Public Inquiries, Accountability and the ‘Implementation Gap’

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Introduction

Our public inquiry system is in the spotlight, with high demand both for new inquiries and for the inquiry system to be improved. As of September 2026, there were 22 ongoing or announced inquiries across the UK, with eight new public inquiries having been announced since the general election in 2024, including the Independent Inquiry into Grooming Gangs, the Southport Inquiry and the Orgreave Inquiry. Even in the last week, a further public inquiry has been announced into the deaths of two men in the October 2025 synagogue attack in Manchester.

Demands for improvement have led to the Public Office (Accountability) Bill, the result of a long campaign by civil society groups for a 'Hillsborough Law'. The Bill, which is currently being considered by the House of Lords, would impose a duty of candour on public authorities and public officials when they deal with inquiries and investigations; and would also make provision about parity at inquiries and investigations involving a public authority, particularly for bereaved family members. It has been commented that the Bill "draws on lessons from major incidents and scandals in which public bodies were alleged to have acted defensively or withheld information, including the Hillsborough disaster, the Post Office Horizon IT scandal, the Grenfell Tower fire and the infected blood scandal". These measures have the potential to strengthen inquiries as an accountability tool, insofar as they enhance the ability of inquiries to investigate and to carry out their purpose, which has been described as being "to establish the facts, find out what happened, why it happened, who may be accountable, and to try and learn lessons to prevent a recurrence of the events" (albeit under the Inquiries Act 2005, inquiries have no power to determine civil or criminal liability).

The academic literature confirms that inquiries are seen as a "major instrument of accountability and play a key role in the way in which the executive addresses major crises". The accountability purpose of inquiries extends beyond understanding past events and failures, and encompasses a future question: how can harms of the same or a similar kind be prevented? Many public inquiries will make recommendations as part of their process and the Institute for Government has reported that between 1990 and 2024, 54 inquiries made 3,175 recommendations. Making recommendations does not in itself achieve accountability, however - the recommendations are addressed to a range of bodies, and it is their subsequent actions that matter. We recognise that government may have good reasons for not accepting and implementing certain recommendations. However, following some inquiries, there is an implementation gap between accepted recommendations and their implementation in practice. This risks similar harms being repeated, and it risks undermining public trust and confidence not only in those responsible for implementing the inquiry's recommendations, but in the institution of inquiries themselves as an accountability tool.

The 'implementation gap' is at the heart of our current Bingham Centre project, 'Promoting More Effective Oversight of the Implementation of Recommendations Made by UK Public Inquiries', funded by the Joseph Rowntree Charitable Trust. The project comes at a time when there is momentum to improve the implementation of public inquiry recommendations from a number of sources, both in Parliament (see e.g., the 2024 report of the House of Lords Statutory Inquiries Committee) and in civil society (see e.g., INQUEST's campaign for a 'National Oversight Mechanism').

In this blog, we introduce this accountability problem and explain how it is addressed by our new report, 'Accountability after Inquiry Recommendations: Improving our Patchwork of Scrutiny and Oversight'.

In Section 1 of the blog, we set out some stark illustrations of the problem with recent inquiries being confronted with a failure to implement recommendations. In Section 2, we highlight that the 'implementation gap' is a major concern in other jurisdictions such as South Africa, New Zealand and Australia, which formed part of our background research. Finally in Section 3, we outline the findings of our new report, including ways forward for improving our current 'patchwork' approach to scrutiny and oversight.

(1) Inquiries confronted with a failure to implement recommendations

The fire at Grenfell Tower in London on 14 June 2017 claimed the lives of 71 people. The ensuing public inquiry was chaired by Sir Martin Moore-Bick and considered the factual narrative of the events (Phase 1) and the causes of these events (Phase 2). The Phase 2 inquiry report stressed that "Our investigations have revealed that some important recommendations affecting fire safety were ignored by the government in the years leading up to the Grenfell Tower fire". It noted that "Recommendations made by the Select Committee in 1999 were not implemented and the department's response to the recommendations made by the Lakanal House coroner was inadequate" and "The department had no system for recording recommendations made by public bodies or keeping track of its response to them". Speaking on the ninth anniversary of the Grenfell Tower fire, Joe Powell MP (who represents the affected constituency in Parliament) stated that, "...Grenfell would not have happened at all if we had properly learned the lessons from the Lakanal House fire in 2009 and listened to the coroner's recommendations. Instead, they sat on a shelf, and an opportunity to save lives was missed".

We also see a failure to implement recommendations in other areas, including healthcare. Last month, the Thirlwall Inquiry (which was established to examine "events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital"), concluded with a blunt statement:

"...the government has a choice about whether to accept recommendations but where the same failings are being identified in different places, repeatedly, effective action must be taken - by implementing recommendations or otherwise. It is inexcusable to ignore such failings".

So stated inquiry Chair Lady Justice Thirlwall in the Inquiry's Final Report, which was published in September 2026.

The Inquiry had carried out a review of "all recommendations made in all inquiries into the NHS in the last 30 years", which showed that "whilst some significant changes have been introduced in response to Inquiry recommendations over the last 30 years, most have not been implemented". Lady Justice Thirlwall also observed that "Even where recommendations are accepted, there is no mechanism to track progress or enforce implementation".

There are signs that the Government is beginning to realise the need to address the implementation gap, at least in the area of healthcare. In response to the Thirlwall Inquiry highlighting problems with past recommendations not being implemented, Health Secretary Yvette Cooper MP stated that her "department is setting up a recommendation hub to properly track our implementation progress internally, not just for this inquiry, but for others right across the NHS".

(2) The implementation gap in other jurisdictions

We find concerns about an implementation gap in three other constitutional democracies which we considered for this project, based on our prior discussions with scholars in the field: South Africa, New Zealand and Australia.

For example, commentators in South Africa have expressed grave concern about the adequacy of implementation of recommendations made about the Zondo Commission into State Capture, following

similar shortcomings in relation to previous inquiries. Such concerns have centred on the quality and timing of the government's response to the Commission's recommendations, and of Parliament's oversight. This has heightened concerns about a current commission of inquiry into organised crime and police corruption. Calls have even been made for some inquiry recommendations to be treated as binding, including in legal scholarship and in Parliament by the former leader of the opposition.

In New Zealand and Australia, it is settled law that inquiry recommendations are not binding. In the late 2000s, both the Law Commission of Australia and its counterpart in New Zealand, had accepted this in their reviews of the legislative framework for inquiries. Despite recognising that the implementation of inquiry recommendations could be a problem area, neither Law Commission recommended legislative change to ensure greater legal accountability or even legally required oversight. However, the New Zealand Law Commission did say that inquiries themselves could play a role, noting that inquiry recommendations for oversight of the implementation of their recommendations could be "extremely useful" for "indicating that ongoing review is required".

Notable examples of commissions doing so in recent years include the Christchurch Attack Commission, which recommended an Implementation Advisory group, with a minister responsible minister be responsible for coordinating implementation. The government accepted this commission's oversight recommendations, but did not respond with full acceptance to the oversight recommendations of the Abuse in Care Commission, which made extensive recommendations for post-inquiry oversight including annual reports to parliamentary committees and an independent review after nine years. However, the government did establish its own Crown Response Unit with responsibility for overseeing implementation of the Abuse in Care Commission and committed to providing annual updates to the public.

The key innovation taken forward in our new report is the model of 'implementation monitors' from Australia. In our report, for example, we give examples of implementation monitors being recommended by inquiries into bushfires, family violence, police informants, and child safety. A key feature of implementation monitors is that they "report directly to Parliament" and their "findings are made publicly available, reinforcing transparency and accountability". In our report, we suggest that implementation monitors could be used in the UK to support Parliament and/or a National Oversight Mechanism.

(3) Key findings from the Bingham Centre's report

In our new report, we explore how to establish more effective monitoring, oversight and scrutiny of the implementation of public inquiry recommendations in the UK, with the aim of providing greater accountability.

Part 1 of our report considers the making of inquiry recommendations. One of the report's key findings is that consideration should be given to the process of making recommendations and how implementation of recommendations will be monitored and scrutinised, from the beginning of the inquiry process, such as when setting an inquiry's terms of reference.

Part 2 considers responses to inquiry recommendations, and the way in which progress on the implementation of inquiry recommendations is reported. The report emphasises that whilst a failure to implement accepted recommendations presents an acute accountability problem, accountability may also be affected by the quality and timeliness of both the response to inquiry reports and any subsequent self-reporting about the implementation of inquiry recommendations.

Part 3 examines the mechanisms currently used or proposed in the UK to monitor, oversee and scrutinise the implementation of inquiry recommendations. It considers the role of Parliament, the role of inquiries themselves, the role of other mechanisms (such as the Cabinet Office Inquiries Unit; existing audit institutions; the media; and advocacy groups, the public and those with lived experience of inquiries), proposals for a National Oversight Mechanism and the model of implementation monitors used in Australia.

In the report, we agree that it is for Parliament to hold the Government to account for the implementation of inquiry recommendations, and that parliamentary committees have a role to play

here. However, we question whether committees have sufficient resources and capacity to take on a much greater role here than at present. We see a particular need for independent, technical assessments of the state of implementation of recommendations (perhaps following the model of 'implementation monitors' used in Australia) to support Parliament's role.

We see a role for inquiries themselves, and we highlight examples of inquiries making recommendations that are particularly relevant to the themes of the report including on responses to inquiry recommendations and on implementation monitoring. We also look at some examples of inquiries monitoring the implementation of some of their recommendations during the lifetime of the inquiry. We suggest these approaches should be considered by future inquiries, where appropriate.

In our view, establishing an independent National Oversight Mechanism or similar body, possibly supported by independent scrutiny from implementation monitors, also emerges as a strong proposal.

Concluding comments: Why this is a rule of law issue

As noted above, inquiries are established in response to complex harms or failures, or events that raise major public concern, which require broader investigation and lesson-learning that go beyond what would normally take place in court proceedings to determine civil or criminal liability. Loss of confidence in the inquiry model due to inadequate implementation of recommendations would be detrimental to the culture of trust in institutions and bodies on which the rule of law depends.

There are strong arguments that more effective monitoring, oversight and scrutiny of the implementation of inquiry recommendations are needed to reduce the likelihood of the failures identified in inquiry reports being repeated. The Bingham Centre's new report highlights that, while there is momentum to introduce new mechanisms and to improve existing ones - and a patchwork of scrutiny and oversight has been developed, including monitoring by inquiry chairs in some circumstances - there is currently no consensus about the most effective and appropriate forms of oversight and scrutiny.

** This piece draws on a recent report by Lucy Moxham, Henry Screaton and Jan van Zyl Smit, 'Accountability after Inquiry Recommendations: Improving our Patchwork of Scrutiny and Oversight', Bingham Centre for the Rule of Law (September 2026). We are grateful to the Joseph Rowntree Charitable Trust for its generous support of this project.*

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