Written evidence from the Institute for Government (RCC27)

Public Administration and Constitutional Affairs Committee
Responding to Covid-19 and the Coronavirus Act 2020 inquiry

Summary

There should be a public inquiry into the government's response to the coronavirus pandemic. We set out the key points we argue in this document below:

- The inquiry should be convened as a statutory inquiry under the 2005 Inquiries Act. While this sacrifices some of the procedural flexibility that a non-statutory inquiry would have it ensures that the inquiry will have the necessary powers to fully investigate the issue.
- This inquiry will be complex – to ensure that it is both timely and effective it should modularise its investigations, deliver its findings via interim reports, and recruit staff with prior experience of inquiries to speed up its establishment.
- In addition to a full public inquiry, a non-statutory rapid review should be instigated by government at the earliest opportunity to learn lessons about government's response ahead of any second wave.
- Delivering lasting change is a crucial purpose of every public inquiry. An inquiry into the coronavirus crisis needs to have a strong focus on lesson learning and policy improvement. Accountability cannot be separated from this endeavour – learning is a crucial component of accountability.
- The inquiry needs an impartial and independent chair who commands public trust. This could be a current and former judge, or a former senior official, or other skilled professional with relevant expertise, independence and impartiality. Whoever is appointed as chair should be supported by a panel of non-partisan experts who bring together a broader set of knowledge, experience and perspectives to the inquiry. These might include former officials, scientists, or healthcare/public health professionals.
- The terms of reference should be drafted in consultation with the public, under the direction of the chair and their panel. There should be room for the chair to update the terms of reference as the initial stage of the inquiry develops.
- Most importantly: too often public inquiries have failed to translate their findings into lasting change. This must not be allowed to happen in any inquiry into coronavirus. We recommend the following to ensure an inquiry leads to change:
- The chair and panellists should consider how they can continue to advocate for and monitor the implementation of their recommendations, drawing on the examples of Lord Laming, who developed a detailed implementation plan as part of his report into the death of Baby P[1] and Lord Bichard, who informally reconvened his inquiry into the Soham tragedy six months after the publication of his report to consider how well the recommendations were being implemented.[2]
- The inquiry should identify people with experience of making policy to help develop recommendations that are ready to be implemented, either through the use of an expert panel and/or through the seminar mechanism used in previous inquiries including the Bristol Inquiry.

- Departments which are subject to recommendations should create transparent reporting mechanisms so that Parliament and the public can track the implementation of recommendations.
- Parliament has a crucial role in holding the government accountable for its implementation of any recommendations that an inquiry makes. Parliamentary select committees should scrutinise the implementation of recommendations – calling ministers and senior officials to report on the progress of their departments.

This is an evidence submission on behalf of the Institute for Government, prepared by Marcus Shepheard (Senior Researcher) and Emma Norris (Director of Research). The Institute for Government works to make government more effective, and we have a long-standing interest in public inquiries. Our previous research in this area has focused on how inquiries can effectively deliver lasting positive change.[3]

Introduction

An inquiry into the government's response to the coronavirus crisis would be an unusual case – inquiries where a sitting government investigates its own actions and decisions are rare. However, there are examples and we note five precedents:

- The Falkland Islands Inquiry was established by Margaret Thatcher in 1982 to consider "the way in which the Government Departments concerned had discharged their responsibilities in the period leading up to the invasion of the Falkland Islands".[4] This inquiry – convened as a 'Committee of Privy Councillors' provided the model for the Butler Review and Iraq Inquiry.
- The Hutton Inquiry was a non-statutory inquiry established by Lord Falconer in July 2003, to investigate the death of David Kelly, a weapons expert.
- The Butler Review was a non-statutory inquiry established by Jack Straw "to review intelligence on weapons of mass destruction".[5] This inquiry would build on earlier investigative work done by the Commons Intelligence and Security and Foreign Affairs Select Committees.[6]
- The Iraq Inquiry was a non-statutory inquiry established by Gordon Brown to investigate the decisions made by the Labour government in the run-up to the invasion of Iraq.[7] The scope of the inquiry included what was known in advance, and how ministers used that information to make decisions.
- The RHI Inquiry was established in January 2017 by Máirtín Ó Muilleoir, the Sinn Fein Minister for Finance in the Northern Ireland Executive to examine "why the botched RHI scheme went wrong and the circumstances surrounding it".[8] This inquiry is notable for being convened under the 2005 Inquiries Act.

While none of these inquiries specifically consider a disease outbreak the theme of their focus is akin to what an inquiry into the government's response to coronavirus might consider – what was known about the virus, when, how was that information used to make decisions, and how were those decisions implemented?

Since 1990 there have been several inquiries looking at how the government has handled disease outbreaks. The BSE inquiry – established by a Labour government in 1997 – looked back to how the BSE epidemic had been managed under the previous Conservative government. The Foot and Mouth Inquiry – established in 2001 – considered how the then-Labour government had managed that crisis itself. These were national outbreaks, and the inquiries looked closely at how decisions were made in central government. These inquiries contrast with others such as the Pennington Group Inquiry (1996-97), the Inquiry into 2005 Outbreak of E. coli O157 in South Wales (2005-09), the Northern Trusts Inquiry (2008-11) and the Vale of Leven Hospital Inquiry (2009-14) which were more focused on the specific failings of parts of the healthcare system during a localised disease outbreak.

There have also been other inquiries where a sitting government has investigated the decisions, actions, or behaviour of its own ministers. The Scott Inquiry was established by John Major in 1992 to investigate earlier decisions made by Conservative ministers relating to the sale of arms to Iraq. Similarly, the Sierra Leone Arms Investigation in 1998 and the Hammond Inquiry in 2001 both dealt with the actions of Labour ministers. These have less direct bearing on the coronavirus inquiry, but we note them as further examples of inquiries that have been directed towards members of the sitting government.

1 - What form is the most appropriate for an inquiry into the UK response to the Coronavirus pandemic? Should it be a statutory inquiry and, if not, what form of non-statutory inquiry should be held?

There are benefits and drawbacks to both models for an inquiry. Here, we set out some of the key features, benefits and drawbacks of both types of inquiry.

Non-statutory public inquiries

Several non-statutory inquiries have been convened as a 'Committee of Privy Councillors'. The Falkland Islands Inquiry established the modern form of this and Margaret Thatcher, when announcing the, outlined what she saw as the advantages of this model:

> *The overriding considerations are that it should be independent, that it should command confidence, that its members should have access to all relevant papers and persons and that it should complete its work speedily. Those four considerations taken together led naturally to a Committee of Privy Councillors. Such a Committee has one great advantage over other forms of inquiry. As it conducts its deliberations in private and its members are all Privy Councillors, there need be no reservations about providing it with all the relevant evidence—including much that is highly sensitive—subject to safeguards upon its use and publication.*
>
> *A Committee of Privy Councillors can be authorised to see relevant departmental documents, Cabinet and Cabinet Committee memoranda and minutes, and intelligence assessments and reports, all on Privy Councillor terms.*[9]

Jack Straw (Foreign Secretary) cited Franks as the model when establishing the Butler Review.[10] Similarly, Gordon Brown, when he established the Iraq Inquiry, noted that the Cabinet Secretary (then Gus O'Donnell) had advised "that the Franks inquiry is the best precedent."[11] When discussing the decision to establish the Iraq as a Privy Councillor Inquiry rather than under the 2005 Inquiries Act Jeremy Heywood (then Cabinet Secretary) remarked:

> *we had a conversation about that and discussed it with internal experts and we don't believe it would have speeded things up. We don't think it would have saved costs. We don't think it would have led to a better, more comprehensive, more credible outcome, so that is our position.*[12]

This made sense as both inquiries shared similar questions at their heart – the decisions made in the run-up to a war. In contrast the BSE Inquiry was established using the Scott Inquiry as its model.[13] **Notably all of these inquiries, with the exception of the Iraq Inquiry, were established long before the 2005 Inquiries Act.**

There has been a prevailing view that non-statutory inquiries are less confrontational and could rely on the support of the government that established them. There has been a presumption that the willingness to establish the inquiry connotes a similar willingness to cooperate with the it. When he announced the Iraq Inquiry Gordon Brown stated:

> *The inquiry will receive the full co-operation of the Government. It will have access to all Government papers, and the ability to call any witnesses.*[14]

There are few examples of outright hostility towards and inquiry from government, however **non-statutory inquiries have no inherent safeguards against this and rely on good will and cooperation to conduct their business.**

Statutory public inquiries

All ten of the ongoing public inquiries are statutory inquiries convened under the 2005 Act. A statutory inquiry has a range of powers that non-statutory inquiries do not, most notably the power to compel individuals to provide documents or testimony. Statutory inquiries can take sworn evidence under oath, meaning that a witness who lies perjures himself.[15]

Statutory inquiries have less procedural flexibility than non-statutory inquiries, in particular they must hold most of their proceedings in public, with a few narrow exceptions. However, this should not prove problematic for an inquiry into coronavirus. Many of the non-statutory inquiries we have noted needed to deal with substantial amounts of sensitive material relating to national security so private proceeding were necessary. This is unlikely to be the case with an inquiry into coronavirus and as such there should be an expectation that it would conduct its business in public. A statutory inquiry would support this ambition.

There are also considerations relating to Article 2 of the Human Rights Act which would favour a statutory inquiry.[16]

Statutory inquiries do not take longer or cost more than non-statutory inquiries

Prior to the inquiries act it was the case that statutory inquiries took longer than non-statutory inquiries, almost three times as long. However, since the 2005 Act this has not been the case, largely because non-statutory inquiries have started taking as long as statutory ones.

	Type of inquiry	Number	Median length (days)
Pre-2005	Non-statutory	17	347
	Statutory	24	1111.5
Post-	Non-statutory	6	1262

2005			
	Inquiries Act 2005 (Completed inquiries)	15	1133
	Inquiries Act 2005 (Including ongoing inquiries)	25	1114

The costs of public inquiries are not widely reported or easy to compare, however it seems that again there is little difference between the costs of statutory and non-statutory inquiries. Eighteen statutory inquiries since 2005 reported a median cost of £5.7m while two non-statutory inquiries in the same period reported a median cost of £7.7m. Ultimately the cost and length of an inquiry is largely determined by its scope, not its precise form, and we do not believe that time and cost should be a strong consideration when choosing whether to hold a statutory inquiry or a non-statutory one.

Conclusion

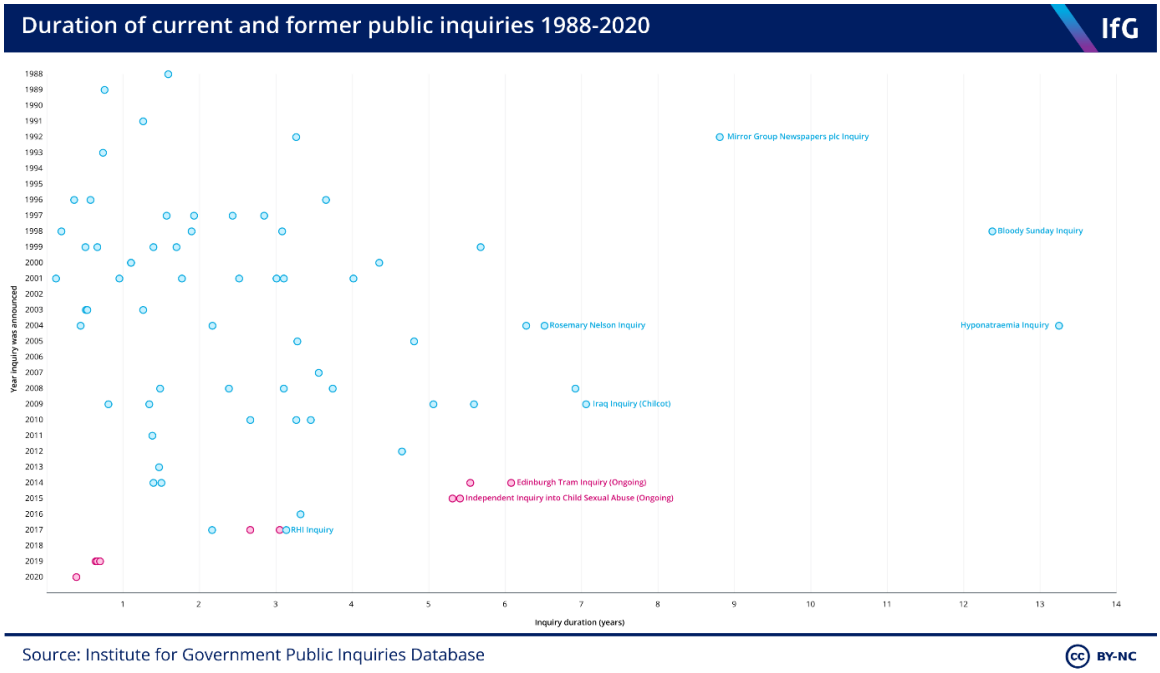
There are pros and cons to both forms of inquiry. The main case for non-statutory inquiries is that they are less confrontational, provide more procedural flexibility in some places, and have historically been cheaper and quicker to run. It is clear from recent experience that there is no difference in how long the different forms of inquiry take, or how much they cost. This is predominantly determined by their scope and other factors. Statutory inquiries have a set of powers around the compulsion of the release of documents and calling witness and the requirement for witnesses to give evidence under oath that make them a more powerful form than non-statutory inquiries.

A public inquiry into the UK's response to the coronavirus pandemic should be convened as a statutory inquiry under the 2005 Act. This would ensure that the inquiry has the necessary powers to do its business and will best assure that the proceedings are as public as possible.

2 - How should the balance between comprehensiveness and timeliness be managed? Can a single inquiry be both comprehensive and timely?

Public inquiries take time. There have been at least 64 inquiries which have completed and published a report since 1990. Of these 50 (78%) took four years or less, only 12 (19%) took less than a year. There are currently a further ten inquiries ongoing, four of which have been running for more than four years.[i]

[i] The Undercover Policing Inquiry, The Independent Inquiry into Child Sexual Abuse, The Scottish Child Abuse Inquiry, and the Edinburgh Tram Inquiry



There are several reasons why inquiries can take so long:

- The work involved with any inquiry is time-consuming. It is not uncommon for an inquiry to need to review millions of documents and take evidence from hundreds of people. This process of considering the evidence prolongs them.[17]
- The scope of each inquiry – as determined by its terms of reference – will also directly influence their length. The broader its scope the more questions an inquiry must answer, and the longer it will take.
- Inquiries have no legal power to determine civil or criminal liability.[18] As such, many inquiries have had to give way to police investigations or legal cases, which have generally taken precedence. This leads to unavoidable delays. This was most notably the case in the Inquiry into Hyponatraemia-related deaths, which took almost six and a half years to hold its first oral hearings.
- Many inquiries have also suffered delays due to avoidable organisational issues. The work it takes to establish the inquiry – such as locating space for offices and hearing chambers, setting up IT systems, and hiring staff – is often more time-consuming than it should be. Similarly, staff churn has prolonged inquiries in the past. This is a particular issue if the chair needs to be replaced, which has happened several times – most notably with the Independent Inquiry into Child Sexual Abuse, which went through four different chairs in just over two years.

Any inquiry into the government's handling of the coronavirus pandemic will be multifaceted and complex. It will cover questions about the decision-making process at the heart of government, the provision of healthcare in response to the pandemic, how prepared services were for this type of emergency and so on. There are some steps which might help expedite any inquiry – or ensure that urgent questions are dealt with quickly:

- There is an urgent need to prepare for a potential second wave of the virus – including by drawing lessons from government's response to date and our increased knowledge

of the virus. To do this, government should urgently establish a non-statutory rapid review of key questions in advance of a full inquiry to help the government prepare for a second wave.[19] The interim report on the London Riots provides one model for this. [20]

- The inquiry may benefit from modularisation – this has been done with large inquiries such as the Baha Mousa Inquiry and the Independent Inquiry into Child Sexual Abuse (IICSA) to help manage the large volume of information.[21] This can be done if the questions that the inquiry seeks to answer are sufficiently discrete. In this case it may be possible to, for instance, separate questions about what was known and how the government used that information to make decisions from questions about how healthcare was delivered in hospitals during the crisis. The decision of how feasible it is to split up these questions, and how to do so, lies with the chair and their panel.[22]
- The full inquiry should produce an interim report to share initial findings as quickly as possible – rather than holding back all material for a full and final report. Many inquiries have followed this model in the last decade (e.g. the Grenfell Inquiry and the Independent Inquiry into Child Sexual Abuse).
- Enlisting experienced staff will help get the inquiry up and running more quickly – and should help it run as effectively as possible over time. Despite the number of inquiries that have been held, the process of establishing them has been a trial-and-error process for many people involved. Chairs and secretaries of inquiries describe being 'thrown in the deep end' and spending long periods of time on basic organisational tasks such as securing premises and setting up IT.[23]. In order to avoid this situation for any coronavirus inquiry, the Cabinet Office Inquiries Unit should provide support and expertise on organisational set-up and the government should appoint at minimum a secretary, counsel and solicitor to the inquiry who all have previous experience of public inquiries.
- Historically there has been a lack of good guidance on how to set up and run an inquiry, this means that the process is often inefficient and slower than it should be.[24] To support the speedy and effective establishment of the inquiry the government should also expedite the publication of the new Public Inquiry Guidelines, currently being drafted by the Cabinet Office.

3 - Should the purpose of the inquiry be on accountability or more forward-looking, focused on lesson learning and improving policy?

Every public inquiry must satisfy three broad questions: what happened, who was responsible and how do we prevent this happening again?[25] The first two questions satisfy the issue of accountability, while the third satisfies the need for learning and change. It is challenging to answer the third question without answering the first two – any public inquiry must implicitly resolve the issue of accountability in order to address the issue of change.

The Institute for Government firmly believes that delivering lasting change is a crucial and inseparable purpose of every public inquiry. As we have written previously:

> *Inquiries should also aim to change the systems that gave rise to the tragedies in the first place and to prevent recurrence. This objective – to be forward-looking, to improve government and public services, and to prevent the same mistakes from being made again – is the most important contribution that an inquiry can make to the*

wider public interest. Government has itself argued that this is the key purpose of an inquiry[26]

Any inquiry into the coronavirus crisis should have a strong focus on lesson learning and policy improvement from the outset. This purpose should be explicit within the terms of reference, which should not only require the inquiry to make recommendations, but also describe the contours of an implementation process – including oversight – that will follow the investigatory phase of the inquiry. This is not separate from accountability - learning is a crucial component of accountability.[27]

4 - How wide should the inquiry range? Should it include the devolved administrations?

The inquiry should focus first and foremost on decision-making at the heart of government. Its remit should include what was known, how this information was used to make decisions, who was involved in that process, and how these decisions were then implemented and, crucially, communicated to the public.

Given the UK-wide scope of the crisis it makes sense for any inquiry to be given a remit that covers the whole of the UK. It should be able to call ministers from the devolved administrations – both to give evidence on the actions they took and their experience of working with the UK government. The inquiry should consider how well the UK government worked with the devolved administrations throughout the crisis.

It would arguably be inappropriate for the UK government to establish an inquiry into the decisions and actions made by a devolved administration. Especially when many of the most pertinent questions sit in reserved areas. An inquiry should focus on questions where the UK government has been responsible for coordinating a UK-wide response. For example: procurement of PPE and ventilators, and the development of novel testing capacity. For decisions such as the timing of lockdowns and the enforcement of social distancing rules, where the devolved governments have responsibility, it would make sense for them to conduct their own inquiries.

5 - What experience and qualities should the Chair have?

Public inquiries have a had a range of chairs over the years. There have been at least 74 public inquiries since 1990, with at least 70 different people serving as chair to one or more inquiries.[ii] Two thirds of all chairs have been current or former judges, and a quarter have been barristers. The remaining 10% (7/70) have other backgrounds including: scientists, accountants, social workers, civil servants, engineers, and clergy. It is important that the government takes time to identify the right chair.

Current or former judges are well-suited for this role, they are skilled investigators and have a wealth of experience piecing together historical events from fragmentary, often contradictory evidence. They also take an oath of office that requires them to be politically neutral and judicial chairs have stood by this principle in all recent inquiries. Judges are also relatively

[ii] Several individuals have chaired multiple inquiries: William Cullen, Baron Cullen of Whitekirk (4), Tony Clarke, Baron Clarke of Stone-cum-Ebony (3), George Penrose, Lord Penrose (2), Michael Redfern QC (2), Professor Hugh Pennington (2), Professor John Uff (2), Ranald MacLean, Lord Maclean (2). Similarly several inquiries have had multiple chairs, most recently the Independent Inquiry into Child Sexual Abuse, which has had four chairs since being established.

easy to appoint – the government can simply ask for a recommendation from the Lord Chief Justice.

However, one possible downside of appointing a judge is that – quite rightly, by nature of their training and experience - judges tend to see the end of an inquiry as a hard point of separation, after which their involvement ceases. However, such a wall between an inquiry and its aftermath can mean inquiries lose one of the most effective advocates for their recommendations.

In some cases, non-judicial chairs have had more continued involvement – treating their report and its recommendations as a beginning, rather than an end in itself. For instance, Baron Laming, a former social worker who chaired the inquiry into the death of Victoria Climbié and the Review of Child Protection in the wake of the Baby P case, developed detailed implementation plans as part of his roles and Lord Bichard informally reconvened his inquiry into the Soham Murders six months after the publication of his report.[28]

Non-judicial chairs may also bring more domain expertise and a focus on implementation, but can lack a judge's investigative skills, experience of running hearings and other benefits. This is a balance that the government will need to weigh when selecting a chair.

Any chair selected to lead an inquiry must possess impartiality and independence. These qualities are more important than any specific domain knowledge that a chair might need, which can be met by the appointment of a panel and other technical assessors. Given the very difficult nature of the questions that an inquiry into the government's response to coronavirus will likely have to consider, it is imperative that the chair is considered an independent actor.

In addition to their role as investigators, chairs are also charged with a powerful moral authority. It is vital that any chair is capable of empathising with the victims of the crisis and articulating their loss.

6 - Should the Chair be supported by a panel? If so, what knowledge and experience must the panel include?

Any inquiry into this crisis would benefit from being led by a panel. There is plenty of precedent for this, the BSE Inquiry, the Butler Review, the Iraq Inquiry and the RHI Inquiry are comparable inquiries which had panels.[iii] These panels broadened the expertise around the chair. In the case of the BSE inquiry this meant adding a civil servant and geneticist to support the judicial chair with a deeper understanding of how government operates and the science of disease. For the Iraq inquiry the panellists included two historians, a former senior diplomat, and crossbench peer. Sir John Chilcot, the chair, commented favourably on the benefits of a panel for this type of inquiry in evidence to Parliament:

> *I think for an inquiry into the workings of central Government in a very critical and controversial area, there is real advantage of having an independent committee of people with direct experience of the workings of Government in that way. I think that it would be more difficult for a judge, operating with counsel through a cross-examination, to arrive at well-judged conclusions in that particular individual situation.*[29]

[iii] See appendix for lists of panellists

More recently the RHI inquiry appointed Dame Una O'Brien, the former permanent secretary at the Department of Health, as its statutory panel member. Her expertise of the workings of central government supported the work of the chair Sir Patrick Coghlin, a judge.

We believe that an inquiry examining the government's response to coronavirus would benefit from a panel. This inquiry is likely to be complex, with a broad scope. A panel would bring a broader range of experience into the heart of the inquiry, enabling it to come to effective conclusions. Areas of expertise which panellists might have would likely include (but not be limited to) the following:

- Experience of working at the heart of government – for example a former permanent secretary.
- Experience of working in healthcare – for example a senior doctor, or the leader of a healthcare trust.
- Experts in epidemiology and public health.
- Experience working with victims.

One further general benefit of a panel is that it helps bring in individuals with experience of policy making and implementation at the highest level of an inquiry. This could help the inquiry to draft better recommendations and thus improve the chances that we see the lasting changes that are needed.

The inquiry could also look to the Independent Panel model that has been largely developed by Bishop James Jones. The Hillsborough and Gosport Independent Panels are a form of non-statutory inquiry which have found success resolving issues of major public concern.[30,31] In both cases the chair was supported by a panel of eight people from a wide range of professional backgrounds.

7 - How should the Terms of Reference be agreed? Should consultation be undertaken first and, if so, how should this be conducted?

The terms of reference for an inquiry offer the clearest exposition of its aims. Decisions on the wording of the terms of reference influence how the inquiry is run, how long it will take, how much it will cost and how it can effect change.[32] As such, being clear and direct in the terms of reference about which of the many potential purposes of inquiries is being pursued is critical. This will ensure that the inquiry is run in a way that supports these aims and importantly will help to avoid disappointment or disillusionment at the end of an inquiry.[33]

Terms of reference have been getting longer over time. This reflects a growing focus on detailed and specific questions within terms of reference, instead of the vague instructions to 'investigate such and such event' that had been common previously. Modern terms of reference are also – where appropriate – better at setting out the need for recommendations as a core part of the inquiry.[34]

Getting the terms of reference right is crucial. Vague or overbroad terms make it harder to run a timely inquiry. However, there is often pressure from those affected by the events that precipitated an inquiry to set broad terms of reference.[35] This needs to be balanced carefully. As we have argued previously:

Wide-ranging remits can also compromise the 'primary purpose of an inquiry',[36] which speaks most to the public interest: the opportunity to learn from what went wrong and prevent recurrence. Lengthy, broad and expensive inquiries can delay or constrain change. In the case of the Chilcot Inquiry, for instance, the remit was so wide that the inquiry took seven years and the report came so long after the events being examined that the window of opportunity for change had closed; systems and institutions had already moved on.[37] If very public mistakes have been made or there is a danger of recurrence, then lessons need to be drawn as soon as possible. Applying a narrower focus can ensure that inquiries deliver more efficiently, and may therefore be able to influence change more effectively.[38]

Historically the terms of reference were often set out at the moment when an inquiry was announced. But conventions around terms of reference are changing. Increasingly inquiries are being established without firm terms of reference to allow time for consultation with victims, other affected groups, or the wider public:

- The Paterson Inquiry was announced in December 2017, but the terms of reference were not published until March 2018. The chair had "worked with affected families to ensure their views are taken into account in shaping the terms of reference"[39]
- The Infected Blood Inquiry held a months-long consultation that included 15 meetings with groups and individuals affected by contaminated blood. This process produced over 700 responses which were used to ensure that the inquiry's terms of reference properly reflected the concerns of those affected.[40]
- The Grenfell Tower Inquiry held a consultation on the terms of reference, however the chair ultimately decided to recommend a narrower focus than what many of the people affected had campaigned for.[41] This undoubtedly harmed the trust between the affected community and the inquiry. The chair argued two reasons for narrower terms. Firstly that it would enable the Inquiry to "complete it's work as quickly as possible", and also because "the inclusion of such broad questions within the scope of the Inquiry would raise questions of a social, economic and political nature which in my view are not suitable for a judge-led inquiry."[42] The chair's recommended terms of reference were accepted in full by Theresa May, then Prime Minister.[43]

Some recent inquiries such as the Manchester Arena Inquiry and the Jermaine Baker Inquiry have been announced with terms of reference already set – although there may have been private consultation in advance.[44,45] In general consultation on the terms of reference is good practice and can help ensure that the scope of the inquiry aligns closely with both the concerns of those affected, and the imperative to deliver lasting change. If the government establishes a statutory inquiry under the 2005 Act and appoints a panel, then they are required by law to be consulted.[46]

In addition to consultation on the Terms of Reference, the chair of any inquiry into coronavirus should be deeply involved in their determination. This should include any chair making use of the right to amend the terms of reference as they begin to gather evidence that helps them better determine the scope.

8 - What role should Parliament play? How much input should it have and how far should it have an oversight role?

The main role for Parliament should be focused on holding the government to account for implementing the recommendations of an inquiry.

Currently, there is very little firm procedure for holding government to account for any promises made in the aftermath of inquiries. The Inquiries Act 2005 does not make any provision for the implementation of inquiry recommendations and recommendations are non-binding.

To improve scrutiny in the aftermath of inquiries, there should be an enhanced role for select committees in undertaking this scrutiny of government. Their routine involvement would provide an opportunity to monitor the state of the implementation of inquiry recommendations. This happened in the case of the Mid Staffs Inquiry – Sir Robert Francis invited the Health Select Committee to review whether implementation of his recommendations was happening, which they did effectively.

In addition to this, scrutinising the implementation of inquiry findings should become a core task for select committees. Given the number of inquiries that government pursues, the burden of running regular sessions on every inquiry might be overwhelming. Therefore, government departments responsible for implementing inquiry recommendations should update the relevant department select committee on progress. In instances where the information provided is unsatisfactory, select committees should move to hold full hearings.

9 - What mechanisms are there to ensure that the recommendations of any inquiry are implemented?

The implementation of inquiry recommendations has been patchy.[47] As Sir Robert Francis noted, ”The implementation of recommendations is… far from guaranteed, even where those to whom they are addressed accept – or appear to accept them. A study of the fate of inquiry recommendations makes grim reading for inquiry panels”.[48] In a few instances – such as the Mid Staffs Inquiry – there was a thorough follow-up process, scrutinised by Parliament. However, it is clear that recommendations are not always implemented, and the worst cases arise when the failure to make change after one inquiry leads to a repeated failure of the same or similar type.

We have seen instances of this with the Inquests after the 7/7 terror attacks, which noted that the emergency services and TfL workers suffered the same interoperability issues with their radio equipment as had been the case during the 1987 Kings Cross Fire, despite recommendations made by the subsequent inquiry into the fire. Similarly, the first report of the Grenfell Inquiry noted similar issues in fire service control rooms which should have been addressed following the inquest into the fire at Lakanal House in 2009. There have almost certainly been other instances like these.[49]

The role of the chair

Acknowledging this issue some inquiry chairs have taken a more direct or hands-on approach to seeing their recommendations implemented:

- Lord Laming developed a detailed implementation plan as part of his report into the death of Baby P which considered the status of recommendations made by his earlier inquiry into the death of Victoria Climbié.[50]
- Lord Bichard, reconvened his inquiry six months after the publication of his report to consider how well the recommendations were being implemented.[51]
- The first recommendation of Sir Robert Francis's report for the Mid Staffordshire NHS Foundation Trust Inquiry specifically invited the House of Commons Select Committee on Health to "consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report."[52]

Structuring an inquiry to support change

An inquiry cannot bind the government to accept its recommendations, however there are steps that can be taken to support implementation and ensure that lasting, positive change occurs. Some of these involve developing better recommendations in the first place:

- All recommendations made by the inquiry should clearly indicate who is supposed to take action and suggested timescales for when they should be implemented.
- Every recommendation should be developed and reviewed by a group of individuals with relevant policy-making and implementation expertise via a series of seminars at the end of the inquiry.[53] These seminars should be used to help determine how quickly it would be reasonable for each recommendation to be implemented, and who should be responsible for the change.

Government leadership

The relevant departments should create transparent mechanisms to implement recommendations. A good example of this followed the Inquiry into Hyponatraemia-Related Deaths in Northern Ireland. There the Department of Health established nine workstreams to oversee the implementation of recommendations made by the inquiry.[54]

The role of Parliament

Select committees should take responsibility for scrutinising the implementation of inquiry recommendations.[55] The Government should publish a response to any inquiry reports and their recommendations, detailing which are accepted or rejected – with clear reasons why. This report should be the roadmap for implementation and select committees should use it to hold the government to account. Relevant committees should call ministers and senior officials to provide regular progress reports.

One example of what this might look like is the Mid Staffs Inquiry:

- Sir Robert Francis published his report on the 6th February 2013, it made 290 recommendations.[56] His first recommendation invited the Commons Health Select Committee to scrutinise the implementation of the report's findings. In response Prime Minister David Cameron told Parliament "We will study every one of the 290 recommendations in today's report and we will respond in detail next month".[57] In response to questions from MPs he provided assurances that the government would implement Sir Francis's recommendations.

- A little over a month later the government publishes 'Patients First and Foremost'. This report was "not, and could not be, a full response to each and every one of Robert Francis' 290 recommendations.". But it outlined how the government planned to engage with the issues raised in the report.[58]
- At the same time the Commons Health Select Committee opened an inquiry into the Mid Staffs Inquiry report. They took oral evidence from several senior people including: Sir Robert Francis, Sir David Nicholson (CEO of NHS England), Dame Una O'Brien (Permanent Secretary at the Department of Health) and Jeremy Hunt (Secretary of State for Health).[59] The committee produced a report which posed questions for the government about its implementation strategy and outline actions the government needed to take.[60]
- The government's preliminary response was followed by a full response to all recommendations in November 2013. This response stated that "the Government and the national organisations that have signed this response accept the Francis report. Where we disagree with any of the specific recommendations in the Inquiry report, or where the relevant organisations have elected to achieve the same goal by a different method, this has been made clear in the accompanying document."[61] The government also published a response to the Health Select Committee's 'After Francis' report alongside this.[62]

Tracking the implementation of any inquiries recommendations is difficult, but a one-year retrospective by the Nuffield Trust suggested that progress was being made.[63] Inquiries are serious affairs and their recommendations are made sincerely. The type of scrutiny that parliament gave to the Mid Staffs Inquiry is not unprecedented, but it is still far from the norm.

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Appendix

Table A1 – Composition of panels for inquiries of note

Falkland Islands Inquiry	1982 – 1983	**Lord Franks (Chair)**	Civil Servant
		Lord Barber	Conservative Peer
		Lord Lever of Manchester	Labour Peer
		Sir Patrick Nairne	Civil Servant
		Rt Hon Merlyn Rees MP	Labour MP
		Lord Watkinson	Conservative Peer
BSE Inquiry	1997 – 2000	**Lord Philips of Worth Matravers (Chair)**	Judge
		June Bridgeman	Civil Servant
		Prof Malcolm Ferguson-Smith	Scientist
Butler Review	2004	**Lord Butler of Brockwell (Chair)**	Civil Servant
		Field Marshall the Lord Inge	Military
		Sir John Chilcot	Civil Servant
		Rt Hon Ann Taylor MP	Politician
		Rt Hon Michael Mates MP	Politician
Iraq Inquiry	2009 – 2016	**Sir John Chilcot (Chair)**	Civil Servant
		Sir Lawrence Freedman	Historian
		Sir Martin Gilbert	Historian
		Sir Roderic Lyne	Civil Servant
		Baroness Prashar	Crossbench Peer
RHI Inquiry	2017 – 2020	**Rt Hon Sir Patrick Coughlin (Chair)**	Judge
		Dame Una O'Brien	Civil Servant

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