2003 to June 2004	Sir Michael Bichard	Non-statutory	To examine the effectiveness of child protection measures in Humberside Police and Cambridgeshire Constabulary

* National Health Service Act 1977, Children Act 1989 and Police Act 1996.

Inquiry	Dates	Chair(s)	Legislative basis	Purpose
Review of Intelligence on Weapons of Mass Destruction (The Butler Review)	February 2004 to July 2004	Lord Robin Butler	Non-statutory	To review the use of intelligence relating to weapons of mass destruction, which led to the Iraq War
Zahid Mubarek Inquiry	April 2004 to June 2006	Brian Keith	Non-statutory	To investigate the circumstances relating to the murder of Zahid Mubarek by his cellmate while in custody
Rosemary Nelson Inquiry	November 2004 to May 2011	Sir Michael Morland	Section 44 of the Police (Northern Ireland) Act 1998	To investigate the circumstances surrounding the murder of Rosemary Nelson and the police response
Robert Hamill Inquiry	November 2004 to February 2011*	Sir Edwin Jowett	Section 44 of the Police (Northern Ireland) Act 1998**	To investigate the events relating to the death of Robert Hamill and the process of the related police investigation
Billy Wright Inquiry	November 2005 to September 2010	Lord Ranald MacLean	Section 7 of the Prison Act (Northern Ireland) 1953***	To investigate the security failures that led to Billy Wright's murder inside the Maze Prison and the police response
Inquiry into the 2005 outbreak of E. coli in South Wales	December 2005 to March 2009	Professor Hugh Pennington	Inquiries Act 2005	To investigate the causes of an outbreak of E. coli in South Wales, which caused five deaths
Redfern Inquiry	April 2007 to November 2010	Michael Redfern	Non-statutory	To investigate the circumstances relating to the unsanctioned removal of human organs from former nuclear workers
ICL Inquiry	January 2008 to July 2009	Lord Brian Gill	Inquiries Act 2005	To investigate the causes of the explosion at the ICL factory in Glasgow, which killed 9 people and injured 45

* The final report was submitted on this date. However, it has not been published publicly and has remained under embargo ever since, awaiting the completion of various legal proceedings.

** Converted to an inquiry under the Inquiries Act 2005.

*** Converted to an inquiry under the Inquiries Act 2005.

Inquiry	Dates	Chair(s)	Legislative basis	Purpose
Fingerprint Inquiry	March 2008 to December 2011	Sir Anthony Campbell	Inquiries Act 2005	To examine forensic procedures used to verify fingerprint evidence submitted to the case <i>HM Advocate v McKie</i> in 1999
Penrose Inquiry	April 2008 to March 2015	Lord George Penrose	Inquiries Act 2005	To establish an historical account of cases of HIV/hepatitis C acquired from transfused blood and blood products
Baha Mousa Inquiry	August 2008 to September 2011	Sir William Gage	Inquiries Act 2005	To investigate the circumstances surrounding the death of Baha Mousa, an Iraqi citizen detained by the UK Army
Northern Trusts Inquiry (The Hine Inquiry)	October 2008 to March 2011	Dame Diedre Hine	Inquiries Act 2005	To investigate the causes of a <i>C. difficile</i> outbreak in the Northern Health and Social Care Trust in March 2009
Bernard (Sonny) Lodge Inquiry	February 2009 to December 2009	Barbara Stow	Inquiries Act 2005	An inquest (converted to an inquiry to grant subpoena powers) to look at the death in custody of Bernard Lodge in 1998
Vale of Leven Hospital Inquiry	April 2009 to November 2014	Lord Ranald MacLean	Inquiries Act 2005	To investigate the circumstances of deaths and illness resulting from an outbreak of <i>C. difficile</i> between 2007 and 2008
Iraq Inquiry (The Chilcot Inquiry)	June 2009 to July 2016	Sir John Chilcot	Non-statutory	To examine the decisions and actions of the Government and others in the run-up to and during the Iraq War
FV Trident Inquiry	October 2009 to February 2011	Sir Stephen Young	Section 269 of the Merchant Shipping Act 1995	To investigate the circumstances of the sinking of <i>FV Trident</i> with a loss of seven lives in 1974
Al-Sweady Inquiry	November 2009 to December 2014	Sir Thayne Forbes	Inquiries Act 2005	To investigate the detention and subsequent death of Iraqi nationals following a firefight with UK soldiers

Inquiry	Dates	Chair(s)	Legislative basis	Purpose
Azelle Rodney Inquiry	March 2010 to July 2013	Sir Christopher Holland	Inquiries Act 2005*	To investigate the circumstances relating to the death of Azelle Rodney, who was shot by the police in April 2005
Mid Staffordshire NHS Foundation Trust Inquiry (The Francis Inquiry)	June 2010 to February 2013	Sir Robert Francis	Inquiries Act 2005	To investigate the circumstances that led to serious failings in standards of care at Mid Staffordshire Hospital, 2005–09
Detainee Inquiry	July 2010 to December 2013	Sir Peter Gibson	Non-statutory	To examine whether the UK was implicated in the mistreatment of detainees by other nations after 9/11
Leveson Inquiry	July 2011 to November 2012	Sir Brian Leveson	Inquiries Act 2005	To examine the culture, practices and ethics of the press and to specifically investigate charges of phone hacking
Historical Institutional Abuse Inquiry	May 2012 to January 2017	Sir Anthony Hart	Inquiry into Historical Institutional Abuse Act (Northern Ireland) 2013	To investigate systemic failures of care of children by institutions in Northern Ireland between 1922 and 1995
Morecambe Bay Inquiry	September 2013 to March 2015	Dr Bill Kirkup	Non-statutory	To examine the management, delivery and outcomes of maternity and neonatal care at Morecambe Bay Hospital
Harris Review of Self-Inflicted Deaths in Custody	February 2014 to July 2015	Lord Toby Harris	Non-statutory	To investigate the causes of self-inflicted deaths of youths in custody and identifying means to prevent more
Edinburgh Tram Inquiry	July 2014 –	Lord Andrew Hardie	Inquiries Act 2005	To investigate the causes of delay, cost overruns and under-delivery in the Edinburgh Trams project
Litvinenko Inquiry	July 2014 to January 2016	Sir Robert Owen	Inquiries Act 2005*	An inquest converted to an inquiry to examine the circumstances relating to the death of Alexander Litvinenko

* Converted from an inquest.

Inquiry	Dates	Chair(s)	Legislative basis	Purpose
Scottish Child Abuse Inquiry	December 2014 –	Lady Anne Smith	Inquiries Act 2005	To investigate historical cases of child abuse by care institutions in Scotland
Independent Inquiry into Child Sexual Abuse	February 2015 –	Professor Alexis Jay	Inquiries Act 2005	To investigate the extent to which major institutions and organisations failed in their responsibility to protect children
Undercover Policing Inquiry	March 2015 –	Sir Christopher Pitchford, Sir John Mitting	Inquiries Act 2005	To investigate the role and management of undercover police operations in England and Wales since 1968
Anthony Grainger Inquiry	March 2016 –	Sir Thomas Teague	Inquiries Act 2005*	To investigate the circumstances surrounding the death of Anthony Grainger, who was shot by police in March 2012
Renewable Heat Incentive Inquiry	January 2017 –	Sir Patrick Coughlin	Inquiries Act 2005	To investigate the design, governance, implementation and operation of the Renewable Heat Incentive scheme
Grenfell Inquiry	June 2017 –	Sir Martin Moore-Bick	Inquiries Act 2005	To investigate the circumstances surrounding the fire in Grenfell Tower, which caused 71 deaths in June 2017
Blood Contamination Inquiry	November 2017 –	To be decided	To be decided	To establish an historical account of HIV and hepatitis C infections in the UK due to contaminated blood and its products

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