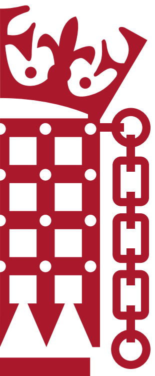


HOUSE OF LORDS

Statutory Inquiries Committee

Report of Session 2024–25

Public inquiries: Enhancing public trust

Ordered to be printed 9 September 2024 and published 16 September 2024

Published by the Authority of the House of Lords

HL Paper 9

Statutory Inquiries Committee

The Statutory Inquiries Committee was appointed by the House of Lords on 24 January 2024 "to consider the efficacy of the law and practice relating to statutory inquiries under the Inquiries Act 2005".

Membership

The Members of the Statutory Inquiries Committee were:

Lord Aberdare	Lord Faulks
Lord Addington	Lord Grantchester
Baroness Berridge	Lord Hendy
Baroness Chakrabarti	Lord Norton of Louth (Chairman)
Lord Davidson of Glen Clova	Baroness Sanderson of Welton
Baroness D'Souza	Lord Wallace of Tankerness

Declaration of interests

See Appendix 1.

A full list of Members' interests can be found in the Register of Lords' Interests: https://committees.parliament.uk/committee/702/statutory-inquiries-committee/publications/7/declarations-of-interest/

Publications

All publications of the Committee are available at:
https://committees.parliament.uk/committee/702/statutory-inquiries-committee/publications/

Parliament Live

Live coverage of debates and public sessions of the Committee's meetings are available at:
https://committees.parliament.uk/committee/702/statutory-inquiries-committee/publications/oral-evidence/

Further information

Further information about the House of Lords and its Committees, including guidance to witnesses, details of current inquiries and forthcoming meetings is available at:
http://www.parliament.uk/business/lords

Committee staff

The staff who worked on this inquiry were Andrea Dowsett (Clerk), Matthew Burton (Policy Analyst) and Emily Tallantire (Committee Assistant).

Contact details

All correspondence should be addressed to the Statutory Inquiries Committee, Committee Office, House of Lords, London SW1A 0PW. Email hlstatutoryinquiries@parliament.uk

You can follow the Committee on Twitter: @HLStatInquiries

CONTENTS

	Page
Summary	3
Chapter 1: Introduction	5
What is this inquiry about?	5
What are public inquiries?	6
Box 1: Who are the main participants in an inquiry?	7
How was this inquiry undertaken?	7
What needs to change?	8
Chapter 2: Establishment and conduct of inquiries	9
Terms of reference: how Ministers shape inquiry design	9
Format and flexibility	10
Statutory vs non-statutory	10
Judge vs expert chair	13
Individual chairs and panels	14
Victims and survivors	15
Box 2: Victims and survivors: good and bad practice	16
Inquiry logistics	18
Regular reporting	19
Chapter 3: Running and sponsoring an inquiry—the recommendations from the 2014 report	21
Figure 1: 2014 report	21
Following up this Committee’s inquiry	22
Chapter 4: After an inquiry—implementation monitoring	24
Why is monitoring the implementation of inquiry recommendations important?	24
Box 3: Implementation monitoring in practice	25
How is implementation monitoring currently undertaken?	27
Monitoring by victims and survivors	27
Monitoring by the inquiry chair	27
Monitoring by Parliament	28
What alternative models are there?	28
Formalising monitoring by the chair	29
Independent implementation monitors	29
Monitoring by supreme audit institutions	30
An independent body	30
Parliamentary monitoring	31
Chapter 5: The Inquiries Unit	35
“Lessons learned”	35
The establishment of an inquiry	36
The Inquiries Unit	37
Recommendations for change	39
Summary of conclusions and recommendations	41
Appendix 1: List of Members and declarations of interest	45
Appendix 2: List of witnesses	47
Appendix 3: Call for evidence	50

Appendix 4: 2014 Report recommendations, Government response and 2024 conclusions 52

Table 1: 2014 Report recommendations, and Government response 52

Appendix 5: Specific examples of good practice in running an inquiry 60

Evidence is published online at https://committees.parliament.uk/committee/702/statutory-inquiries-committee/publications/ and available for inspection at the Parliamentary Archives (020 7219 3074).

Q in footnotes refers to a question in oral evidence.

SUMMARY

Every week the press reports on public inquiries. This year, we have read news on the Grenfell Tower and Infected Blood inquiries, watched the hearings of the Post Office and the Covid-19 inquiries and heard discussions about the remit of the Thirlwall Inquiry. These are only five of the 18 public inquiries that have been taking place in the UK this year.

We frequently hear calls from the press, politicians and the public for new inquiries to be established; yet, just as regularly, there is serious criticism of their cost, duration, remit and effectiveness.

Inquiries sit in an uneasy space between politics and the justice system, while combining elements of both. At their best, they conduct detailed investigations into major failures and disasters, establish facts, find where mistakes have been made and identify who is accountable for them. This information is used to establish what lessons must be learned, while recommendations for change are given to the Government to prevent disasters from recurring. In addition, inquiries can provide catharsis for those most closely affected by a tragedy—victims, survivors and their families—giving them confidence that a similar tragedy is less likely to be repeated.

Yet too often, inquiries are failing to meet their aims because inquiry recommendations are not subsequently implemented, despite being accepted by the Government. This is inexcusable, as it risks the recurrence of a disaster and undermines the whole purpose of holding an inquiry in the first place. For example, we heard that had the recommendations from the inquiry into deaths at the Bristol Royal Infirmary in 2001 been implemented, then the patient deaths investigated by the Mid-Staffordshire Hospitals Inquiry in 2013 may have been less likely to occur. And we heard that if the changes recommended by the 2013 inquest into the Lakanal House fire had been made, then the Grenfell Tower fire might have been prevented.

The Committee therefore wants to **ensure that inquiry recommendations are followed up and implemented** (Chapter 4). We recommend the formation of a new, independent committee of Parliament which should conduct oversight of public inquiries, monitor the publication of and government response to inquiry recommendations and hold the Government to account to ensure that the inquiry recommendations it accepts are actually implemented.

We also conclude that better decisions at the start of an inquiry would **expedite their work and reduce costs** (Chapter 2). Ministers have sole decision-making power over whether to launch an official public inquiry and (through its terms of reference) influence its overall direction: deciding on its statutory basis, the identity of the chair, the involvement of victims and survivors, its budget and its timetable. For example, Ministers should be more willing to consider appointing chairs who are not judges, or a panel, which would encourage more subject-area expertise. Ministers should consider including a deadline in their terms of reference and (where appropriate) mandate a modular structure to the inquiry, with regular interim reports, so that recommendations for change can be implemented more quickly. Finally, they should keep in mind the undoubted strengths of the non-statutory inquiry model.

To facilitate this, the **sharing of best practice in setting up and running an inquiry** (Chapter 5) is essential and must be improved. We heard that inquiries are wasting time and money by 'reinventing the wheel' or repeating easily avoidable mistakes, and often fail to properly involve victims and survivors in the inquiry process. We recommend that the work started by the Inquiries Unit in the Cabinet Office should be built upon to grow a "community of practice" for academic, legal and policy experts on public inquiries, as well as civil servants, former inquiry chairs and secretaries and representatives of victims and survivors' groups. This will help ensure that there is a bank of information from which chairs and inquiry secretariats can be offered proven approaches when starting an inquiry, to ensure that each is properly tailored to be as effective and efficient as possible.

The Statutory Inquiries Committee was set up to consider whether the Inquiries Act 2005 provides an effective framework for public inquiries. Public inquiries can indeed deliver change for victims, survivors and the public. However, the Committee has found that the 2005 Act and the wider governance structure of public inquiries must be improved. In particular, more scrutiny is needed to ensure that accepted inquiry recommendations are actually implemented, so as to avoid the recurrence of disasters. The findings of this report aim to make inquiries as effective, cost-efficient and trusted as possible.

Public Inquiries: Enhancing public trust

CHAPTER 1: INTRODUCTION

What is this inquiry about?

1. The Statutory Inquiries Committee was appointed in January 2024 to consider the efficacy of the law and practice relating to statutory public inquiries held under the Inquiries Act 2005.[1] This is the second time that the 2005 Act has been reviewed by a committee of the House of Lords, having previously been considered by the Inquiries Act 2005 Committee in 2014.[2] In its report, the 2014 Committee described public inquiries as "a major feature of our unwritten constitution [that] play an important part in the way the executive deals with major crises."[3] The subsequent ten years have seen many more inquiries into major crises, some of which have been active during this committee's work, including the Grenfell Tower Inquiry, the Infected Blood Inquiry, the Post Office Horizon IT Inquiry and the UK Covid-19 Inquiry.[4]

2. Ideally, public inquiries should provide catharsis to victims, ensure accountability by identifying those responsible and, crucially, make recommendations to avoid disasters repeating. Often, inquiries are the only way for victims and survivors to seek redress, especially when access to justice through the courts is impossible, when the issue is too complex for the political process or when an inquest would be too narrow in scope. In fact, the problem-solving potential of public inquiries means they should combine elements of law and politics, deliver redress and thus increase trust in both. The promise of these positive outcomes means the call for a public inquiry is now a well-established response by the public, the media and politicians to the apparent failure of institutions to avoid major tragedies.

3. This does not mean that inquiries are themselves not the subject of criticism by the public and commentators, most often in relation to their length and cost. Inquiries can occupy an uneasy space, which can straddle the political and, as finder of fact, the quasi-judicial. Yet they are not fully accountable to either, or to Parliament and are entirely separate from court proceedings. Often, there is a perception that inquiries are established by ministers in response to political pressure and—because of the time they take to complete—they are used to 'kick a problem into the long grass'. By combining elements of law and politics, public inquiries can appear to 'freeze' both, if they postpone action while an inquiry is ongoing.

4. There is a lack of clarity as to what public inquiries can achieve. This is not altogether surprising given the objects of the 2005 Act: "to make inquiries swifter, more effective at finding facts and making practical recommendations,

---

1 Inquiries Act 2005

2 Select Committee on the Inquiries Act 2005, *The Inquiries Act 2005: post-legislative scrutiny* (Session 2013–14, HL Paper 143)

3 *The Inquiries Act 2005: post-legislative scrutiny*, para 14

4 Grenfell Tower Inquiry: https://www.grenfelltowerinquiry.org.uk/, Infected Blood Inquiry: https://www.infectedbloodinquiry.org.uk/, Covid-19 Inquiry: https://www.covid19.public-inquiry.uk/

and less costly, while still meeting the need to satisfy the public's expectation for a thorough and wide-ranging investigation."[5] The Act is supposed to make inquiries swifter, but also to satisfy public expectations for a thorough and wide-ranging investigation. There is an inherent tension in these objects. All of these factors mean that public inquiries have thus become a perennial yet occasionally contentious part of the political and justice systems in the UK.

What are public inquiries?

5. There are broadly two main types of public inquiry. Statutory inquiries are established with the authority of a specific Act. This is normally the Inquiries Act 2005 but could also be one of a small number of other statutory provisions, which vest ministers with the power to establish an inquiry in response to a specific set of circumstances.[6] This Committee is primarily concerned with inquiries established under the 2005 Act. The 2005 Act confers powers that compel witnesses to attend inquiries and give evidence under oath.[7] As a result, statutory inquiries must abide by certain procedural rules, which are set out in the Inquiry Rules 2006 and the Inquiries (Scotland) Rules 2007.[8] The 2005 Act extends to Scotland. We received some evidence from Scottish sources and there was a written submission from Thompsons Solicitors Scotland who have served as recognised legal representative in five of the seven public inquiries held in Scotland since the introduction of the 2005 Act.[9] We have not been made aware of any significant differences in approach or operation of the Act in the respective jurisdictions.

6. There is a second group of inquiries, often referred to as "non-statutory inquiries", which include independent departmental reviews, independent panels and ad hoc inquiries. They are not set up under the authority of an Act of Parliament, and their chief distinction from statutory inquiries is that they do not have the power to compel the production of evidence. They appear to be the preferred format when the inquiry already has access to all the documentation and evidence required to conduct its work. While they encompass a range of different types of inquiry, non-statutory inquiries are broadly regarded as using more informal procedures, and being shorter and less expensive than statutory inquiries. The reason why a minister chooses a non-statutory inquiry over a statutory inquiry (and whether deficiencies in the 2005 Act are the reason) was one area of interest to the present Committee.

7. Inquests and non-statutory inquiries can be converted into statutory inquiries, using the 2005 Act.[10] For inquests, this might take place because there are wider policy failings to investigate and make recommendations about, beyond the death in question. For non-statutory inquiries, conversion might be required so that the inquiry has the power to compel the production of evidence from uncooperative witnesses.

---

5 Ministry of Justice, *Memorandum to the Justice Select Committee: Post-Legislative Assessment of the Inquiries Act 2005*, Cm 7943, October 2010, p 4: https://assets.publishing.service.gov.uk/media/5a756e20ed915d7314959e5c/7943.pdf [accessed 11 September 2024]

6 It is not known how many laws (besides the 2005 Act) contain a provision to establish a statutory inquiry. Officials giving evidence to the 2014 inquiry were unable to provide a list. Examples include the Merchant Shipping Act 1995 and the Health and Safety at Work Act 1974.

7 Written evidence from Jason Beer KC (STI0015)

8 The Inquiry Rules 2006, The Inquiries (Scotland) Rules 2007

9 Written evidence from Thompsons Solicitors Scotland (STI0011)

10 Written evidence from Jason Beer KC (STI0015)

8. It is worth noting that the Government announced its intention in the King's Speech earlier this year to bring forward legislation to introduce a duty of candour for public servants, one element of a longstanding campaign for the introduction of a 'Hillsborough law'.[11]

Box 1: Who are the main participants in an inquiry?

Public inquiries involve a consistent group of participants. Typically, the following individuals and groups will be part of an inquiry:

- The **chair** is appointed by the sponsoring minister and is responsible for running the inquiry and drafting the final report.
- The **counsel to the inquiry** is the chief legal advisor to the chair and cross-examines witnesses.
- The **inquiry secretary** is the head of the inquiry's administration, overseeing all logistical and policy support functions.
- The **solicitor to the inquiry** instructs counsel, manages the oral hearings and evidence collection and liaises with witnesses.
- The inquiry secretariat is team of policy experts, technicians and administrative assistants who support the day-to-day work of the inquiry. This includes setting-up inquiry hearings, briefing the chair and providing HR and IT services. Secretariat members are often seconded civil servants.
- **Core participants** are interested parties who are officially designated by the inquiry chair. Core participant status confers access to private briefings on the inquiry's proceedings and the right to legal representation at the inquiry. Core participants are typically those who have been affected by the event of public concern or are likely to be criticised by the inquiry. Victims and survivors are often, but not always, designated as core participants. Victims and survivors are not always a homogeneous group and the sometimes fractious relationship between different representative groups can make the designation process more difficult or controversial.

Source: Public Inquiries, Beer, J. (2011)

How was this inquiry undertaken?

9. This inquiry was initiated at the request of the House of Lords Liaison Committee and a special inquiry committee was subsequently appointed by the House on 24 January 2024 to carry out the inquiry and publish a report by 30 November 2024[12]. Twelve members of the House of Lords were appointed to the Committee, with Lord Norton of Louth as its chair.

10. The Committee published a call for evidence in February 2024, outlining specific questions for respondents to address.[13] This is reproduced in appendix 3. Between February and May 2024, the Committee also conducted a series of oral evidence sessions.[14] Witnesses included academic experts, government officials, former ministers, former inquiry chairs, former inquiry

11 The King's Speech 2024, 17 July 2024, para 17: https://www.gov.uk/government/speeches/the-kings-speech-2024 [accessed 11 September 2024]

12 HL Debate: 24 January 2024, cols 751-757 [Lords Chamber]

13 Statutory Inquiries Committee, 'How is the Law and Practice of inquiries working?': https://committees.parliament.uk/committee/702/statutory-inquiries-committee/news/199896/how-is-the-law-and-practice-of-inquries-working/ [accessed 10 September 2024]

14 Statutory Inquiries Committee, 'Publications': https://committees.parliament.uk/committee/702/statutory-inquiries-committee/publications/ [accessed 10 September 2024]

secretaries, solicitors and representatives from campaign organisations and other interest groups. Cabinet Office officials and ministers gave evidence to the Committee.

11. The Committee heard oral evidence from 19 witnesses and received 29 pieces of written evidence.

What needs to change?

12. Based on this evidence, the Committee found four main areas where the governance structure for public inquiries can be improved:

(a) The way that inquiries are designed and established (covered in chapter 2)

(b) Ensuring that the accepted recommendations from the previous 2014 House of Lords report into public inquiries are put into effect by the Government (chapter 3).

(c) How public inquiry recommendations are monitored to ensure they are implemented by the Government (chapter 4); and

(d) Enhancing the role of the Cabinet Office's Inquiries Unit (chapter 5).

CHAPTER 2: ESTABLISHMENT AND CONDUCT OF INQUIRIES

13. The decisions taking during the establishment of an inquiry are key to its subsequent conduct and therefore its overall efficiency and effectiveness. There are examples of public inquiries that have had to be re-constituted because of the decisions taken during the early stages of establishing the inquiry. For example, the Independent Inquiry into Child Sexual Abuse was re-established because of a lack of confidence of victims and survivors in the independence of the chair.[15]

14. During our inquiry, we heard of many different examples from witnesses of good practice in the establishment and conduct of an inquiry. Many witnesses told us that each public inquiry was different, that what was appropriate for one inquiry may not be for another, and of the need for a flexible approach.[16] Dr Alastair Stark characterised this as "rejecting the one size fits all at the start."[17] Brian Altman KC explained that "much depends on the view that the chair takes of the nature of the inquiry" and that therefore the design of an inquiry will depend on the topic that it is investigating.[18] This Committee does not, therefore, seek to make detailed recommendations regarding the day-to-day running of an inquiry. Such decisions are for each individual chair, with the support of their secretariat.

15. While the day-to-day running of the inquiry will depend on the topic under investigation, the Committee will make recommendations relating to the content of the inquiry's terms of reference, as this is where the Minister can influence the overall direction and design of the inquiry.

16. While we are not making detailed recommendations on how an inquiry should be run day-to-day, we were keen not to lose the valuable thoughts and contributions made by witnesses, in written and oral evidence, on good practice, and we have therefore compiled a list of those and include them in Appendix 5 to this report. This non-exhaustive list might include helpful tips for future chairs and their secretariat, or the basis of advice for an expanded Inquiries Unit but will not be relevant for every inquiry.

Terms of reference: how Ministers shape inquiry design

17. A statutory or non-statutory inquiry is established by a Government minister, who appoints its chair and, sometimes after discussion with the chair, produces and publishes the inquiry's terms of reference. Once published, the interpretation of the terms of reference and the way in which the inquiry is run are entirely a matter for the chair and central to the inquiry's independence.

18. The terms of reference are the only opportunity the Government has to establish the parameters of the inquiry, and to have a hand in its design. They also determine features of the inquiry which are difficult to change once the inquiry is underway, such as the identity of the chair and the exact scope of the investigation.

19. In order for an inquiry to be properly established from the start, its terms of reference must be written carefully in order to give the chair the necessary

15 Q 3 (Brian Altman KC)
16 Q 20 (Mark Fisher)
17 Q 45 (Dr Alastair Stark)
18 Q 5 (Brian Altman KC)

direction to achieve its aims, recognise the expectations of the public, victims, survivors and other interested parties and to avoid unnecessary cost.

20. As this Committee seeks to make recommendations to the Government, rather than to inquiry chairs, our focus in this chapter is on four areas that might usefully be included in the terms of reference for a new inquiry. These are areas where the actions of the Minister may have an impact on the subsequent efficiency and effectiveness of the inquiry. They are:

(a) Format and flexibility (the statutory basis of the inquiry and the nature of the chair)

(b) The role of victims and survivors

(c) Logistics (controlling the budget and length of the inquiry)

(d) The use of interim reports

Format and flexibility

21. There can be a perception amongst interested parties that there is a hierarchy of inquiry formats, with statutory inquiries seen as more important or powerful than non-statutory inquiries. Ken Sutton, the Director of the Hillsborough Independent Inquiry, explained:

> "The biggest difficulty for me is the prioritisation of statutory inquiries over non-statutory inquiries. … The Act, either intentionally or unintentionally, has given a sense of hierarchy. This affects families in particular who think and are told that, for their inquiry to be important and seen to be powerful enough, it has to be a statutory inquiry under the 2005 Act."[19]

22. There is also, in the words of Professor Alexis Jay OBE, the chair of IICSA: "a consistent view that the most appropriate persons to lead a public inquiry are judges."[20] During the course of our inquiry, we heard compelling evidence that contradicted both these views, which appeared based on misunderstandings about the powers of different models of inquiry, and of the breadth of powers held by inquiries established under the 2005 Act. We treat each of these topics below.

Statutory vs non-statutory

23. We heard evidence of the advantages and disadvantages of statutory and non-statutory inquiries, and of public perceptions of the benefits of each that were sometimes overly simplistic and meant that there was a risk that non-statutory inquiries failed to win public confidence.[21] Most witnesses felt that flexibility was important when choosing the format for a particular inquiry and that Ministers should: "retain discretion to initiate statutory or non-statutory inquiries depending on the circumstances of a particular case."[22]

---

19 Q 87 (Ken Sutton)
20 Written evidence from Professor Alexis Jay OBE (STI0026)
21 Written evidence from Matthew Hill (STI0021)
22 Written evidence from Peter Skelton (STI0008)

24. Dr Emma Ireton explained that:

> "there is little difference between a non-statutory inquiry and a statutory inquiry other than the powers of compulsion, the presumption that it be heard in public, and taking evidence on oath … "[23]

The chief disadvantage of non-statutory inquiries was felt to be their inability to compel evidence and we heard of some non-statutory inquiries that had "struggled to overcome this limitation".[24] Other non-statutory inquiries had converted into statutory inquiries where their inability to compel evidence was "proving to be a barrier to meeting its terms of reference."[25] Deborah Coles spoke of INQUEST's work on the Lampard inquiry into "deaths in mental health settings in Essex" which had been initially "set up as an independent review, but because of a lack of candour and co-operation from Essex trust and the staff there, they converted it into a public inquiry."[26]

25. We also heard evidence, however, of the advantages of different non-statutory approaches to evidence-giving. In its written evidence, Eversheds Sutherland LLP suggested that "while a non-statutory inquiry does not have powers to compel witnesses or evidence, this model can also result in witnesses feeling able to give more frank and open evidence."[27] Ken Sutton also believed that the Hillsborough Independent Panel (a non-statutory inquiry) had been: "able to discover things through what you might call the informality of it, which would never have emerged through a statutory inquiry."[28] Professor Sir Malcolm Evans felt a non-statutory inquiry: "might be able to get closer to the heart of what has occurred by being able to use processes which are more truly investigatory in nature."[29] Baroness May of Maidenhead (former Prime Minister and Home Secretary) told the Committee that non-statutory inquiries "may also capacitate greater cooperation and secure witnesses offering greater candour, particularly in military and governmental organisations and victim groups".[30]

26. We also heard that non-statutory inquiries were sometimes seen as treating victims and survivors more appropriately because it permits them to address the chair directly, rather than through counsel to the inquiry. Ken Sutton explained:

> " … the Hillsborough families still say to me, "We valued the ability to talk directly to the bishop and other members of the panel. We valued talking directly to the secretariat and not having to go through their legal teams to do that." [31]

27. Brian Altman KC described the "frustration" for counsel at a statutory inquiry acting on behalf of core participants: " … to sit there with both hands behind your back, as it were, hoping but not necessarily knowing whether counsel to the inquiry will ask the questions or ask them in the way that you

23 Q 29 (Dr Emma Ireton)
24 Written evidence from Matthew Hill (STI0021)
25 Written evidence from Eversheds Sutherland (International) LLP (STI0016)
26 Q 84 (Deborah Coles)
27 Written evidence from Eversheds Sutherland (International) LLP (STI0016)
28 Q 91 (Ken Sutton)
29 Written evidence from Professor Sir Malcolm Evans (STI0024)
30 Response letter from Baroness May of Maidenhead, 21 May 2024: https://committees.parliament.uk/publications/45310/documents/224403/default/
31 Q 88 (Ken Sutton)

would have done … ”[32] Therefore, non-statutory inquiries are perceived as having some advantageous characteristics.

28. We heard that limited flexibility existed under the 2005 Act to allow families to ask questions in statutory inquiries, at the chair's discretion. Sir John Saunders described how the Manchester Arena Inquiry:

> " … started as an inquest. We became [a statutory] inquiry only because there was national security material that could not be heard at an inquest. At an inquest, families have the right to ask questions, so then to say to them, "No, you can't ask any questions now it's become an inquiry", seemed to us not to be the right approach—although, of course, we used Rule 10 to make sure that they were kept in a reserved way."[33]

Rule 10 explains the situations in which witnesses can be cross-examined by counsel to core participants, rather than counsel to the inquiry. Brian Altman KC described a work-around, where core participants could suggest questions to counsel and the chair, with an iterative process of negotiation. This gives core participants some influence over lines of questioning, although the extent to which their suggested wording is used would be reliant on the opinion and goodwill of the chair and counsel.[34]

29. The Act and Rules which govern a statutory inquiry and inherent flexibility of a non-statutory inquiry both confer on the chair a wide discretion to direct the inquiry as they see fit. For example, Sir John Saunders described how a chair can ensure that an inquiry is following an inquisitorial rather than an adversarial approach.[35] This means that the inquiry is seeking to establish why a disaster occurred and how it could be avoided in future, rather than simply seeking to apportion blame or advance a pre-conceived view. Nonetheless, seeking accountability and establishing responsibility for disasters is a legitimate aim of an inquiry and therefore chairs will aim to find an appropriate balance between inquisitorial and adversarial approaches. Overall, no inquiry should lose sight of their primary role as an investigatory body.

30. In a letter following his appearance before the Committee, the Parliamentary Secretary at the Cabinet Office, Alex Burghart MP described the benefits of a non-statutory inquiry:

> "A non-statutory inquiry can be held in public or private, so may be able to offer a greater degree of flexibility to meet the wide range of circumstances for which an inquiry might be required. … [They] are generally less costly than statutory inquiries and can often be completed more quickly. … There may therefore be such circumstances where a non-statutory model is the better option, where there is confidence that witnesses and bodies will cooperate fully with the inquiry, and/or where vulnerable core participants might be more comfortable with a less formal approach than that generally adopted by a statutory inquiry."

31. Pete Weatherby KC and Anna Morris KC, however, had "concerns that Ministers establish non-statutory inquiries with the false impression that

32 Q 6 (Brian Altman KC)
33 Q 5 (Sir John Saunders)
34 Q 5 (Brian Altman KC)
35 Response letter from Sir John Saunders to Lord Norton of Louth, 21 February 2024: https://committees.parliament.uk/publications/44525/documents/221287/default/

they will be quicker and more cost-effective than a Statutory Inquiry."[36] The Centre for Effective Dispute Resolution (CEDR) also explained that "best practice in how an Inquiry is run does not differ on whether it is a statutory or non-statutory inquiry."[37] Neither the non-statutory nor the statutory inquiry format is superior and Ministers should continue to have the freedom to select the inquiry format that best fits the topic under investigation. This is important as they seek to balance the involvement of victims and survivors, value for money and the length of the inquiry.

Judge vs expert chair

32. Choosing the correct chair is paramount, and yet there is a "lack of transparency"[38] around the selection process, and "no guidance or indication as to who that person should be, orthe qualities they need to have."[39] Dr Emma Ireton described the skills of an effective chair:

> "You can see that the inquiries that work well have chairs who are very open-minded to adopting a different, inquisitorial, approach, and to being innovative, finding new ways of approaching things, looking at best practice. There is certainly a mind-set. It also works particularly well when they are team players, because it is a team role. It is very important that the chair has a good working relationship with counsel to the inquiry, with the secretary to the inquiry and with the solicitor to the inquiry.[40]"

33. We heard that former or serving judges are frequently chosen to chair inquiries.[41] Judicial experience does, of course, have advantages. Mark Fisher felt that they gave "a huge amount of weight" to an inquiry.[42]

34. However, serving judges return to the Bench once the inquiry is complete. The requirement for judicial independence and impartiality means they may feel unable to comment on the Government's success or failure in implementing recommendations after the inquiry has concluded.[43] The increasing number of public inquiries also means that the limited number of senior judges cannot be solely relied upon to chair inquiries.[44] In addition, when chairs are judges, there is a risk of the perception that an inquiry will mimic a court hearing, with a consequent loss of flexibility.

35. In some cases, a non-judicial chair with professional expertise in the topic under investigation may be more suitable. Dr Nathan Critch noted that while judges: "are seen to be objective and impartial and used to gathering evidence and fact-finding… There are other figures in public life besides judges who carry legitimacy and are seen to be objective and are used to gathering evidence." The examples he gave were where: "[s]ome inquiries into scandals in healthcare have been chaired by people who had some medical expertise or background, which seems to be appropriate."[45]

---

36 Written Evidence from Pete Weatherby KC and Anna Morris KC (STI0014)
37 Written evidence from Frederick Way and Dr Karl Mackie (STI0022)
38 Q 35 (Dr Emma Ireton)
39 Written evidence from Frederick Way and Dr Karl Mackie (STI0022)
40 Q 35 (Dr Emma Ireton)
41 Written evidence from Frederick Way and Dr Karl Mackie (STI0022)
42 Q 16 (Mark Fisher)
43 Written evidence from Sir Brian Leveson (STI0027)
44 Written evidence from Sir Brian Leveson (STI0027)
45 Q 41 (Nathan Critch)

36. Kate Eves, chair of the Brook House Inquiry, described how, despite the "uncertainty that comes with a non-judicial chair", as a chair with subject matter expertise, she had understood "the policy and procedural side of government; perhaps that gave me an advantage in thinking about recommendations and what would be practical and implementable … "[46] Other witnesses gave examples of inquiries whose subject matter was highly technical and where it made sense to have an expert chair with knowledge of the subject area.[47]

37. There are situations where a non-legal chair requires legal advice. Brian Altman KC listed various technical applications of the Act's provisions where the chair would need legal understanding but went on to note that: "this can be provided by the counsel to the inquiry."[48] The assistance provided by the counsel to the inquiry means that it is possible for the chair to be a subject expert, if appropriate, rather than a judge or lawyer.

Individual chairs and panels

38. The Act contains the presumption that an Inquiry should be chaired by a single person and this view was reinforced by the 2014 report.[49] However, we have heard that there are occasions when an inquiry should be overseen by a panel of experts, rather than a single chair.

39. Dr Alistair Stark told us that: "The best panel I ever saw was a judge, a former ombudsman, doing the front-of-house hearings, real inquisitorial policy analysis, and a public sector commissioner making sure that everything was implementable. That was a fierce combination and division of labour"[50]

40. Likewise, Bishop James Jones (who chaired the Hillsborough Independent Panel) described:

> "having expertise around the table in nine different experts. I saw my job as chair being simply to ensure that the expertise of each expert around the table could be brought to bear on the million documents that we were accessing, analysing and using to write an account of what occurred."[51]

41. Brian Stanton believed that there were "benefits to panels consisting of more than one member" and that there should be "subject matter expertise, as opposed to process expertise."[52] This is certainly desirable, but care should be taken to invite expert witnesses with opposing views to give evidence, to maintain the independence and investigative spirit of the inquiry.

42. For statutory inquiries, the Act makes no provision for replacing a chair who falls ill or dies.[53] Appointing a panel, rather than a single chair, would have

---

46 Q 7 (Kate Eves)
47 Q 7 (Brian Altman KC), Q 41 (Dr Nathan Critch)
48 Response letter from Brian Altman KC to Lord Norton of Louth, 22 February 2024: https://committees.parliament.uk/publications/44509/documents/221263/default/ Response letter from Sir John Saunders to Lord Norton of Louth, 21 February 2024: https://committees.parliament.uk/publications/44525/documents/221287/default/
49 *The Inquiries Act 2005: post-legislative scrutiny*, para 136
50 Q 41 (Dr Alistair Stark)
51 Q 109 (Bishop James Jones)
52 Q 16 (Brian Stanton)
53 Written evidence from Professor Alexis Jay OBE (STI0026)

the additional advantage of allowing the inquiry to continue its work in those circumstances.

43. **The format (statutory basis, identity and panel or chair) for a particular inquiry should be chosen on the basis of the nature and requirement of the particular inquiry and included in its terms of reference.**

44. **The choice of chair is crucial to the success of the inquiry and should be made by a Minister based on the purpose and requirements of the particular inquiry. Ministers should feel prepared to choose whoever is best qualified to oversee the legal, technical and administrative elements of the particular topic. We reiterate the conclusion of the 2014 report, which stated that "ministers have in the past been too ready to assume that a serving judge would be the most suitable chairman."**

45. **When drawing up the terms of reference for an inquiry, Ministers have the discretion to appoint a single chair, a panel, or a team of assessors to support the chair. Ministers should not feel limited to appoint a single chair only, particularly when the inquiry is expected to be wide-ranging or when the subject matter is particularly technical, as a panel of experts could be particularly useful in those instances.**

46. ***Ministers should select the legal basis and chair of an inquiry on a case-by-case basis and not feel tied to a particular model. Guidance on models other than statutory or judge-led inquiries should form part of the early advice of the Inquiries Unit to the department and Minister setting up an inquiry. Ministers should keep in mind the option of holding a non-statutory inquiry (given its relative agility) and then converting it if witnesses fail to cooperate. Ministers should also consider selecting non-judge chairs or appointing a panel. Ministers should meet and consult victims and survivors' groups before publishing the terms of reference.***

Victims and survivors

47. Many, though not all, public inquiries concern a disaster that has a direct and devastating effect on a group of people and their families. The term "victims and survivors" describes those people who have been directly affected by the major event of public concern which triggered the inquiry, as well as their families. Other inquiries investigate failures which might entail a cost to society, but lack an obvious "victim" (for example, the Edinburgh Tram inquiry, which looked into costs and delays to an infrastructure project).

48. Bill Wright, Chair of Haemophilia Scotland, described the inquiry process for victims and survivors:

> " … as being in three stages. The first stage is getting a statutory inquiry. That itself can be a very challenging exercise. … The second stage is the conduct of an inquiry itself [which] is highly traumatic. … The third stage is what happens afterwards. That, again, can be a highly

frustrating exercise. … We have to see it through and, once the truth has been revealed, see justice from the recommendations.” [54]

49. The inquiry process can be extremely arduous for victims, survivors and their families, who often spend many years campaigning for an inquiry. Often, victims and survivors are simply seeking the catharsis that comes from official recognition of the event of public concern they experienced. If they are successful and an inquiry is established, victims and survivors then need to retell their story in a formal court environment, which can be re-traumatising, especially if the inquiry proceedings are not properly designed to accommodate their needs. Insult can be added to injury if the final recommendations of the inquiry are not subsequently implemented, as this means that the event under investigation might be more likely to reoccur.

Box 2: Victims and survivors: good and bad practice

In his evidence to the Committee, Bill Wright, the co-chair of the Scottish Haemophilia campaign and a survivor of the infected blood scandal, described his experience of two public inquiries. His evidence demonstrates the trauma and anguish suffered by victims and survivors as they seek redress through the inquiry process.

Mr Wright described the difficulty in persuading the Government to hold an inquiry and his disappointment when, initially, only an “internal review” was instituted. This review was chaired by “a senior medical officer who had been involved [in treating patients] during the time when [Mr Wright and others] were infected”.[55] Mr Wright also expressed concern about Government departments sponsoring inquiries investigating their own conduct creating a conflict of interest.[56] These examples demonstrate a common concern amongst victims and survivors, that inquiries are ‘establishment’ processes designed to protect those in power, rather than truly independent bodies.

The inquiry process can be made accessible for victims and survivors. Stephanie Needleman suggested that “inquiries should incorporate a non-evidential forum to allow people who have been affected to give evidence in a manner that is less formal”, for example.[57]Mr Wright told the Committee that “it is also very important that you have some support psychologically, not only on the day but afterwards.”[58] This is important for the inquiry process, as well as the victims and survivors, because “pastoral care is important in getting the best evidence out of witnesses.”[59] Inquiries can be proactive in their care for victims and survivors by ensuring—for example—that staff are “trauma-informed”, meaning they have received training on how to treat witnesses sensitively during the hearing process.[60] More information on this and other examples of good practice for involving victims and survivors can be found in appendix 5.

50. When an inquiry is established, representative groups of victims and survivors can be nominated as core participants, giving them legal representation, privileged access to documents and the right—through counsel—to interact with the chair and cross examine other witnesses.

54 Q 48 (Bill Wright)
55 Q 50 (Bill Wright)
56 Q 51 (Bill Wright)
57 Q 59 (Stephanie Needleman)
58 Q 59 (Bill Wright)
59 Q 59 (Bill Wright)
60 Q 60 (Stephanie Needleman)

51. Stephanie Needleman observed that "[t]here are some examples of good practice with involvement of the bereaved and survivors and some examples of not so good practice."[61] The way that the inquiry is designed, particularly in the evidence-taking stages, can have a considerable impact on the experience of the victims and survivors, including whether they are able to access and contribute to the proceedings. The optimal role of victims and survivors within different inquiries will not however always be the same. Sir Brian Leveson noted that: "[t]he proper role of victims and survivors in an inquiry will depend on what the inquiry is trying to achieve."[62] Nor are their objectives necessarily the same as other core participants. Dr Raphael Schlembach described how, as well as wishing to "contribute to lessons learning and the identification of recommendations" the victims, bereaved and injured "often frame their expectations of an inquiry to be an *acknowledgement* of the truth and a public recognition of their experiences."[63]

52. While we are not making detailed recommendations on the day-to-day running of inquiries, we have included the contributions made by witnesses, in written and oral evidence, on good practice in the involvement of victims and witnesses in an inquiry in Appendix 5. The better that inquiries are at sharing best practice with each other, including on the best way to involve victims and survivors, the more effective the overall governance structure for public inquiries will be and the more trust victims and survivors can have in the process. The enhanced Inquiries Unit described in Chapter 5 should be involved in sharing best practice between inquiries on the best way to involve victims and survivors.[64]

53. The terms of reference allow the Minister to exercise some control over the overarching approach to victims and survivors during the course of the inquiry, including by setting up an advisory panel to the chair. We heard that while the involvement of victims and survivors is essential, it is important that this is not done in a way that prejudices the independence of the inquiry and that "appropriate boundaries are set".[65] Matthew Hill wrote that core participants should not have: "any role in determining who should be appointed to the chair and panel of any inquiry. This would fundamentally erode the independence of the inquiry.[66] The Bar Council told the Committee about the importance of ensuring "that the terms of reference are consulted upon with those affected by the incident in question prior to the setting up of the inquiry"[67] though Eversheds Sutherland warned that "a formal consultation process can increase scope" if interest groups suggest further areas of investigation which the Minister feels obliged to include. [68] Indeed, Baroness May of Maidenhead warned that broader inquiries "could risk losing focus on the initial purpose" that "an inquiry should always have a key purpose to ensure that its investigation is not a general overview through a broad subject".[69]

---

61 Q 49 (Stephanie Needleman)
62 Written evidence from Sir Brian Leveson (STI0027)
63 Written evidence from Dr Raphael Schlembach (STI0002)
64 Written evidence from Frederick Way and Dr Karl Mackie (STI0022), Q 49 (Stephanie Needleman)
65 Written evidence from Eversheds Sutherland (International) LLP (STI0016)
66 Written evidence from Matthew Hill (STI0021)
67 Written evidence from The Bar Council (STI0023)
68 Written evidence from Matthew Hill (STI0021)
69 Response letter from Baroness May of Maidenhead, 21 May 2024: https://committees.parliament.uk/publications/45310/documents/224403/default/

54. **The Government should ensure that future inquiries build on the good work of recent inquiries and better involve victims and survivors.**

55. ***Ministers should, where appropriate, consult with victims and survivors on the overall terms of reference. Guidance should be given by the Inquiries Unit to Ministers and departments setting up a new inquiry on the options available for involving and consulting with victims and survivors. New inquiries should normally contain provisions in the terms of reference for the appropriate involvement of victims and survivors.***

Inquiry logistics

56. Many of the witnesses from whom we heard spoke of inquiries taking too long to report and costing too much.[70] The Institute for Government has estimated that the 30 public inquiries that took place between 1990–2017 (some therefore pre-dating the 2005 Act), took on average two and a half years to publish their report and cost in total £639 million.[71] Professor Lucy Easthope, a specialist in disaster response and recovery, described the results of these delays as "people dying during the process, families feeling justice is delayed, other similar incidents happening before the inquiry reports."[72]

57. Dr Emma Ireton noted that:

> "The precise role of a public inquiry differs between inquiries, depending on its subject matter and terms of reference … For many survivors and the bereaved, the primary role might be obtaining long sought after answers to specific questions, having their voice heard, and preventing recurrence. This may require a long and detailed inquiry, and oral hearings and the involvement of survivors and the bereaved will play a very central role. For others, the primary role of the same inquiry might be to publish recommendations to inform future policy decisions in as cost-effective and timely a manner as possible."[73]

One of the reasons that inquiries last so long and cost so much is because the terms of reference for the inquiry are too wide. Rather than focussing on the key purpose of learning lessons and avoiding the recurrence of an event of public concern, there is a danger that inquiries investigate too widely and collect too much information. This means that all stages of the inquiry—from evidence taking to analysis and report writing—take longer than is necessary.[74] Brian Leveson reminded the committee that inquiries do not need to collect exhaustive quantities of evidence: rather, they only need collect *sufficient* evidence to establish the facts of the incident under investigation and to make recommendations for change.[75] This is the core purpose of an inquiry and Ministers should resist the temptation to charge an inquiry with the responsibility of investigating wider policy areas. Inquiries can have different roles and some will need to have longer timetables and larger budgets. In all circumstances, well-crafted terms of reference, carefully tailored to their particular purpose, will help keep their length and cost in line with their aims and purpose.

---

70 Written Evidence from Pete Weatherby KC and Anna Morris KC (STI0014)
71 Written evidence from Dr Emma Ireton (STI0012)
72 Written evidence from Professor Lucy Easthope (STI0018)
73 Written evidence from Dr Emma Ireton (STI0012)
74 Written evidence from Sir Brian Leveson (STI0027), written evidence from Matthew Hill (STI0021)
75 Written evidence from Sir Brian Leveson (STI0027)

58. **There is a perception that inquiries are frequently too long and expensive, leading to a loss of public confidence and protracted trauma for victims and survivors. Delays and cost can be minimised by better sharing of best practice, which is covered in Chapter 5. However, the overall planning of some inquiries at their outset by the chair and secretariat would be made easier if there was a limited time.**

59. ***When establishing an inquiry, the sponsoring Minister should consider including an indicative deadline in the terms of reference, keeping in mind the particular purpose and aim of the inquiry. A deadline should concentrate the efforts of the inquiry chair and secretariat, while also reassuring victims and survivors that redress is forthcoming. Inquiry chairs should aim to report within this time and must seek the permission of the Minister if they wish to exceed it. (for example, in the event that the inquiry discovers evidence which leads to new lines of inquiry). Inquiries which are conducted more quickly will also be more cost-effective.***

Regular reporting

60. The Inquiries Act makes clear that the single, formal, output of an inquiry is the final report.[76] However, we heard examples of inquiries having successfully published interim reports. Both the Independent Inquiry into Child Sexual Abuse and the Manchester Arena Inquiry published interim reports at intervals, meaning that recommendations reached the Government—and entered the public domain—more quickly.[77] So have the Grenfell Tower and Undercover Policing Inquiries.[78]

61. We heard different views about whether inquiry chairs had the authority to publish interim reports or undertake interim implementation monitoring (to ensure that recommendations from interim reports are being implemented). Whether or not publishing an interim report was permitted depended on the inquiry's specific terms of reference.[79] For inquiries with a narrower term of reference, interim reports are less likely to be necessary, as the inquiry can be completed more quickly. For larger or more complex inquiries, a requirement to produce interim reports, or simply publish updates about their progress, might be included in the inquiry's terms of reference. This can ensure that inquiry recommendations are given to the Government—and therefore implemented—more quickly, reducing the likelihood of an event of public concern reoccurring. In addition, updates on inquiry progress and interim reports reassure victims and survivors that the inquiry is undertaking useful work and that redress remains a possibility. Publishing settled findings promptly can ensure restitution for victims and survivors happens quickly, making it more meaningful and effective (for example, by ensuring that compensation schemes are established quickly enough for victims and survivors to access). Interim reports and a modular inquiry structure should only be used when this expedites, rather than prolongs, the inquiry process.

---

76 Inquiries Act 2005

77 Written evidence from Professor Sir Malcolm Evans (STI0024), Q 8 (Brian Altman KC), Q 8 (Sir John Saunders)

78 Grenfell Tower Inquiry: https://www.grenfelltowerinquiry.org.uk/ and Undercover Policing Inquiry: https://www.ucpi.org.uk/

79 Written evidence from Frederick Way and Dr Karl Mackie (STI0022); Q 80, Q 70 (Deborah Coles)

62. **Inquiries should provide regular, public, updates on their work—both administrative activities, as well as public hearings. Longer inquiries should, where appropriate, publish interim reports.**

63. ***When an inquiry is likely to be of long duration, Ministers may consider including the requirement to publish interim reports in an inquiry's terms of reference, along with a requirement to publish updates on the inquiry's website about inquiry activity. This will help maintain public trust and ensure there is accountability to both individuals and Parliament.***

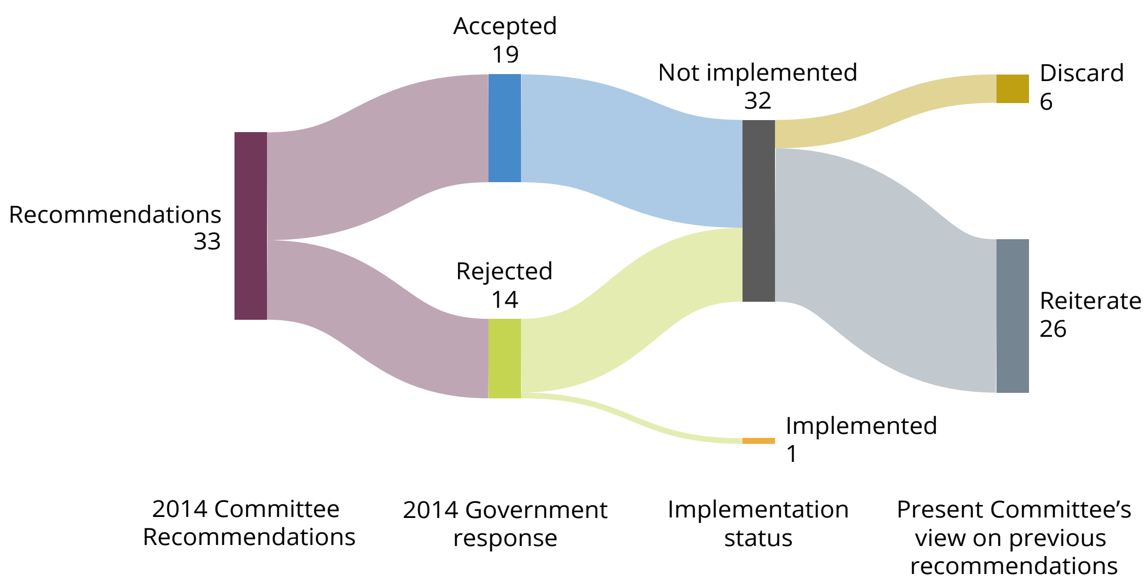
CHAPTER 3: RUNNING AND SPONSORING AN INQUIRY—THE RECOMMENDATIONS FROM THE 2014 REPORT

64. This inquiry builds on the work of an earlier House of Lords select committee report into the Inquiries Act 2005, which was published in 2014.[80] The 2014 report made 33 recommendations to the Government. 19 were accepted and 14 were rejected.[81] Of the recommendations accepted by the Government, none was subsequently implemented.

65. Public inquiries should not operate in isolation and the progress of the implementation of past recommendations from public inquiries should be monitored. We apply this same principle to our own inquiry. This chapter will therefore analyse the implementation of the recommendations from the 2014 report and assess their merit.

66. Appendix 4 contains a table listing each recommendation from 2014, the Government response at the time and the current Committee's view on the merits of the recommendation.

Figure 1: 2014 report



Source: Ministry of Justice, Government Response to the Report of the House of Lords Select Committee on the Inquiries Act 2005, Cm 8903 (June 2014): https://www.parliament.uk/globalassets/documents/lords-committees/Inquiries-Act-2005/Cm8903_Government-response-to-HL-Committee-on-the-Inquiries-Act-2005_260614_TSO_Print.pdf *[accessed 11 September 2024]*

The 2014 report made 33 recommendations to the Government about how the Inquiries Act and governance structure for public inquiries should be changed. 19 recommendations were accepted by the Government and 14 were rejected. Accepted recommendations tended to be those that put existing practices on a statutory footing. These therefore required amendments to the Act and Rules but the Government explicitly stated that it would only introduce primary and

---

80 *The Inquiries Act 2005: post-legislative scrutiny*

81 Ministry of Justice, *Government Response to the Report of the House of Lords Select Committee on the Inquiries Act 2005*, Cm 8903 (June 2014): https://www.parliament.uk/globalassets/documents/lords-committees/Inquiries-Act-2005/Cm8903_Government-response-to-HL-Committee-on-the-Inquiries-Act-2005_260614_TSO_Print.pdf [accessed 11 September 2024]

secondary legislation "when parliamentary time allows".[82] No amendments to the legislation have been made since then. Rejected recommendations were typically, and unsurprisingly, those which reduced the powers of Ministers to set the overall direction of the inquiry.[83]

67. Of the 19 recommendations which were accepted by the Government, none have been implemented, as far as we can tell. Some of the recommendations, if implemented, would be included in the Guidance for Chairs and Secretaries, but this is not published. There is little information in the public domain about their status, as the guidance is not publicly available.

68. Of those recommendations which were rejected by the Government, one was in fact subsequently implemented. This was the recommendation to establish an Inquiries Unit (although this was within the Cabinet Office, rather than His Majesty's Court and Tribunal Service (HMCTS) as the 2014 Committee recommended). The other rejected recommendations were not implemented.

69. Appendix 4 lists the 33 recommendations from 2014 and gives a recommendation on whether they:

(a) Should be **discarded**, because the present Committee has collected contrary evidence or because the overall context has changed, making it irrelevant.

(b) Are correct in principle but should be **modified** to ensure they are up-to-date.

(c) Have not been implemented, but are still required, so are **reiterated**.

Following up this Committee's inquiry

70. The present Committee has heard how the effectiveness of public inquiries is undermined if recommendations are not implemented by the Government (see chapter 4). The 2014 Committee did not have the impact it could have done on the governance structure for public inquiries because many of the accepted recommendations were not subsequently implemented by the Government.

71. This chapter has tracked the progress of the recommendations from the House of Lords 2014 report. It is important that the recommendations of *this* Committee are also monitored in the months and years to come. As a Special Inquiry, the Statutory Inquiries Committee, which authored this report, ceased to exist when the report was published. This means that the Committee itself cannot conduct follow-up scrutiny of Government progress in implementing the recommendations in this report.

72. Helpfully, following a review of House of Lords committee activity in 2019, the Liaison Committee of the House of Lords agreed a process for previous

82 Ministry of Justice, *Government Response to the Report of the House of Lords Select Committee on the Inquiries Act 2005*, Cm 8903 (June 2014): https://www.parliament.uk/globalassets/documents/lords-committees/Inquiries-Act-2005/Cm8903_Government-response-to-HL-Committee-on-the-Inquiries-Act-2005_260614_TSO_Print.pdf [accessed 11 September 2024]

83 Ministry of Justice, *Government Response to the Report of the House of Lords Select Committee on the Inquiries Act 2005*, Cm 8903 (June 2014): https://www.parliament.uk/globalassets/documents/lords-committees/Inquiries-Act-2005/Cm8903_Government-response-to-HL-Committee-on-the-Inquiries-Act-2005_260614_TSO_Print.pdf [accessed 11 September 2024]

special inquiry topics to be subject to follow-up scrutiny.[84] After publication, response and debate, the former Chair of this Committee—Lord Norton of Louth—can write to the Liaison Committee to request a short series of evidence sessions to assess how effectively the recommendations of the inquiry have been implemented. It is important that this takes place in a timely manner, so that the findings and recommendations of this and the 2014 report have maximum impact.

73. **The Committee endorses the overall findings of the 2014 report, along with most of its conclusions and recommendations. It is unacceptable that many of the accepted recommendations from the 2014 report were not subsequently implemented by HMG. The Committee concludes that:**

(a) **Recommendation 12, on the establishment of an Inquiries Unit, has been implemented.**

(b) **Recommendations 1, 6–7, 25, 31 and 33 can be discarded.**

(c) **The remaining recommendations continue to have merit and should be put to HMG again (either in original or modified form).**

74. ***Recommendations 2–5, 8, 10–11, 13–24, 26–30 and 32 of the 2014 report are put to the Government again. Recommendation 9 remains relevant in principle and will be put to the Government again in modified form (see table in appendix 4). If the Government accepts this recommendation, the Committee expects that they will be implemented in a timely manner. In order to effect this, the Government should:***

(a) ***Introduce primary legislation to implement those recommendations from 2014 which require it.***

(b) ***Identify and draft changes to the Inquiry Rules required to implement the recommendations from 2014.***

(c) ***Swiftly implement those recommendations from 2014 which do not require any primary or secondary legislation.***

75. ***The Liaison Committee of the House of Lords should monitor the implementation of this Committee's recommendations over the coming months and years, as recommended by the Liaison Committee's report, Towards a New Thematic Committee Structure. This is desirable because—as a special inquiry committee—the Statutory Inquiries Committee ceased to exist on the publication of this report.***

84 Liaison Committee, Review of House of Lords Investigative and Scrutiny Committees: towards a new thematic committee structure (6th report, Session 2017–19, HL Paper 398) para 68

CHAPTER 4: AFTER AN INQUIRY—IMPLEMENTATION MONITORING

76. "Implementation monitoring" describes the process of verifying whether the Government has acted on the recommendations from a public inquiry.

77. Inquiries establish facts about a disaster, failure by an organisation or another serious event and then present recommendations for change to the Government or another relevant public body. These recommendations advocate policy change that would reduce the chance of the disaster under investigation from recurring. The Government considers the recommendations and publishes a response, detailing which recommendations are accepted and which are rejected. This choice is the Government's prerogative, because accepted recommendations become Government policy and might entail the commitment of Government money and resources.[85] Inquiries do not have binding powers to change Government policy, as there may be political, financial or practical reasons why inquiry recommendations are rejected.[86] We heard that the Government's view is that: "apart from in exceptional circumstances, [inquiry reports] should be responded to within six months."[87] It is the sign of an effective inquiry if recommendations are meritorious and feasible and therefore accepted by the Government.[88]

Why is monitoring the implementation of inquiry recommendations important?

78. One of the main purposes of a public inquiry is for the implementation of its recommendations (which are accepted by the Government) helping to prevent similar disasters from reoccurring.

79. Deborah Coles from INQUEST described the impact of recommendations not being implemented:

> "At worst, … similar deaths and similar harms and injustice will carry on. I mentioned earlier the psychological impact for people of seeing an inquiry set up because of something terrible happening and then seeing the fruits of that inquiry disappear into the ether or left on a shelf and it being left to individuals to keep this alive. As I said earlier, that is really damaging to trust and confidence, and it is a wasted opportunity, because these inquiries should be able to result in meaningful change, and proper transparency and accountability."[89]

80. Implementation monitoring can help ensure that inquiry recommendations are implemented and thus help prevent disasters reoccurring.[90] Once the Government has accepted an inquiry recommendation, implementing it could entail (for example) passing or amending a law, publishing guidance, setting up a new public body or commissioning research. Implementation monitoring describes the process of tracking the accepted recommendations from an inquiry's report to check whether the Government has carried out the work the inquiry calls for. Sir John Saunders argued that monitoring is

85 Q 135 (Simon Madden), Q 67 (Deborah Coles), Q 151 (Alex Burghart)
86 Q 13 (Sir John Saunders), Q 72 (Emma Norris), Q 77 (Emma Norris)
87 Q 135 (Luke Hughes)
88 Q 135 (Luke Hughes)
89 Q 83 (Deborah Coles)
90 Written evidence from Peter Skelton (STI0008)

sufficiently urgent that once an inquiry concludes, monitoring should start "immediately afterwards—within three months or six months—where we … can check that someone is doing something, that they have understood what we want and that it works."[91]

Box 3: Implementation monitoring in practice

The Committee took evidence from Neil Comrie, who was the Chief Commissioner of Victoria Police in Australia and then worked as an implementation monitor. Mr Comrie's experience illustrates the value that implementation monitoring adds to the governance structure for public inquiries.

In 2009, the Australian state of Victoria experienced bush fires, which led to 173 fatalities and significant damage to property and farmland. In response, a Royal Commission (a form of public inquiry) was established to make recommendations, to ensure that public services and society more widely were better prepared for future bush fires. The final report made 67 recommendations. To ensure that these recommendations were actioned and that a recurrence of such a tragedy was less likely. Neil Comrie was appointed to act as an "implementation monitor". He reported annually to the Parliament of Victoria on the progress the Government was making in implementing the recommendations.

By way of example, Mr Comrie told the Committee about a recommendation from the Commission which advocated that the Government establish "incident control centres" to coordinate fire-fighting in the event of a bushfire. Mr Comrie was told that "these incident control centres had all been set up—the equipment was installed, ready to go." However, he "sent a couple of my team members out to do an inspection of one of them, only to find that that was not true at all. The equipment was there but it was not installed; it was not ready to function." In response, he:

"immediately went back and reported that to the committee [of Parliament] monitoring the agency's work. That resulted in a dramatic change in the attitude of the people responsible for implementation, because they realised that someone was actually out there looking at what they were doing and signing off on it. After that, with each of them I have to say that the operational response improved dramatically from that point on. It is that approach of "Don't tell me. Show me what you're doing".

This example illustrates the reality that much of the work to reduce the chance of a disaster recurring happens after the public inquiry's report is published. Implementation monitoring is an essential, but currently neglected, part of the governance structure for public inquiries. The Committee does not recommend the same model used in Australia by Mr Comrie. Nonetheless, his example demonstrates the importance of creating new structures to ensure that accepted recommendations are implemented.

Source: Q 66–85 *(Neil Comrie)*

81. We heard that implementation monitoring does already take place, but informally and therefore "the challenge is that it is ad hoc".[92] This does not imply that public inquiries do not lead to change, however. Emma Norris told the Committee that:

91 Q 12 (Sir John Saunders)
92 Q 67 (Emma Norris)

> "There are some instances that we can point to where inquiries have led to positive change … the changes that were made to the process for CRB [Criminal Records Bureau] checking, which came on the back of the Soham inquiry. That has certainly been credited with improving child protection. There are also examples of changes made to rail safety that have made crashes and serious misses less likely. Likewise, laws on gun ownership were changed on the back of a public inquiry after Dunblane."[93]

82. Nonetheless, we heard from many witnesses that there are widespread problems with recommendations not being implemented. We heard that if the recommendations from the inquiry into deaths at the Bristol Royal Infirmary had been comprehensively implemented, then the events investigated by the Mid-Staffordshire Hospitals Inquiry may have been less likely to have occurred, in the view of an experienced firm of solicitors.[94] A lack of implementation is not just a problem for statutory inquiries. Witnesses told the Committee that if the recommendations from the inquest into the Lakanal House fire had been implemented, then the Grenfell Tower fire may have been less likely to have occurred.[95] Emma Norris told the Committee that: "we see inquiry after inquiry make similar recommendations because the recommendations of former inquiries have not been implemented." She gave the example of inquiries into healthcare where "almost every inquiry" makes "recommendations on the patient voice and blame culture. You see the same recommendations again and again."[96] This can come at a tragic cost to human lives and the suffering of the victims and survivors, and with a needless repetition of public inquiries.

83. The Government has a statutory duty to respond to a public inquiry which is established under the 2005 Inquiries Act, but no has obligation to give reasons for accepting or rejecting recommendations.[97] Although the Government undertakes to respond within six months, there is no deadline for making a response, meaning that they are frequently published long after the end of an inquiry.[98] The wait for the Government's response and uncertainty about Government action also further protracts the suffering of victims and survivors.[99]

84. The Inquiries Act does not contain any provision for monitoring whether accepted inquiry recommendations are actually implemented and, in the words of Jason Beer KC: "there is presently not an appropriate framework in place to ensure that the work of statutory inquiries, and in particular their recommendations, is appropriately followed up."[100]

85. This lack of monitoring makes it more likely that an inquiry recommendation could be accepted by the Government yet subsequently "wither on the vine".[101]

---

93 Q 74 (Emma Norris)
94 Written evidence from Eversheds Sutherland (International) LLP (STI0016)
95 Q 70 (Deborah Coles)
96 Q 71 (Emma Norris)
97 Q 67 (Emma Norris)
98 Q 135 (Luke Hughes), Written evidence from INQUEST Charitable Trust (STI0013)
99 Q 48 (Bill Wright)
100 Written evidence from Jason Beer KC (STI0015)
101 Written evidence from Sir Brian Leveson (STI0027)

How is implementation monitoring currently undertaken?

Monitoring by victims and survivors

86. Sir Brian Leveson noted that: “Pressure groups and representatives of victims and survivors can scrutinise implementation. However, this informal scrutiny will not always be sufficient, as these groups may not in fact agree with the inquiry’s recommendations and feel that they ‘do not go far enough’.”[102] Victims and survivors may have already experienced significant stress and trauma when campaigning for and giving evidence to an inquiry. Therefore, it is unfair to burden them further with the expectation that they should be the sole source of follow-up scrutiny.

Monitoring by the inquiry chair

87. We heard of examples of informal monitoring being undertaken by chairs after the conclusion of the inquiry. Sir John Saunders organised a follow-up meeting with the emergency services to learn about how they had responded to his report into the Manchester Arena bombing.[103] Professor Alexis Jay told us:

> “I suggested to government that a small, independent group, possibly including myself and victim and survivor representation should continue the process we initiated in the Inquiry, to monitor and publicly report on progress made on the implementation of all the recommendations set out in the course of the public inquiry. I received no response, and latterly raised this again with the present Home Secretary, who said he would consider it.”[104]

88. Implementation monitoring by a chair has many advantages, as they will have a deep knowledge of exactly what the report recommends. The personal qualities and reputation which commended them to the role of chair would also serve them well as an implementation monitor.

89. However, this form of implementation should not be relied upon. Public inquiries are frequently chaired by a serving judge, who returns to the Bench once the inquiry concludes. Judges should not be involved in campaigning or political activity and may feel inhibited in commenting on Government failures to implement recommendations, assuming the judge actually had time to undertake the monitoring.[105] If any inquiry is chaired by a non-legal professional, then they may be too busy with their work as well, with one witness telling the Committee that “once concluded [inquiries] are de-constituted and the chair, panel, lawyers, and staff all move on to other work.”[106] Indeed, chairs may be happy to undertake the neutral role of head of an inquiry, but wary of acting as “the overseer or enforcer as to whether recommendations have been implemented” as this is a more political and contentious role.[107]

---

102 Written evidence from Sir Brian Leveson (STI0027)

103 Response letter from Sir John Saunders to Lord Norton of Louth, 21 February 2024: https://committees.parliament.uk/publications/44525/documents/221287/default/

104 Written evidence from Professor Alexis Jay OBE (STI0026)

105 Q 16 (Mark Fisher), Written evidence from Sir Brian Leveson (STI0027), Written evidence from Thompsons Solicitors (STI0011)

106 Written evidence from Peter Skelton (STI008)

107 Written evidence from Frederick Way and Dr Karl Mackie (STI0022)

90. Once the inquiry concludes, there is no mechanism for funding the secretariat. This means that unless the Act and Rules are amended, the chair would not have the research, policy, communications or secretarial support to undertake implementation monitoring. Inquiries cannot rely on previous chairs to conduct implementation monitoring after their remuneration has come to an end.

91. Minister Burghart told the Committee that asking chairs to advise on and monitor implementation:

> " … would probably sit outwith the skills of a lot of our very able people who chair inquiries. They have never worked in government and do not know how the machinery of government works."[108]

Therefore, informal implementation by inquiry chairs is not a generally viable model.

92. If inquiries publish interim recommendations (see chapter 2), then it is possible for chairs to undertake implementation monitoring before the inquiry publishes its final report and ceases to exist. Sir John Saunders undertook interim implementation monitoring during the Manchester Arena (statutory) inquiry, while the same took place in the (non-statutory) Telford Child Sexual Abuse inquiry.[109] As Chapter 2 has noted, we encourage the publication of interim reports, and if inquiries can begin monitoring implementation of these interim recommendations immediately, then this is helpful.[110] However, this will not be possible for every inquiry; for example, inquiries with short timeframes are less suited to interim reports. In addition, this style of monitoring is only possible for interim recommendations as the chair ceases to hold their position once the final report is submitted.

Monitoring by Parliament

93. We heard of examples of Parliamentary Select Committees doing "some in-depth dives into the state of implementation" of the recommendations of some public inquiries, though resourcing and time pressures made this rare.[111] The Institute for Government's report into public inquiries found that: "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."[112]

What alternative models are there?

94. The Committee heard about different models of implementation monitoring which go beyond scrutiny by Parliament and informal scrutiny by campaign groups. Some are already in use—in the UK or abroad—while others are future possibilities.

108 Q 150 (Alex Burghart)
109 Q 70 (Deborah Coles), Written evidence from Eversheds Sutherland (International) LLP (STI0016)
110 Written evidence from Frederick Way and Dr Karl Mackie (STI0022)
111 Q 70 (Emma Norris)
112 Institute for Government, *How public inquiries can lead to change* (2017), p. 6: https://www.instituteforgovernment.org.uk/sites/default/files/publications/Public%20Inquiries%20%28final%29.pdf [accessed 11 September 2024]

Formalising monitoring by the chair

95. Implementation monitoring by inquiry chairs *after* reporting could be put on a formal basis by amending the Inquiries Act 2005. Professor Sir Malcom Evans told the Committee that:

> "whilst Inquiries end with the submission of the Final Report, in some ways this is a new beginning. If the purpose of an Inquiry is to go beyond fact finding and to make recommendations for the future, then the dissolution of the Inquiry at that point is a weakness."[113]

96. Thompsons Solicitors suggested that the 2005 Act:

> " … should provide that 6 months after delivering their report the Chair may reconvene to consider (any lack) of implementation and to issue fresh Notices requiring the Government to provide information. That could ultimately result in a further set of hearings on implementation and a further/supplementary Report by the Inquiry."[114]

97. However, this option—even if possible—is not always going to be attractive, as chairs and staff may wish to return to other work. In addition, monitoring by chairs is inferior to monitoring by a central organisation, which can perform a meta-analysis of the trends for recommendations across multiple inquiries. A meta-analysis would examine multiple inquiry reports on different topics, allowing researchers to identify wider policy failures more easily. This level of analysis is more likely to be undertaken by a central organisation with responsibility for inquiries generally. Simon Madden stated that "the Government's view [is] that chairs routinely should not have a role in monitoring the implementation of recommendations … "[115]

98. Therefore, this option (and inquiry-level monitoring generally) is not the Committee's first preference.

Independent implementation monitors

99. The Committee heard about the governance structure for public inquiries using independent implementation monitors.[116] This is a model used in Australia, where in some cases they led to "a 100% success rate in implementation".[117] Implementation monitors are independent figures, often with a similar profile to inquiry chairs, who produce regular reports on how effectively governments are implementing inquiry recommendations. They were first appointed following a Royal Commission into bushfires, which recommended the creation of the role to reduce the chance of the disaster reoccurring.[118] Implementation monitors can report to their jurisdiction's Parliament, who can then hold Ministers to account.[119] Implementation monitors are an effective and trusted part of the governance structure for public inquiries in Australia (see box 3, above). However, we noted that they

---

113 Written evidence from Professor Sir Malcolm Evans (STI0024)

114 Written evidence from Eversheds Sutherland (International) LLP (STI0016), Written evidence from INQUEST Charitable Trust (STI0013), Written evidence from Frederick Way and Dr Karl Mackie (STI0022), Written evidence from Professor Sir Malcolm Evans (STI0024), Written evidence from Thompsons Solicitors (STI0011)

115 Q 25 (John O'Brien), Q 130 (Simon Madden)

116 Q 32, Q 46 (Dr Alastair Stark)

117 Q 32 (Dr Alastair Stark)

118 Q 67 (Neil Comrie)

119 Q 68 (Neil Comrie)

work on individual inquiries and are not able to complete meta-analysis based on multiple inquiries.

Monitoring by supreme audit institutions

100. Monitoring can be undertaken by a country's supreme audit institution.[120] For example, the Renewable Heat Incentive (RHI) Inquiry in Northern Ireland was monitored by the Northern Ireland Audit Office.[121] This is a reasonable approach and is appropriate for inquiries like RHI, which made highly technical recommendations about public finance. In the UK, this model could take advantage of the fact that our audit institutions are independent and accountable to the national and devolved parliaments. However, requiring the National Audit Office (NAO) to undertake implementation monitoring for non-financial inquiries would constitute a radical shift in the expertise required of it and require the recruitment of new teams. In any case, though its function is to help Parliament scrutinise the work of Government, the NAO is overseen by the House of Commons, so that it is not for this Committee to make recommendations about what duties it should undertake.

An independent body

101. Some witnesses told us about the need for a new National Oversight Mechanism, whose role would be to: "to collate, analyse and follow up exactly what has happened to … reports and recommendations."[122] Deborah Coles described the functions of such a body as threefold: creating and managing a publicly available database that would collate all inquiry recommendations, categorising those recommendations and conducting thematic analysis. It would produce an annual report to Parliament and "have a follow-up role, which is particularly important, because then it could have that important oversight of recommendations and be equipped with the necessary powers to follow up and alert the relevant bodies as to whether the recommendations have been enacted. It could also alert Select Committees to its thematic findings."[123]

102. Further, the body would be "accountable to bereaved people or victims, possibly through an advisory board, because one of the real challenges is how they, as affected individuals, learn and understand what has taken place on the ground."[124]

103. Some witnesses advocated that monitoring functions should be conferred on the Cabinet Office Inquiries Unit, whether in its current form or as a new independent body.[125] However, this would be undesirable, because it would create a conflict of interest, with one part of the Civil Service responsible for 'independently' monitoring the progress of another part in implementing recommendations. Others suggested monitoring was undertaken by a new non-departmental public body.[126] This is undesirable firstly for practical reasons: it would require a considerable outlay of time and resources to

120 Q 32 (Dr Alastair Stark)
121 Q 68 (Emma Norris)
122 Q 76 (Deborah Coles)
123 Q 76 (Deborah Coles)
124 Q 76 (Deborah Coles)
125 Written evidence from The Bar Council (STI0023) and (STI0023), Q 9 (Kate Eves), Q 19 (John O'Brien), Written evidence from The Bar Council (STI0023) and (STI0023)
126 Q 32 (Dr Alastair Stark), Q 66 (Bill Wright), Q 98 (Bishop James Jones)

establish a new organisation. In addition, it should primarily be the role of Parliament to scrutinise the Government's progress in implementing accepted recommendations.

Parliamentary monitoring

104. The most frequently expressed view from witnesses was that there was a role for Parliament in monitoring the implementation of inquiry recommendations accepted by the Government.[127] Alex Burghart MP told us:

> " … there is a role here for both Houses of Parliament and for Select Committees. That is probably the best, most independent, most durable and most cost-effective route. Your powers as committees to summon people are strong and tested. It would enable different aspects of different inquiries to be picked up by different committees, or there might be a committee such as your own that persists and chooses to consider these matters. My strong preference is for these things to be done by Parliament."[128]

105. A parliamentary committee is superior to the other options because it plays to the strengths of the existing committee system: the committee would have oversight for multiple inquiries, enabling it to undertake meta-analysis of wider systemic policy failures. The committee system is flexible and internally regulated by the House, meaning that a new committee could be established relatively quickly. It is also constitutionally sounder to vest Parliament with the responsibility of holding Government to account for this area of policy, rather than an independent arms-length body. This could take the form of a new Public Inquiries Committee, which could be a joint or House of Lords committee. Of course, existing committees of Parliament have the right to undertake their own scrutiny in the area of public inquiries, but having a single committee to focus on this function would reduce duplication and ensure more systematic and comprehensive scrutiny.

106. In addition to monitoring the implementation of public inquiry recommendations, a new committee could also review inquest recommendations. This would mean that the new committee would help fulfil the Grenfell Tower Inquiry's call for a "publicly accessible record of recommendations made by select committees, coroners and public inquiries together with a description of the steps taken in response".[129] The following sections outline some of the other functions such a committee might perform.

Tracking and publishing

107. Currently, inquiry reports are laid before Parliament and often published on inquiry websites. However, the reports and Government responses are not uploaded in one place and lack the identifying features which would prioritise their ranking in search engine results. This makes it difficult for Members of Parliament, victims and survivors, campaigners and academics to easily find and collate inquiry recommendations and view the Government

127 Q 12 (Sir John Saunders), Q 25 (John O'Brien), Q 16, Q 25, Q 26 (Mark Fisher), Q 77, Q 80 (Emma Norris), Written evidence from The Bar Council (STI0023) and (STI0023), Written evidence from Sir Brian Leveson (STI0027)

128 Q 148 (Alex Burghart)

129 Grenfell Tower Inquiry, *Phase 2 Report* (14 June 2017) volume 14, para 113.40: https://www.grenfelltowerinquiry.org.uk/sites/default/files/CCS0923434692-004_GTI%20Phase%202%20Volume%207_BOOKMARKED.pdf [accessed 11 September 2024]

response. A new committee of Parliament could publish all inquiry reports and responses on one 'landing page' on the committee website, creating a complete and authoritative repository of documents.

108. Finding and analysing individual inquiry recommendations is made more difficult because recommendations are listed within the overall inquiry report and not always on a separate summary page. The report is normally uploaded in PDF (rather than HTML) format, which makes navigating to specific recommendations or copying them for analysis more difficult.[130] This means that it is more difficult for victims and survivors and researchers to find and disseminate recommendations. A new committee could list inquiry recommendations individually on their website, along with the Government response. Recommendations could be 'tagged' or categorised according to variables like policy area, government response, implementation status or responsible department, as well as the inquiry they originated from. The committee would thus make inquiry recommendations and responses accessible in one place.[131] At the moment, too much of this potential learning is difficult to find and analyse.

Scrutinising Government sponsorship

109. Both statutory and non-statutory inquiries are established by a Minister and resourced by a government department. Currently, the Inquiries Unit in the Cabinet Office provides cross-government advice to departments on how to most effectively sponsor inquiries. The Inquiries Unit is the subject of the next chapter. The new Public Inquiries Committee could supplement this function of government, holding evidence sessions or writing to officials to ensure that best practice for running inquiries is being disseminated effectively and that Ministers are making appropriate decisions about establishing and resourcing inquiries.

110. The Committee could use its scrutiny function to ensure that Government is setting up inquiries in a timely manner and responding to inquiry reports promptly. The Committee could help ensure that reports receive responses quickly.

Research

111. Witnesses told the present Committee that public inquiries often make recommendations which are common to other inquiries. Public policy failings rarely happen in isolation and there are often common themes which can only be identified by conducting meta-analyses of multiple inquiries. This function is currently missing from the governance structure for public inquiries and is not undertaken by the Inquiries Unit.[132] A Public Inquiries Committee of Parliament could use its research secretariat to compare and analyse multiple inquiry reports to identify common failures, which amount to more than the sum of individual public inquiry recommendations. The Committee could bring these to the attention of the Government. This is a key advantage to having a central body undertake implementation monitoring, rather than the chair or an appointed person undertaking monitoring at inquiry level.

130 Government Digital Service, 'Why GOV.UK content should be published in HTML and not PDF' (16 July 2018): https://gds.blog.gov.uk/2018/07/16/why-gov-uk-content-should-be-published-in-html-and-not-pdf/ [accessed 10 September 2024]

131 Written evidence from Professor Lucy Easthope (STI0018)

132 Written evidence from Professor Lucy Easthope (STI0018)

Encouraging the establishment of inquiries

112. In its reports to Parliament, a new Public Inquiries Committee could make recommendations to Government about when a public inquiry should be held. The Committee could use its expertise and general oversight of public inquiries to adjudge the relative urgency and importance of different events of public concern. This would allow it to make occasional, reasoned and informed calls to the Government about the most important topics which should be the subject of public inquiries.

113. Once all other avenues have been exhausted, a new Public Inquiries Committee could also run its own parliamentary inquiries, publishing reports, requiring a government response and then monitoring implementation. There is historical and constitutional precedent for this: before 2005, statutory public inquiries were established by parliamentary authority and before 1921 they were committees of Parliament itself. Select Committee inquiries overlap considerably in their function with public inquiries and occasionally investigate events of public concern, as well as policy failings.

114. In 1999, the House of Lords undertook an inquiry into the Mull of Kintyre Chinook crash, which took place in 1994. This example demonstrates Parliament's right to set up inquiries, regardless of the option of statutory inquiries available to Ministers.[133] It also shows how parliamentary inquiries can fulfil the same purpose as a public inquiry and bring redress, even when the Government refuses to hold a statutory inquiry. Running a parliamentary inquiry would require significant resourcing and should therefore be seen as a last resort.

115. **Insufficient implementation monitoring has damaged the reputation of public inquiries and made them less effective. This risks the recurrence of disasters and fails to provide victims and survivors with the clear reassurance that everything has been done to prevent recurrence of a disaster. Currently, millions of pounds are spent on public inquiries, yet too little is done to ensure that the desired outcomes of inquiries are achieved. Implementation monitoring is an essential—but currently neglected—part of the inquiry process.**

116. ***We recommend to the Liaison Committee that formal implementation monitoring should be undertaken by a new, joint, select committee of Parliament: the Public Inquiries Committee. Should a new joint committee not be desired, then it should be a sessional committee of the House of Lords. Until such a committee is established, the need to monitor the implementation of public inquiry recommendations should be borne in mind by the Liaison Committee when establishing new committees, including special inquiry committees. A new committee on public inquiries should be resourced to discharge the following functions:***

(a) ***Publish inquiry reports and government responses in one place, online.***

(b) ***Monitor the implementation of accepted public inquiry and major inquest recommendations through policy research,***

133 Committee to review Chinook ZD 576 crash, *Chinook ZD 576* (Report of Session 2001–02, HL 25 (iii))

correspondence with Government departments and evidence sessions with Ministers and officials.

(c) ***Publish reports on recommendation implementation and maintain an online, publicly available, tracker. This would show the status of individual recommendations, perhaps using a "traffic light" grading system.***

(d) ***Make recommendations to the Inquiries Unit of the Cabinet Office on best practice for establishing and running public inquiries, based on evidence from experts on inquiries.***

(e) ***Scrutinise the Government's sponsorship of and formal response to individual inquiries.***

(f) ***Conduct thematic research and meta-analysis of recommendations common to multiple inquiries, so as to identify systemic policy failures and prevent future disasters.***

CHAPTER 5: THE INQUIRIES UNIT

117. Inquiries have a core purpose: to publish recommendations for change, so as to prevent the reoccurrence of an event of public concern. Yet despite having a simple remit and only existing temporarily, inquiries entail all sorts of organisational complexities. These include planning a budget, procuring a venue and IT system, and recruiting a support team and HR function. This is all in addition to the inquiry's initial tasks of selecting witnesses, planning evidence sessions, creating the timetable for its work, and, if appropriate, agreeing the best way of involving victims and survivors for the particular inquiry.

118. While the subject matter of public inquiries varies, the underlying principles and processes for running them are broadly similar, regardless of their statutory basis. A new inquiry is unlikely to encounter a practical problem to which a previous inquiry has not already found a solution.

119. Nonetheless, we heard from many of our witnesses that inquiries make too many avoidable mistakes and fail to learn from the experience of earlier inquiries. This causes delay, waste and more trauma for victims and survivors, due to the protracted process. In its 2014 report, the House of Lords Committee recommended the creation of a central inquiries unit: "responsible for all the practical details of setting up an inquiry, whether statutory or non-statutory, including but not limited to assistance with premises, infrastructure, IT, procurement and staffing … "[134] Such a unit was set up in 2019, within the Cabinet Office, rather than HMCTS as the report had originally recommended.[135] We heard that the Unit supports "the inquiries community across government to share best practice and to make sure that inquiries are running appropriately."[136]

120. Despite the existence of the Unit, there remains a perception that new inquiries are continuing to "reinvent the wheel" and that opportunities to learn from shared best practice are being missed. [137] This chapter will analyse the ways that inquiries are failing to learn lessons and recommend how the Inquiries Unit in the Cabinet Office can be improved to make this less likely.

"Lessons learned"

121. We heard that inquiries are too frequently "reinventing the wheel" and repeating the same mistakes. Bishop James Jones told us about an inquiry where:

> " … the original layout of the room was dominated by lawyers at their tables, and the families were literally squeezed to the side in chairs that were locked together and put at the back of the room, and then there was an overflow room. That demonstrated that the forensic was taking priority over the empathy."[138]

122. Realising that this was alienating the inquiry's core participants, the layout was subsequently changed. This example illustrates how easily inquiries—

134 *Inquiries Act 2005: post-legislative scrutiny*
135 *Inquiries Act 2005: post-legislative scrutiny*
136 Q 115 (Luke Hughes)
137 Written evidence from Eversheds Sutherland (International) LLP (STI0016), Written evidence from Frederick Way and Dr Karl Mackie (STI0022), Written evidence from Dr Emma Ireton (STI0012)
138 Q 88 (Bishop James Jones)

staffed by able, well-meaning but potentially inexperienced people—can inadvertently make mistakes which undermine the confidence of interested parties and the public. The singular nature of public inquiries makes them particularly vulnerable to failing to learn lessons from earlier inquiries. Baroness May of Maidenhead stated that "one major cause of the unnecessary length and cost of inquiries has been that the secretariat of every new inquiry has had to start from scratch". More needs to be done so that new inquiries can learn from the mistakes and innovations of those which came before.[139]

123. In its 2014 report, the House of Lords Committee recommended that: "[t]he inquiries unit should ensure that on the conclusion of an inquiry the secretary delivers a full Lessons Learned paper from which best practice can be distilled and continuously updated."[140] This was accepted by the Government, who stated that they would: "take a more proactive stance on this in future, making clear to inquiry secretaries that a lessons learned paper must be produced … to ensure that any lessons to be learned can be picked up and best practice shared."[141] However, the Government admitted to the present Committee that "this does not happen consistently".[142] This reflects the view of other witnesses that not enough inquiries are producing those papers.[143] This means that there is a continuing "failure to capture knowledge of best practice and using that to inform future inquiries."[144] We heard that having access to a comprehensive suite of papers through "a central source of the documents would … be valuable for future inquiries."[145] We also heard about the difficulty in assessing: "how effectively these papers are being produced because the Government does not routinely put them in the public domain."[146]

124. A failure to produce, collate and share these papers between inquiries constitutes a missed opportunity to avoid costly and reputationally damaging mistakes by inquiries. Compared to the time and resources required to produce an inquiry report, a lessons learnt paper is not a demanding undertaking. Yet they could help avoid much more costly mistakes in future inquiries.

The establishment of an inquiry

125. The establishment of an inquiry involves a similar set of tasks each time, which can often prove frustrating for new inquiries and their participants. We heard examples of difficulties in acquiring a venue and sourcing and setting-up IT systems.[147] This is despite these requirements being held in common by all inquiries, and the inherent risk of increased costs and lost time if the tasks are carried out inefficiently.[148] These tasks take place at the same time

139 Response letter from Baroness May of Maidenhead, 21 May 2024: https://committees.parliament.uk/publications/45310/documents/224403/default/
140 Recommendation 13 (See end of report)
141 Ministry of Justice, *Government Response to the Report of the House of Lords Select Committee on the Inquiries Act 2005*, Cm 8903 (June 2014): https://www.parliament.uk/globalassets/documents/lords-committees/Inquiries-Act-2005/Cm8903_Government-response-to-HL-Committee-on-the-Inquiries-Act-2005_260614_TSO_Print.pdf [accessed 11 September 2024]
142 Letter from the Alex Burghart MP to Lord Norton of Louth, 1 March 2024: https:/committees.parliament.uk/publications/44395/documents/220732/default/
143 Q 29 (Dr Emma Ireton); Written evidence from Sir Brian Leveson (STI0027)
144 Q 29 (Dr Emma Ireton)
145 Written evidence from Eversheds Sutherland (International) LLP (STI0016)
146 Q 146 (Alex Burghart)
147 Q 19 (John O'Brien), Q 19 (Mark Fisher), Q 16 (John O'Brien)
148 Written evidence from Eversheds Sutherland (International) LLP (STI0016)

as the chair and secretariat are getting to grips with plans for conducting the inquiry, including: "how they are going to take the evidence and when they are going to start sending out calls for evidence."[149] Therefore, it is all the more important that they are completed efficiently. Yet, as John O'Brien noted: "There are lots of pitfalls in getting the start-up wrong. I personally think that is where much more support could be given."[150]

126. Sir Brian Leveson suggested that inquiries should conclude by publishing "working papers", on "how inquiries should be organised and run".[151] He contrasted these with "lessons learnt papers" which deal with the policy and legal tasks, implying that both are useful. His evidence states that he offered to produce this document for the Cabinet Office but was not taken up on this offer.[152]

The Inquiries Unit

127. Since 2019 the Cabinet Office has run an Inquiries Unit, whose remit is for the whole of the UK, including Scotland, to help share best practice. This was recommended in the 2014 report, though the Government rejected the recommendation at the time.[153] The Home Office also has a small, dedicated Inquiries Unit, which advises on Home Office-sponsored inquiries.[154] Other departments sponsoring inquiries set up sponsorship teams on an ad hoc basis. A separate team within the Cabinet Office Inquiries Unit also sponsors Cabinet Office inquiries. Luke Hughes, the deputy director in charge of the Unit, describes its work as follows:

> "The inquiries policy side of that team focuses on providing advice and guidance to departments across government. It does this in a variety of ways. First, it corrals written advice and guidance. Over the last couple of years we have set up a digital inquiries hub online, which has over 300 active users from across the cross-government inquiries community. We hold a quarterly meeting with inquiry secretaries and a quarterly meeting with inquiry sponsorship teams. Those networks are thriving and flourishing now and a lot of best practice is being shared among them."[155]

We were assured that officials from the devolved administrations are involved in these meetings too.[156]

128. We heard evidence of the work that the Inquiries Unit is doing to build a community of practitioners and experts in the field of public inquiries. For example, the Unit does hold some lessons learnt reports, including an example copy which the Government shared with us. They do also convene

149 Q 19 (John O'Brien)
150 Q 19 (John O'Brien)
151 Written evidence from Sir Brian Levison (STI0027)
152 Written evidence from Sir Brian Leveson (STI0027)
153 Ministry of Justice, *Government Response to the Report of the House of Lords Select Committee on the Inquiries Act 2005*, Cm 8903 (June 2014): https://www.parliament.uk/globalassets/documents/lords-committees/Inquiries-Act-2005/Cm8903_Government-response-to-HL-Committee-on-the-Inquiries-Act-2005_260614_TSO_Print.pdf [accessed 11 September 2024]
154 Response letter from John O'Brien CBE to Lord Norton of Louth 8 March 2024, https://committees.parliament.uk/publications/44529/documents/221309/default/, Response letter from Kate Eves to Lord Norton of Louth, 1 March 2024: https://committees.parliament.uk/publications/44528/documents/221308/default/
155 Q 115 (Luke Hughes)
156 Q 122 (Luke Hughes)

a quarterly meeting for inquiry secretaries for sharing best practice.[157] The unit should be better at publicising the work it is doing and building links with non-governmental experts on inquiries.

129. However, we are concerned that despite existing for a number of years, many of the subject experts and stakeholders we spoke to did not know the unit existed. For example, a witness told us that "there is still no forum for retaining the lessons learned in running a public inquiry with a view to conveying that knowledge and experience to subsequent inquiry chairs."[158] Another witness—an expert on public inquiries—stated that "On occasions, good practice is being missed and examples of weaker practice are being repeated. The establishment of a central inquiries unit to act as a repository of examples of best practice would help to address this."[159] This is despite the Inquiries Unit existing since 2019 and convening meetings for inquiry secretaries to share best practice since October 2020.[160] It is clear that the Cabinet Office should be ensuring that these lessons learned documents are produced.[161]

130. Experienced chairs and lawyers told the Committee that they had had no involvement in sharing best practice through the Inquiries Unit, despite their involvement in many inquiries.[162] Even if they were not formally involved or regular attendees of best practice sharing meetings, it is surprising that they have not been involved in any opportunity to share best practice with their peers or with the Inquiries Unit itself. This is not a reflection on those individuals, but rather a sign that the Inquiries Unit has not sufficiently built up a "community of practice" which reflects all of the different roles involved in an inquiry.

131. The fact that that academic and legal experts on public inquiries are not being asked to share knowledge and best practice with current inquiry chairs and secretaries and are unaware of each others' existence is regrettable. It is telling and unfortunate that around 10 witnesses recommended to us that an Inquiries Unit should be established, because this implies that they are not aware that it in fact exists.[163] John O'Brien said that: "although some efforts have been made, they are patchy and we still do not really have a system where there is a central place to which you can go to get that sort of start-up help."[164] This is more of a reflection on the Government than

157 Q 116, Q 127, Q 129 (Luke Hughes), Q 121 (Simon Madden), Letter from the Alex Burghart MP to Lord Norton of Louth, 1 March 2024: https:/committees.parliament.uk/publications/44395/documents/220732/default/, Response letter from Mark Fisher CBE to Lord Norton of Louth, 24 February 2024: https:/committees.parliament.uk/publications/44589/documents/221472/default/

158 Written evidence from Eversheds Sutherland (International) LLP (STI0016)

159 Written evidence from Dr Emma Ireton (STI0012)

160 Letter from the Alex Burghart MP to Lord Norton of Louth, 1 March 2024: https:/committees.parliament.uk/publications/44395/documents/220732/default/

161 Written evidence from Sir Brian Leveson (STI0027), Written evidence from Eversheds Sutherland (International) LLP (STI0016), Written evidence from INQUEST Charitable Trust (STI0013)

162 Response letter from Brian Altman KC to Lord Norton of Louth, 22 February 2024: https:/committees.parliament.uk/publications/44509/documents/221263/default/, Response letter from Kate Eves to Lord Norton of Louth, 1 March 2024: https://committees.parliament.uk/publications/44528/documents/221308/default/, Response letter from Sir John Saunders to Lord Norton of Louth, 21 February 2024: https://committees.parliament.uk/publications/44525/documents/221287/default/

163 Written evidence from Eversheds Sutherland (International) LLP (STI0016), Written evidence from INQUEST Charitable Trust (STI0013), Written evidence from Dr Emma Ireton (STI0012), Written evidence from Frederick Way and Dr Karl Mackie (STI0022), Q 16 (John O'Brien), Q 19 (Brian Stanton), Q 46 (Dr Emma Ireton), Q 46 (Dr Nathan Critch)

164 Q 16 (John O'Brien)

it is on our witnesses, because sharing best practice is essential to ensure that inquiries meet their terms of reference in a timely and cost-effective way, with appropriate engagement of core participants and maximum public trust.

132. Ignorance is not limited to academic experts. The public have a very poor understanding of public inquiries generally.[165] The Inquiries Unit should have more of an online presence and publish information about the governance structure for public inquiries.[166]

133. Some witnesses felt that the Inquiries Unit should be made independent of the Government.[167] Others added that once independent, it should decide if an inquiry takes place and maintain a library of findings for public access, as well as engage with victims and survivors and monitor recommendations.[168] This is undesirable because inquiries are political as well as quasi-judicial processes and entail significant cost implications. Therefore, the Government should maintain control over the decision of whether or not to hold an inquiry.

134. The Committee heard that although there is a forum for inquiry secretaries to share best practice, there is no similar forum for chairs. Inquiry chairs have the most crucial role in an inquiry and it is important that they can meet to share best practice. The decisions taken by chairs are more likely to be heterogeneous than those made by secretaries and there could be more pressure on their time as they are essentially lay appointees. Therefore, they may not want to meet quarterly like inquiry secretaries, but there should still be some forum. Former chairs could share best practice with chairs who are just setting up an inquiry on an informal basis and this could be organised through the Inquiries Unit.

135. The Cabinet Office inquiries unit maintains a Guide for Inquiry Chairs and Secretaries. This document is the main official guidance on how to undertake a statutory or non-statutory inquiry. This document was first prepared in 2012 and this is the only version available publicly. The Cabinet Office say that the guidance is periodically updated and is therefore not released into the public domain. The 2014 report called for the Government to release this guidance and the Government agreed, yet this was not done. The Committee understand that inquiry chairs must have flexibility and must not therefore be held to the letter of guidance, however a more recent copy must be made available in a form for the public.

Recommendations for change

136. This Committee has received a considerable quantity of evidence on good practice for inquiries. However, it is not for this Inquiry to make a large number of specific recommendations about how inquiries should be run. The Committee is strongly of the view that flexibility is important and that is it is not possible to prescribe exactly how an inquiry should be undertaken.

165 Written evidence from Crest Advisory (STI0020)
166 Q 46 (Dr Nathan Critch)
167 Written evidence from Peter Skelton (STI0008), Written evidence from The Bar Council (STI0023) Written evidence from The Bar Council (STI0023), Q 21, Q 22 (John O'Brien), Q 21 (Mark Fisher), Q 9 (Kate Eves)
168 Written evidence from The Bar Council (STI0023), Q 9 (Kate Eves), Q 19, Q 23 (John O'Brien), Q 49 (Stephanie Needleman)

For reference—and by way of illustration—a list of examples of good practice is given in appendix 5.

137. Inquiries have fallen short because there is insufficient guidance on the flexibility inherent in the 2005 Act on sharing of best practice and learning from past mistakes. Improvements in inquiry practice will increase efficiency, effectiveness and therefore public trust in inquiries.

138. **Sharing best practice between inquiries and learning from past inquiries is essential. The Inquiries Unit should more effectively engage expert opinion on inquiries and share this across Government departments and the Civil Service. It is disappointing that the Inquiries Unit have failed to engage with non-governmental experts. Nonetheless, we commend the unit for the good work it does and the improvements that has taken place since its establishment in 2019.**

139. ***Inquiry terms of reference should contain an obligation on Chairs and Secretaries to produce (at a minimum) a lessons-learnt paper (on legal and policy challenges) and a working paper (on logistics), detailing what went well for the inquiry and what could be improved in the future. This requirement should also be included in the chair's terms of appointment so that their full salary cannot be paid until the documents have been presented. The reports should be written as the inquiry progresses and submitted with the inquiry report, so that they can be considered by the Inquiries Unit and shared at the regular meetings of inquiry practitioners. This way, best practice would be disseminated and avoidable mistakes averted. They should also be supplied to (but not published by) the new Public Inquiries Committee of Parliament, so the Committee can make undertake meta-analyses of the successes and failures common to inquiries and make recommendations for improvement.***

140. ***The Inquiries Unit in the Cabinet Office should be sufficiently resourced, so it can establish a wider "community of practice" for public inquiries, which includes more non-governmental experts. There should be a forum so that inquiry chairs can also share best practice, as well as inquiry secretaries. A form of the Handbook for Inquiry Chairs and Secretaries should be publicly available. The Unit should also use policy-making and Civil Service expertise to support chairs in making practicable recommendations.***

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Establishment and conduct of Inquiries

1. The format (statutory basis, identity and panel or chair) for a particular inquiry should be chosen on the basis of the nature and requirement of the particular inquiry and included in its terms of reference. (Paragraph 43)

2. The choice of chair is crucial to the success of the inquiry and should be made by a Minister based on the purpose and requirements of the particular inquiry. Ministers should feel prepared to choose whoever is best qualified to oversee the legal, technical and administrative elements of the particular topic. We reiterate the conclusion of the 2014 report, which stated that "ministers have in the past been too ready to assume that a serving judge would be the most suitable chairman." (Paragraph 44)

3. When drawing up the terms of reference for an inquiry, Ministers have the discretion to appoint a single chair, a panel, or a team of assessors to support the chair. Ministers should not feel limited to appoint a single chair only, particularly when the inquiry is expected to be wide-ranging or when the subject matter is particularly technical, as a panel of experts could be particularly useful in those instances. (Paragraph 45)

4. *Ministers should select the legal basis and chair of an inquiry on a case-by-case basis and not feel tied to a particular model. Guidance on models other than statutory or judge-led inquiries should form part of the early advice of the Inquiries Unit to the department and Minister setting up an inquiry. Ministers should keep in mind the option of holding a non-statutory inquiry (given its relative agility) and then converting it if witnesses fail to cooperate. Ministers should also consider selecting non-judge chairs or appointing a panel. Ministers should meet and consult victims and survivors' groups before publishing the terms of reference.* (Paragraph 46)

5. The Government should ensure that future inquiries build on the good work of recent inquiries and better involve victims and survivors. (Paragraph 54)

6. *Ministers should, where appropriate, consult with victims and survivors on the overall terms of reference. Guidance should be given by the Inquiries Unit to Ministers and departments setting up a new inquiry on the options available for involving and consulting with victims and survivors. New inquiries should normally contain provisions in the terms of reference for the appropriate involvement of victims and survivors.* (Paragraph 55)

7. There is a perception that inquiries are frequently too long and expensive, leading to a loss of public confidence and protracted trauma for victims and survivors. Delays and cost can be minimised by better sharing of best practice, which is covered in Chapter 5. However, the overall planning of some inquiries at their outset by the chair and secretariat would be made easier if there was a limited time. (Paragraph 58)

8. *When establishing an inquiry, the sponsoring Minister should consider including an indicative deadline in the terms of reference, keeping in mind the particular purpose and aim of the inquiry. A deadline should concentrate the efforts of the inquiry chair and secretariat, while also reassuring victims and survivors that redress is forthcoming. Inquiry chairs should aim to report within this time and must seek the permission of the Minister if they wish to exceed it. (for example, in the event that*

the inquiry discovers evidence which leads to new lines of inquiry). Inquiries which are conducted more quickly will also be more cost-effective. (Paragraph 59)

9. Inquiries should provide regular, public, updates on their work—both administrative activities, as well as public hearings. Longer inquiries should, where appropriate, publish interim reports. (Paragraph 62)

10. *When an inquiry is likely to be of long duration, Ministers may consider including the requirement to publish interim reports in an inquiry's terms of reference, along with a requirement to publish updates on the inquiry's website about inquiry activity. This will help maintain public trust and ensure there is accountability to both individuals and Parliament.* (Paragraph 63)

Running and sponsoring an inquiry—the recommendations from the 2014 report

11. The Committee endorses the overall findings of the 2014 report, along with most of its conclusions and recommendations. It is unacceptable that many of the accepted recommendations from the 2014 report were not subsequently implemented by HMG. The Committee concludes that:

    (a) Recommendation 12, on the establishment of an Inquiries Unit, has been implemented.

    (b) Recommendations 1, 6–7, 25, 31 and 33 can be discarded.

    (c) The remaining recommendations continue to have merit and should be put to HMG again (either in original or modified form). (Paragraph 73)

12. R*ecommendations 2–5, 8, 10–11, 13–24, 26–30 and 32 of the 2014 report are put to the Government again. Recommendation 9 remains relevant in principle and will be put to the Government again in modified form (see table in appendix 4). If the Government accepts this recommendation, the Committee expects that they will be implemented in a timely manner. In order to effect this, the Government should:*

    (a) Introduce primary legislation to implement those recommendations from 2014 which require it.

    (b) Identify and draft changes to the Inquiry Rules required to implement the recommendations from 2014.

    (c) Swiftly implement those recommendations from 2014 which do not require any primary or secondary legislation. (Paragraph 74)

13. *The Liaison Committee of the House of Lords should monitor the implementation of this Committee's recommendations over the coming months and years, as recommended by the Liaison Committee's report, Towards a New Thematic Committee Structure. This is desirable because - as a special inquiry committee— the Statutory Inquiries Committee ceased to exist on the publication of this report.* (Paragraph 75)

After the inquiry—implementation monitoring

14. Insufficient implementation monitoring has damaged the reputation of public inquiries and made them less effective. This risks the recurrence of disasters and fails to provide victims and survivors with the clear reassurance that everything has been done to prevent recurrence of a disaster. Currently, millions of pounds are spent on public inquiries, yet too little is done to ensure that the desired outcomes of inquiries are achieved. Implementation

monitoring is an essential—but currently neglected—part of the inquiry process. (Paragraph 115)

15. *We recommend to the Liaison Committee that formal implementation monitoring should be undertaken by a new, joint, select committee of Parliament: the Public Inquiries Committee. Should a new joint committee not be desired, then it should be a sessional committee of the House of Lords. Until such a committee is established, the need to monitor the implementation of public inquiry recommendations should be borne in mind by the Liaison Committee when establishing new committees, including special inquiry committees. A new committee on public inquiries should be resourced to discharge the following functions:*

    (a) Publish inquiry reports and government responses in one place, online.

    (b) Monitor the implementation of accepted public inquiry and major inquest recommendations through policy research, correspondence with Government departments and evidence sessions with Ministers and officials.

    (c) Publish reports on recommendation implementation and maintain an online, publicly available, tracker. This would show the status of individual recommendations, perhaps using a "traffic light" grading system.

    (d) Make recommendations to the Inquiries Unit of the Cabinet Office on best practice for establishing and running public inquiries, based on evidence from experts on inquiries.

    (e) Scrutinise the Government's sponsorship of and formal response to individual inquiries.

    (f) Conduct thematic research and meta-analysis of recommendations common to multiple inquiries, so as to identify systemic policy failures and prevent future disasters. (Paragraph 116)

The Inquiries Unit

16. Sharing best practice between inquiries and learning from past inquiries is essential. The Inquiries Unit should more effectively engage expert opinion on inquiries and share this across Government departments and the Civil Service. It is disappointing that the Inquiries Unit have failed to engage with non-governmental experts. Nonetheless, we commend the unit for the good work it does and the improvements that has taken place since its establishment in 2019. (Paragraph 138)

17. *Inquiry terms of reference should contain an obligation on Chairs and Secretaries to produce (at a minimum) a lessons-learnt paper (on legal and policy challenges) and a working paper (on logistics), detailing what went well for the inquiry and what could be improved in the future. This requirement should also be included in the chair's terms of appointment so that their full salary cannot be paid until the documents have been presented. The reports should be written as the inquiry progresses and submitted with the inquiry report, so that they can be considered by the Inquiries Unit and shared at the regular meetings of inquiry practitioners. This way, best practice would be disseminated and avoidable mistakes averted. They should also be supplied to (but not published by) the new Public Inquiries Committee of Parliament, so the Committee can make undertake meta-analyses of the successes and failures common to inquiries and make recommendations for improvement.* (Paragraph 139)

18. *The Inquiries Unit in the Cabinet Office should be sufficiently resourced, so it can establish a wider "community of practice" for public inquiries, which includes more*

non-governmental experts. There should be a forum so that inquiry chairs can also share best practice, as well as inquiry secretaries. A form of the Handbook for Inquiry Chairs and Secretaries should be publicly available. The Unit should also use policy-making and Civil Service expertise to support chairs in making practicable recommendations. (Paragraph 140)

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

Lord Norton of Louth (Chair)
Lord Aberdare
Lord Addington
Baroness Berridge
Baroness Chakrabarti
Lord Davidson of Glen Clova
Baroness D'Souza
Lord Faulks
Lord Grantchester
Lord Hendy
Baroness Sanderson of Welton
Lord Wallace of Tankerness

Declaration of interest

Lord Norton of Louth (Chair)

No relevant interests to declare

Lord Aberdare

No relevant interests to declare

Lord Addington

No relevant interests to declare

Baroness Berridge

Witness at the Independent Inquiry into Child Sexual Abuse

Potential witness in future inquiries as former Parliamentary Under-Secretary at Department for Education

Non-practising barrister

Baroness Chakrabarti

A panel member of the Leveson Inquiry into press standards 2011–12

Lord Davidson of Glen Clova

Practising member of the Scots bar, and previously involved in a number of statutory inquiries in the UK, though none currently.

Baroness D'Souza

No relevant interests to declare

Lord Faulks

Barrister at Deka Chambers

Chair of Independent Press Standards Association

Judge of Astana Financial Centre Court (Kazakhstan)

Lord Grantchester

No relevant interests to declare

Lord Hendy

Advises the Fire Brigades Union from time to time in relation to the Grenfell Tower Fire Inquiry

Represents (on an occasional basis) various trade unions in the Undercover Policing Inquiry.

Previously involved in a number of statutory inquiries in the UK

Baroness Sanderson of Welton

As special adviser, helped set up the Independent Inquiry into Child Sexual Abuse (IICSA), Infected Blood Inquiry and Grenfell Inquiry

Worked on the Truth Project for IICSA

Community advisor to Rt Hon Nick Hurd, independent adviser to PM on Grenfell, and in that capacity works with Grenfell Community, including delivering inquiry recommendations.

In touch informally with members of IICSA and Infected Blood stakeholder groups.

Lord Wallace of Tankerness

Non-practising member of the Faculty of Advocates

Advocate General for Scotland 2010–2015

A full list of Members' interests can be found in the Register of Lords Interests: https://members.parliament.uk/members/lords/interests/register-of-lords-interests

APPENDIX 2: LIST OF WITNESSES

Evidence is published online at https://committees.parliament.uk/work/8207/statutory-inquiries and available for inspection at the Parliamentary Archives (020 7219 3074).

Evidence received by the committee is listed below in chronological order of oral evidence session, and then in alphabetical order. Those witnesses marked with ** gave both oral evidence and written evidence. Those marked with * gave oral evidence and did not submit any written evidence. All other witnesses submitted written evidence only.

Oral evidence in chronological order

*	Kate Eves, former Chair, Brook House Inquiry	QQ 1–13
*	Brian Altman KC, counsel to multiple inquiries	QQ 1–13
*	Sir John Saunders, former Chair, Manchester Arena Inquiry	QQ 1–13
*	John O'Brien CBE, Senior Associate, Crest Advisory	QQ 14–26
*	Mark Fisher CBE, former Head of Administration, Grenfell Tower Inquiry	QQ 14–26
*	Brian Stanton, former inquiry solicitor and Director, Innovo Law	QQ 14–26
**	Dr Emma Ireton, Associate Professor, Nottingham Trent University	QQ 27–46
*	Dr Alastair Stark, Associate Professor, University of Queensland	QQ 27–46
*	Dr Nathan Critch, teaching associate, University of Birmingham	QQ 27–46
*	Bill Wright, Co-chair, Haemophilia Scotland	QQ 47–65
*	Stephanie Needleman, Legal Director, Justice	QQ 47–65
*	Deborah Coles, Executive Director, INQUEST	QQ 66–85
*	Emma Norris, Deputy Director, Institute for Government	QQ 66–85
*	Neil Comrie, Implementation monitor, former 2009 Victorian Bushfires Royal Commission, Australia	QQ 66–85
*	Bishop James Jones KBE, former chair of the Hillsborough Independent Panel	QQ 86–113
*	Ken Sutton, former Advisor, Hillsborough Independent Panel	QQ 86–113
*	Simon Madden, Director of Propriety and Ethics, Cabinet Office	QQ 114–144
*	Luke Hughes, Deputy Director, Propriety & Ethics, Cabinet Office	QQ 114–144
*	Alex Burghart MP, Parliamentary Secretary, Cabinet Office	QQ 145–160

★	Luke Hughes, Deputy Director, Propriety & Ethics, Cabinet Office	QQ 145–160

Alphabetical list of witnesses

★	Dr Alastair Stark , Associate Professor, University of Queensland (QQ 27–46)	
	Australian High Commission	STI0028
	Bar Council	STI0023
	Sir David Bell, Senior Director, Cambridge University Press and Assessment	STI0005
★	Simon Madden, Director of Propriety and Ethics, Cabinet Office (QQ 114–144)	
★	Luke Hughes, Deputy Director, Propriety & Ethics, Cabinet Office (QQ 114–144)	
★	Mark Fisher CBE, former Head of Administration, Grenfell Tower Inquiry (QQ 14–26)	
	CEDR (Centre for Effective Dispute Resolution)	STI0022
★	Deborah Coles, Executive Director, INQUEST (QQ 66–85)	
★	Neil Comrie, Implementation monitor, Australia (QQ 66–85)	
★	Crest Advisory (QQ 14–26)	STI0020
★	Dr Nathan Critch, Teaching associate, University of Birmingham (QQ 27–46)	
	DWF	STI0006
	Professor Lucy Easthope, Visiting Professor, Centre for Death and Society, University of Bath	STI0018
	Professor Sir Malcolm Evans	STI0024
	Eversheds Sutherland (International) LLP	STI0016
★	Kate Eves, Chair, Brook House Inquiry (QQ 1–13)	
	Factor 8	STI0004
	Matthew Hill	STI0021
★	Luke Hughes, Deputy Director, Propriety & Ethics, Cabinet Office (QQ 145–160)	
★	INQUEST Charitable Trust	STI0013
★★	Dr Emma Ireton, Associate Professor in Law, Vocational Courses, Nottingham Law School, Nottingham Trent University (QQ 27–46)	STI0029 STI0012
★	Bishop James Jones KBE (QQ 86–113)	
	Pete Weatherby KC Anna Morris KC, Barristers, Garden Court North Chambers, and Barristers, Garden Court North Chambers	STI0014

	Jason Beer KC, Barrister, 5 Essex Chambers	STI0015
*	Brian Altman KC (QQ 1–13)	
	Sir Brian Leveson	STI0027
	The Rt Hon the Lord Lilley Peter Lilley, Peer, House of Lords	STI0003
	Medical Justice	STI0025
*	Alex Burghart MP, Parliamentary Secretary, Cabinet Office (QQ 145–160)	
*	Stephanie Needleman, Legal Director, Justice (QQ 47–65)	
*	Emma Norris, Deputy Director, Institute for Government (QQ 66–85)	
	Professor Alexis Jay OBE	STI0026
	Royal Statistical Society	STI0017
*	The Hon Sir John Saunders, Chair, Manchester Arena Inquiry (QQ 1–13)	
	Dr Raphael Schlembach, Principal Lecturer, University of Brighton	STI0002
	Peter Skelton, King's Counsel, 1 Crown Office Row, Temple, London EC4Y 7HH	STI0008
	Miss Amelia Smith	STI0009
	Professor Sir David Spiegelhalter, Emeritus Professor of Statistics, University of Cambridge	STI0007
*	Brian Stanton, former inquiry solicitor and Director, Innovo Law (QQ 14–26)	
*	Ken Sutton, Former Advisor, Hillsborough Independent Panel (QQ 86–113)	
	Thompsons Solicitors Scotland	STI0011
	Dr Stuart Wallace, Associate Professor, University of Leeds	STI0010
*	Bill Wright, Co-chair, Haemophilia Scotland (QQ 47–65)	

APPENDIX 3: CALL FOR EVIDENCE

The inquiry

The House of Lords Statutory Inquiries Committee was set up on 24 January 2024 to "consider the efficacy of the law and practice relating to the Inquiries Act 2005". Its task, in other words, is to consider how well that Act is working, and whether statutory inquiries run as efficiently and effectively as possible, and with the right degree of oversight. The Committee must report by 30 November 2024.

This is a public call for written evidence to be submitted to the Committee. The deadline is 5pm on Friday, 19 April 2024.

An inquiry can be set up by a minister under section 1 of the Inquiries Act 2005 into "a matter of public concern".

The objects of the Act were "to make inquiries swifter, more effective at finding facts and making practical recommendations, and less costly, while still meeting the need to satisfy the public's expectation for a thorough and wide-ranging investigation."

The House of Lords has previously carried out post-legislative scrutiny of the 2005 Act. Its Report was published in 2014 and made 33 recommendations to Government, 19 of which were accepted. As part of its own inquiry, the Committee will be considering the extent to which those recommendations, and in particular those agreed to by the Government, have been implemented.

The questions

The Committee would welcome views on whether the Act has achieved its objectives. It would in particular welcome views on the following issues:

1. Does the 2005 Act provide the right framework for ensuring that inquiries are:

   (a) Effective

   (b) Efficient

   (c) Appropriately overseen, and

   (d) Followed-up?

2. How could the following be improved?

   (a) The Inquiries Act 2005.

   (b) The Inquiry Rules 2006 and the Inquiries (Scotland) Rules 2007.

3. The 2014 House of Lords report made 33 recommendations to the Government, of which 19 were accepted.

   (a) How effectively have the accepted recommendations been implemented?

   (b) Do any of the rejected recommendations still have merit?

4. Since the publication of the 2014 Lords report, how has the use and operation of the 2005 Act changed?

5. Ministers have recourse to statutory and non-statutory inquiries. Should the 2005 Act be amended to reflect or change this in any way?

6. Does the Act ensure that official core participants and wider stakeholders are sufficiently and appropriately involved in the proceedings?

Table 1: 2014 Report recommendations, and Government response

	2014 recommendation	2014 Government response	2024 conclusion
How can the decision to establish an inquiry be improved?			
1	Unless there is a very good reason to use another mechanism, inquiries should normally be held under the 2005 Act, so that witnesses can be compelled to attend.	HMG **rejected** this recommendation, because it felt that ministers should not be constrained from considering other options which may be better suited to the circumstances.	**Discard**: The Committee has heard evidence suggesting that there can be many benefits to non-statutory inquiries. Therefore, the Committee does not feel the need to press this recommendation again.
2	Ministers should have to explain to Parliament why they have ignored a recommendation from an official body to hold a public inquiry.	HMG **accepted** this recommendation, although it did point out that these particular circumstances are very rare.	**Reiterate**: Ministers should be accountable to Parliament about the decisions they take in relation to public inquiries. The present Committee recommends that a new committee of Parliament should scrutinise a Minister's decision not to hold a public inquiry (see chapter 4).
3	Ministers should always give reasons why they have denied a request from a coroner to convert an inquiry to an inquest.	HMG **accepted** this recommendation, although it did point out that these particular circumstances are very rare.	**Reiterate**: Ministers should be accountable to Parliament about the decisions they take in relation to public inquiries. The present Committee recommends that a new committee of Parliament should scrutinise a Minister's decision not to hold a public inquiry (see chapter 4).

	2014 recommendation	2014 Government response	2024 conclusion
How can the chronology of establishing an inquiry be improved?			
4	The Act should be amended so that the minister is obliged to announce the establishment of the inquiry and the selection of an inquiry chair separately.	HMG **accepted** this recommendation but stated that this would require primary legislation, which it had no immediate plans to initiate.	**Reiterate**: The Committee has not heard new, significant evidence on this topic. However, HMG committed to implementing this in 2014 and should do so.
5	The Act should be amended so that the minister must seek the consent of a senior judge if they want to appoint a serving judge to an inquiry.	HMG **accepted** this recommendation in principle, saying that it would put what is already current practice on a statutory footing. However, it had no plans to legislate.	**Reiterate**: Ministers are relying excessively on serving judges for chairing inquiries, to the detriment of the courts system.
6	The Act should be amended so the minister can only appoint a member to the inquiry panel with the consent of the chair (rather than just consulting them).	HMG **rejected** this recommendation, stating that they would always work with the chair to appoint further members and would want to keep the power the appoint who they see fit.	**Discard**: the Committee has heard evidence that panels have advantages and therefore the Minister should have the power to add to the inquiry panel if necessary.
7	The inquiry panel should consist of a single member unless there are strong arguments to the contrary.	HMG **accepted** this recommendation as it helps control the costs of an inquiry.	**Discard**: the Committee has heard evidence that panels have advantages.
8	The Act should be amended so that assessors can only be appointed with the consent of the chair.	HMG **rejected** this recommendation, stating that they would always work with the chair when appointing assessors and would want to keep the power the appoint who they see fit.	**Reiterate**: The Committee has heard some new evidence on the importance of inquiry independence.

	2014 recommendation	2014 Government response	2024 conclusion
9	The Act should be amended so that consent of the chair is needed for the minister to set (or amend) the terms of reference.	HMG **rejected** this recommendation, stating that while they would always work with the chair to design or change the terms of reference, the minister should keep control of this.	**Reiterate** (in modified form) The Committee has heard some new evidence on the importance of inquiry independence. The Minister should need the consent of the chair to change the terms of reference of the inquiry once it is underway, as this helps maintain the independence of the inquiry. However, the Minister should be able to set the terms of reference at the outset of the inquiry. A new Public Inquiries Committee can write to the Minister regarding the terms of reference.
10	The Act should be amended so that when the minister announces an inquiry, they set out only draft terms of reference. The final terms of reference should (when agreed with the chair) be the subject of a further statement.	HMG **rejected** this recommendation, stating that it would be "neither practical nor sensible for there to be two sets of terms of reference". This appears to contradict their view that "on announcing an inquiry, ministers will invariably set out the broad scope of the inquiry which will then be finessed for the formal announcement of the terms of reference."	**Reiterate**: this would give time for interest groups and parliamentarians to consider the terms of reference.
11	Interested parties, particularly victims and victims' families, should be given an opportunity to make representations to the minister about the final terms of reference.	HMG **partially accepted** this recommendation, stating that in some instances it could lead to wider acceptance of the inquiry findings, but in other cases could slow down the inquiry.	**Reiterate**: we have heard how the involvement of victims and survivors can increase the overall legitimacy of an inquiry.

	2014 recommendation	2014 Government response	2024 conclusion
How can the practicalities of running an inquiry be improved?			
12	HMG should make resources available to create an “inquiries unit” within HMCTS which would be responsible for all the practical details of setting up an inquiry (including infrastructure, IT and staffing).	HMG **rejected** this recommendation because a standing operational team would have a limited role once an inquiry was established. Instead, Cabinet Office processes to support inquiry establishment should be improved and a practitioners’ forum for inquiries should be established to share best practice.	**Implemented**: an Inquiries Unit was established in the Cabinet Office.
13	A new inquiries unit should ensure that at the end of an inquiry, the secretary delivers a full ‘lessons learned’ paper.	HMG **accepted** that ‘lessons learnt’ papers should be produced and said that the Cabinet Office would take a more proactive role in collecting these. However, HMG did not accept that an inquiries unit should be established.	**Reiterate**: see chapter 5
14	A new inquiries unit should update Cabinet Office inquiries guidance and publish it on the Ministry of Justice website.	HMG **accepted** that inquiries guidance should be updated and published online but said that this should be done by the Cabinet Office.	**Reiterate**: see chapter 5
15	A new inquiries unit should also retain the contact details of previous secretaries and solicitors and be prepared to put them in touch with staff of new inquiries.	HMG **accepted** this but said that this should be done by the Cabinet Office, rather than a new inquiries unit.	**Reiterate**: see chapter 5
16	A new inquiries unit should collate protocols of procedure issued by inquiries and make them available to subsequent inquiries.	HMG **accepted** this but said that this should be done by the Cabinet Office, rather than a new inquiries unit.	**Reiterate**: see chapter 5

	2014 recommendation	2014 Government response	2024 conclusion
17	Inquiry officials should consult the new inquiries unit and the Treasury Solicitor to ensure that counsel are appointed on terms which give the best value for money.	HMG **accepted** this but said that this should be done by the Cabinet Office, rather than a new inquiries unit.	**Reiterate**: see chapter 5
18	A scoping exercise should be carried out by the staff involved in planning a new inquiry to examine all the key issues, in particular to address matters of timescale and cost.	HMG **accepted** this recommendation.	**Reiterate**: see chapter 5
How can the independence of an inquiry be guaranteed?			
19	The Act should be amended to remove the minister's power to restrict public access to an inquiry, as the chair's power to do this is sufficient.	HMG **rejected** this on the basis that only the minister may have a full understanding of the national security implications of inquiry proceedings.	**Reiterate**: The Committee has not heard any compelling evidence on this topic specifically, but the Committee has heard some new evidence on the importance of inquiry independence generally.
20	The Act should be amended so that (apart from cases of national security) only the chair can withhold information from publication.	HMG **rejected** this on the basis that the inquiry chair should not be responsible for judging any risks to national security. However, this recommendation specifically excepted national security.	**Reiterate**: The Committee has not heard any compelling evidence on this topic specifically, but the Committee has heard some new evidence on the importance of inquiry independence generally.
21	The Act should be amended so that if a minister wishes to dismiss a panel member, they must first seek the permission of the chair.	HMG **rejected** this on the basis that ministers should have flexibility to make and terminate appointments and that they would always work with the Chair to do so.	**Reiterate**: The Committee has not heard any compelling evidence on this topic specifically, but the Committee has heard some new evidence on the importance of inquiry independence generally.

	2014 recommendation	2014 Government response	2024 conclusion
22	The Act should be amended so that if the minister wishes to terminate the appointment of the chair, they should explain the reasons for this to Parliament.	HMG **accepted** this recommendation in principle, saying that it would put what is already current practice on a statutory footing. However, it had no plans to legislate.	**Reiterate**: the Minister should write to the new Public Inquiries Committee to explain the reasons for their decision.
How can the procedure of inquiry hearings be improved?			
23	The Act should be amended so that only the chair can appoint counsel to the inquiry.	HMG **rejected** this, stating that as the appointment of counsel affects budgets and the interpretation of the remit, HMG should choose them.	**Reiterate**: The Committee has heard some new evidence on the importance of inquiry independence.
24	The fourth and sixth Salmon principles (right to examination by one's own counsel and cross-examination of evidence) are over-prescriptive and led to an adversarial, rather than inquisitorial, approach. They should be disregarded and the Chair should be relied on to ensure that the inquiry is carried out fairly.	HMG **rejected** this, stating that Rule 10 of the Inquiry Rules 2006 sets out very limited circumstances in which these rights can be exercised. The Rules place the responsibility for arbitrating this on the chair.	**Reiterate**: the Committee received considerable evidence on adversarial procedure. Inquiries should be primarily inquisitorial and chairs should use the flexibility inherent in the rules to avoid adversarial proceedings. This should be the subject of guidance.
25	Rules 13–15 of the Inquiry Rules 2006 (on warning letters) are too complex. They should be revoked and replaced with a simpler rule, to save time and avoid difficulties with interpretation.	HMG **rejected** this recommendation but did not address the main criticism that the rules are too detailed.	**Discard**: The Committee has heard how improvements to the warning letter process are possible within the Rules. This should be the subject of guidance.

	2014 recommendation	2014 Government response	2024 conclusion
26	Rules 2 and 18 should be amended to give discretion on which documents should be included in a permanently archived record, to reduce the quantity of unimportant documents preserved.	HMG **accepted** this recommendation.	**Reiterate**: The Committee has not heard new, significant evidence on this topic. However, HMG committed to implementing this in 2014 and should do so.
27	Rule 9 should be amended so that the inquiry can take written evidence directly from a witness, rather than having to go via a witness's solicitor.	HMG **accepted** this recommendation.	**Reiterate**: This continues to be a problem. HMG committed to implementing this in 2014 and should do so.
28	Rules 20–34 (on awarding expenses) are over-prescriptive and should be simplified.	HMG **accepted** this recommendation but warned that any new regime should be cost effective.	**Reiterate**: The Committee has not heard new, significant evidence on this topic. However, HMG committed to implementing this in 2014 and should do so.
29	Rules 18 and 20 should be repealed and amended, respectively, to continue FoI exemption for inquiry records beyond the conclusion of the inquiry.	HMG **rejected** this recommendation on the basis that the records of non-statutory inquiries cannot be protected too and that there should be transparency for inquiry records.	**Reiterate**: The Committee has not heard new, significant evidence on this topic specifically. However, the Committee has heard evidence advocating that proceedings should be inquisitorial in nature and that witnesses should be able to speak candidly to inquiries, without fear of reputational damage as result.
Government responses to inquiries			
30	When Government responses are laid before both Houses, they should be accompanied by a statement. The response should also clearly state which recommendations are accepted.	HMG **accepted** this recommendation, with the caveat that it would not be possible if this had national security implications.	**Reiterate**: see chapter 4

	2014 recommendation	2014 Government response	2024 conclusion
31	If an inquiry makes recommendations which pertain to a public body, the body should have a statutory duty to respond.	HMG **accepted** this but said that the duty should be voluntary and not statutory.	**Discard**: the new Public Inquiries Committee can follow-up the responses of public bodies.
32	Responses should be published within three months, with reasons being given when recommendations are not accepted. HMG should explain how recommendations should be fulfilled. Reports should have an implementation plan and there should be follow-up reports issued to Parliament annually.	HMG **accepted** this recommendation, but with a six-month response period, rather than three.	**Reiterate**: see chapter 4
Summary			
33	The Act and Rules should be fit for purpose so that the vast majority of public inquiries can take place under their authority.	HMG **rejected** the idea that inquiries should take place under the Act by default.	**Discard**: The Committee agrees the Act and Rules are generally fit for purpose, but has heard evidence that there can be situations in which a non-statutory inquiry is more appropriate.

APPENDIX 5: SPECIFIC EXAMPLES OF GOOD PRACTICE IN RUNNING AN INQUIRY

During the course of our inquiry, we heard many different examples from witnesses in written and oral evidence of good practice in running an inquiry, and suggestions for ways in which some inquiries might be better run. It is not the aim of this Report to make detailed recommendations on best practice. Indeed, our [cross ref to Chapter 2 conclusion and recommendation] is that Ministers and chairs ought to be alive to the different options for conducting an inquiry that are available to them, and be advised on those by the expanded Inquiries Unit (cross ref Chapter 5) on the ways in which they might suit different sets of circumstances.

The purpose of this Appendix of to record the examples that we heard about, so that they are not lost, and can be considered and taken forward by the Inquiries Unit, in improving and expanding their guidance to sponsoring Ministers and departments, as they see fit.

Improving the efficiency of inquiries

Preventing the recurrence of a disaster should be a key focus of inquiries. **Aviation accident inquiries** are a good example of how to focus on learning lessons from an event. "Their overriding priority is to learn how to make us safer in future—not to apportion blame for the past."[169]

The increasing quantity of documentary evidence risks increasing the length of time an inquiry takes. **A proportionate approach** is important in dealing with a large amount of material.[170] Inquiries only need look at a sufficient number of examples to make recommendations about how public policy should be changed.[171] Inquiries should be realistic and make it clear that "there is a trade-off between the inquiry being conducted in a timely manner and a more proportionate approach being taken to disclosure." The Covid Inquiry was given as an example of one following this approach.[172]

Inquiries should make use of **statistical expertise**.[173] An inquiry's terms of reference should include information about how statistical evidence will be investigated and handled.[174] The Infected Blood Inquiry was a good example of how statistical analysis can be used.[175]

The length of time that it takes for a final Report to be published by an inquiry can be improved by a **modular approach**, and the publication of interim reports.[176]

There is often a "bureaucratic gap" while an **inquest is converted to an inquiry**, when no work can be done.[177]

169 Written evidence from Lord Lilley (STI0003)
170 Written evidence from Eversheds Sutherland (International) LLP (STI0016)
171 Written evidence from Sir Brian Leveson (STI0027)
172 Written evidence from Matthew Hill (STI0021)
173 Written submission from Professor Sir David Spiegelhalter (STI0007), Written evidence from RSS (STI0017), Written evidence from Professor Alexis Jay OBE (STI0026) Written submission from Professor Sir David Spiegelhalter (STI0007)
174 Written submission from Professor Sir David Spiegelhalter (STI0007), Written evidence from RSS (STI0017)
175 Written evidence from RSS (STI0017)
176 Q 30 (Nathan Critch)
177 Written evidence from Jason Beer (STI0015)

The involvement of victims, survivors and the bereaved

Hearing rooms can often be set out to look like a court hearing. The **layout of inquiry rooms** should be considered more carefully. There are good examples of ways of ensuring those directly affected are seated at the heart of the inquiry.[178]

There should be more efforts to engage those affected by a public disaster.[179] The Inquiries Unit might "be supported by an **independent advisory board** to enhance the involvement of victims and survivors."[180] A number of witnesses referred to the **Truth Project**,[181] set up as part of the Independent Inquiry into Child Sexual Abuse (IICSA), as a good example of how a large group of victims and survivors can be included in an inquiry, and their experiences recognised and acknowledged.[182] **Pen portraits** can be used to put victims and victims' groups at the heart of an inquiry's work.[183] Inquiries also offer an opportunity for **community rehabilitation projects** to be run in tandem with inquiries for affected families.[184]

Good practice exists in how best to **take evidence from witnesses** most closely affected by the subject of an inquiry.[185] Successful processes have also developed "for the giving of human impact evidence in the course of an inquiry."[186] Thought should be given to the use of **sensitive and inclusive language.**[187] Key staff on inquiries should receive "basic training in a **trauma-informed approach** to dealing with people."[188] There are examples of professionals also being trained in tragedy and trauma.[189]

The Secretariat and other logistical arrangements

Civil servants are concerned that working for an inquiry is not seen as a means of **career progression**. There should be a career path for inquiries in the Civil Service.[190]

The description 'secretary to an inquiry' is not widely understood. Inquiries should instead have **CEOs**.[191]

178 Q 17 (Mark Fisher)
179 Written evidence from Matthew Hill (STI0021), Written evidence from Frederick Way and Dr Karl Mackie (STI0022)
180 Q 57 (Stephanie Needleman)
181 Written evidence from Professor Alexis Jay OBE (STI0026)
182 Q 11 (Brian Altman KC), Q 59 (Stephanie Needleman) , Written evidence from Dr Raphael Schlembach (STI0002), Written evidence from Frederick Way and Dr Karl Mackie (STI0022)
183 Written evidence from Eversheds Sutherland (International) LLP (STI0016), Q 44 (Dr Emma Ireton)
184 Written evidence from Frederick Way and Dr Karl Mackie (STI0022)
185 Written evidence from The Bar Council (STI0023), Written evidence from Dr Emma Ireton (STI0012)
186 Written evidence from Dr Raphael Schlembach (STI0002)
187 Q 100 (Ken Sutton), Q 100 (Bishop James Jones)
188 Q 20 (John O'Brien)
189 Q 101 Bishop James Jones
190 Q 22 (John O'Brien)
191 Q 19 (John O'Brien)