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Accountability after Inquiry Recommendations: Improving our Patchwork of Scrutiny and Oversight

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Executive Summary[1]

> *"Bereaved families report that they participate in protracted, intrusive, and distressing processes following a death in the hope of establishing the truth about how their loved one died, holding those responsible to account, and for there to be learning to prevent other deaths in the future. … The gap in accountability – from recommendations made to actions completed – is a disservice and insult to bereaved families seeking change".*
>
> --- INQUEST, 'No More Deaths: Learning, action, and accountability: the case for a National Oversight Mechanism'

Public inquiry recommendations can be important for addressing the harms an inquiry identifies and for preventing similar harms from occurring in future. They are the result of what is often a costly and lengthy process, which can be traumatic especially for victims and their families. There is, however, an 'implementation gap' between inquiry recommendations and their implementation in practice. When inquiry recommendations go unaddressed, it risks similar harms being repeated, and it risks undermining public trust and confidence in inquiries as an accountability tool.

This problem is at the heart of our research project which explores 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.

This report comes at a time when there is momentum to improve the implementation of public inquiry recommendations from a number of sources, both in Parliament and in civil society. It highlights that, while there is momentum to introduce new mechanisms and to improve existing ones, there cannot be a one-size-fits-all approach here and there is currently no consensus about the most effective and appropriate forms of oversight and scrutiny.

Part 1: Making inquiry recommendations

In Part 1, we consider the number, presentation and categories of recommendations made by public inquiries. We also explore some wider themes relating to the framing and development of inquiry recommendations.

Ways forward for making inquiry recommendations[2]

- From the beginning, consideration should be given to the process of making recommendations and how implementation of recommendations will be monitored and scrutinised.
- Inquiries should review past inquiries on similar or the same subject matter to see what recommendations were made and which have been implemented (and to what extent).
- Recommendations should be focused in number and scope.
- Recommendations should be clearly presented and categorised.
- Responsibility for implementing recommendations should be clearly assigned.
- Recommendations should be considered throughout the inquiry process, grounded in evidence, and developed through consultation with experts and other stakeholders, including those with lived experience of the issues raised by the inquiry.

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[1] Detailed references are not being used in this summary. Detailed referencing is available in the main report.
[2] See Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025).

- Consideration should be given to the 'implementability' of recommendations.

Part 2: Responding to inquiry recommendations and reporting on progress

This part of the report considers responses to inquiry recommendations, and the way in which progress on the implementation of inquiry recommendations is reported. This includes the new Cabinet Office collection of dashboards, which records public inquiry recommendations made since 2024, the government's response, and implementation updates.

Ways forward for responding to inquiry recommendations

- The responsible minister will be expected to respond to an inquiry report and the Cabinet Office has noted that, unless there is a compelling reason not to do so, departments should respond to an inquiry's final report within six months.
- In 2013-2014, a House of Lords Select Committee undertook post-legislative scrutiny of the Inquiries Act 2005.[3] We agree with its Recommendations 30, 31 and 32:
    - "In the case of many inquiries, publication of the formal Government response is accompanied by a statement to both Houses. We recommend that this should be the invariable practice. If a second, more detailed, written response is produced, as [is] often the case, it should also be published. It should say exactly which recommendations are accepted."
    - "If the inquiry specifies that particular recommendations are for implementation by particular public bodies, those bodies should have a statutory duty to say within a specified time whether they accept the recommendations, and if so, what plans they have for implementation."
    - "We recommend that in all cases, the response should be published not more than three months after receipt of an inquiry report. Reasons should be given for not accepting recommendations. For those which are accepted, details of when and how they will be implemented are essential. The report should include an implementation plan, and a commitment to issue further reports to Parliament at 12-monthly intervals."
- As regards the three-month time frame suggested in Recommendation 32, we note that the then government considered a six-month timeframe for publication of the Government's response would be more achievable. However, we would emphasise that public inquiries are set up in response to events that raise major public concern, and public inquiry recommendations can be important for addressing the harms an inquiry identifies and for preventing similar harms from occurring in future.
- In addition to giving reasons for not accepting recommendations, we believe there should be a requirement to provide reasons in relation to partial acceptance and, further down the line, there should be a requirement to give reasons for previously accepted recommendations no longer being implemented and for any alternative measures being adopted.

Ways forward for reporting on progress

- The Cabinet Office webpage collection should be expanded to include all inquiries with accepted recommendations that remain to be implemented. However, it will remain the case that, as currently set up, the collection is based on self-reported data.
- Therefore, 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).

[3] See House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014).

Part 3: Monitoring the implementation of inquiry recommendations

Part 3 begins by considering some recent examples of legal cases concerning the response to recommendations, and we see the limitations of legal challenges in this area. It is clear that we need 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 3 then 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.

Ways forward for the role of Parliament

- We have highlighted some examples from our sample of UK inquiries[4] of parliamentary debates about inquiry reports. Given the public importance of inquiries, we suggest this should be routine for all inquiry reports.
- We have also highlighted some examples of inquiries in our sample calling for (specific) parliamentary committees to monitor the implementation of their recommendations. This approach should be considered by future inquiries, where appropriate.
- More broadly, 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.
- In addition, the suggestion that the select committee model should be combined with another independent body, such as the National Oversight Mechanism proposed by INQUEST, also emerges as a strong proposal from the research.[5]

Ways forward for the role of inquiries

- We would like to highlight, in particular, the approach suggested by Sir John Saunders, Chair of the Manchester Arena Inquiry, of "early monitoring by the inquiry team… followed by monitoring by a named individual who will report periodically to the public on progress which has been made",[6] which in that case appeared to focus minds and generate action on the inquiry's recommendations.
- In Part 1 of this report, we noted our view that, from the beginning, consideration should be given to the process of making recommendations and how implementation of recommendations will be monitored and scrutinised.
- In Part 1 and in this part, we saw that inquiries are making recommendations that are particularly relevant to the themes of this report including the categories on responses to inquiry recommendations; implementation monitoring; and implementation of a previous recommendation. We suggest this approach should be considered by future inquiries, where appropriate.
- In this part, we considered the use of interim recommendations and we looked at some examples of inquiries monitoring the implementation of some of their recommendations

[4] We considered reports from 18 inquiries held in the UK, including some in Scotland and Northern Ireland, all of which reported between 1 January 2018 and 31 July 2025. While we are aware of more recent inquiry reports published since July 2025 and reference them on occasion in this report, our analysis focused on our sample.
[5] See Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Emma Norris (Deputy Director, Institute for Government) at Q77.
[6] See 'Manchester Arena Inquiry: General Observations on the Conclusion of the Inquiry' (4 July 2023).

during the lifetime of the inquiry. We suggest this approach should be considered by future inquiries, where appropriate.
- Using interim recommendations may not always be practical or appropriate, and it will depend on the particular circumstances of an inquiry. Where interim recommendations are made, consideration should be given to whether it would be appropriate for the inquiry to monitor them during its lifetime.

Ways forward for the role of other mechanisms
- The Cabinet Office Inquiries Unit should share best practice from inquiries and other experts. In particular, there should be a focus on sharing best practice about the process of making recommendations and how implementation of recommendations will be monitored and scrutinised.
- Inquiry chairs should consider whether there may be a role for the National Audit Office or other existing bodies in monitoring and scrutinising implementation of their recommendations.
- Consideration should be given to the form(s) of monitoring, oversight and scrutiny those with lived experience of the issues raised by inquiries would like to see, which include support for INQUEST's proposal for a National Oversight Mechanism.

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

Ways forward for the role of implementation monitors
- The role of implementation monitors is inquiry-specific.
- We have suggested that implementation monitors could be used to support Parliament and/or a National Oversight Mechanism.[7]
- Combining inquiry-specific implementation monitors with other mechanisms that take an overarching view could also help to ensure that meta-analysis across inquiries can be conducted, and learning can be transferred from inquiry to inquiry.
- It will depend on the particular circumstances of an inquiry whether it is appropriate to recommend the appointment of an implementation monitor, and this should be considered on an inquiry-by-inquiry basis.

[7] See Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at sections 4.8 and 4.9.

Introduction

1. Background

Public inquiries are set up by a government minister in response to events that raise major public concern,[1] such as the recent inquiries into the Covid-19 pandemic, Grenfell Tower fire, Manchester Arena attack and the Infected Blood scandal. Public inquiries can be statutory or non-statutory, with statutory inquiries generally being governed by the Inquiries Act 2005.[2] Statutory inquiries have more powers (e.g., to compel witnesses) whereas non-statutory inquiries may offer more flexibility.[3] It is possible for non-statutory inquiries to be converted into statutory inquiries.[4] In January 2023, for example, the then Chair of the Essex Mental Health Independent Inquiry explained her view that the Inquiry "would not be able to meet its Terms of Reference with its non-statutory status given the levels of staff engagement it had received so far".[5] Later in 2023, the Inquiry was converted into a statutory inquiry and relaunched as the Lampard Inquiry.[6] An inquest can also be converted into a statutory inquiry and, for example, the Chair of the Manchester Arena explained that "My investigation into the Attack began as twenty-two inquests. …it became necessary to continue that investigation as a statutory public inquiry".[7] Most inquiries are now established using the 2005 Act.[8]

It is important to clarify at the outset that public inquiries "form part of the political rather than the legal process" and, for example, they have "no power to determine civil or criminal liability, nor can they impose sanctions on any individual or organisation".[9] Public inquiries are set up by a government minister, the inquiry report is sent to the minister, and it is for the Government to decide whether or not to implement a public inquiry's recommendations.[10]

It is also important to highlight the relevance of the Public Office (Accountability) Bill. The Bill was introduced in the 2024-2026 parliamentary session and has been carried over into the new session.[11] The Bill seeks to give effect to the Labour Party's manifesto commitment to introduce a 'Hillsborough Law'.[12] Among other things, the Bill would impose a duty of candour on public authorities and public officials when they deal with inquiries and investigations; impose criminal liability for breach of the duty of candour; and make provision about parity at inquiries and investigations involving a public authority, particularly for bereaved family members.[13] The organisation INQUEST, which has strongly supported the campaign for a Hillsborough Law,[14] has in particular welcomed the new Bill's proposed expansion of legal aid for inquests.[15] While not the focus of this report, the measures put forward in the Bill are relevant here because, like the issues we explore below, they are also aimed at making inquiries more effective as an accountability tool.

We also highlight here the recent report of the Public Accounts Committee ("PAC") inquiry into government compensation schemes.[16] A key message from the report is that "Trust in government compensation schemes collapses when people have to rely on the same body that caused them harm to manage the compensation process".[17] Among other things, the report recommended the Cabinet Office should "provide a comprehensive update on the establishment of an independent body responsible for designing and administering government compensation schemes".[18] Compensation is sometimes a recommendation made by inquiries and so the findings of the PAC inquiry may be relevant to some of the themes in this report.

2. The problem

Many public inquiries will make recommendations as part of their process. The Institute for Government ("IfG"), which has worked extensively on the issue of public inquiries, has reported that between 1990 and 2024, 54 inquiries made 3,175 recommendations.[19] Public inquiry recommendations can be important for addressing the harms an inquiry identifies and for preventing similar harms from occurring in future. They are the result of what is often a costly and lengthy process,[20] which can be traumatic especially for victims and their families.

There is, however, an 'implementation gap' between inquiry recommendations and their implementation in practice. This problem is at the heart of our research project which explores 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.

The implementation gap comes against a background of increasing levels of inquiry activity in the UK. The IfG has recently highlighted some statistics on public inquiries including that "Across the UK, since 2005, 63 inquiries have been launched, compared with 41 in the 20 years prior".[21] It also noted that "Since 1997 there have never been fewer than five public inquiries running at any one time, and as of January 2026 there were 27 inquiries ongoing or announced – the most ever at one time."[22]

When inquiry recommendations go unaddressed, it risks similar harms being repeated, and it risks undermining public trust and confidence in inquiries as an accountability tool. From a rule of law perspective, inquiries are temporary, ad hoc bodies 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 would be detrimental to the culture of trust in institutions and bodies on which the rule of law depends. Indeed, as INQUEST has stressed, "Bereaved families report that they participate in protracted, intrusive, and distressing processes following a death in the hope of establishing the truth about how their loved one died, holding those responsible to account, and for there to be learning to prevent other deaths in the future. … The gap in accountability – from recommendations made to actions completed – is a disservice and insult to bereaved families seeking change".[23] In addition, INQUEST'S Executive Director Deborah Coles has emphasised the psychological impact on families: "Too often, the only way you know that something has not been enacted is when something goes wrong again. I cannot overstate the psychological impact on the families with whom we work of finding out that somebody else has died in a similar way to their loved one, when they have looked to those processes to try to effect change".[24] Indeed, from the outset, it is crucial to emphasise the importance of families and those most affected by the issues raised by the inquiry being at the centre throughout an inquiry's work.[25]

We recognise that government may have good reasons for not accepting and implementing certain recommendations. However, there is an implementation gap between accepted recommendations and their implementation in practice that goes beyond this. As the House of Lords Statutory Inquiries Committee stated in 2024, "too often, inquiries are failing to meet their aims because inquiry recommendations are not subsequently implemented, despite being accepted by the Government".[26] Failure to implement accepted recommendations presents an acute accountability problem, but 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.

This report comes at a time when there is momentum to improve the implementation of public inquiry recommendations from a number of sources, both in Parliament and in civil society.[27] There are strong arguments that more effective monitoring, oversight and scrutiny of the implementation of inquiry recommendations is needed to reduce the likelihood of the failures identified in inquiry reports being repeated.[28] This 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.

3. Our research

We prepared four working papers to inform this final report. The first paper considered the mechanisms currently used or proposed in the UK to monitor, oversee and scrutinise the implementation of inquiry recommendations. The second paper looked at the number and categories of recommendations made by inquiries, and wider themes relating to the development of inquiry recommendations. The third paper explored legal challenges relating to public inquiries. Finally, in order to contextualise the UK experience, we also carried out desk-based comparative research and prepared a working paper on the approaches in Australia, New Zealand and South Africa. This comparative research revealed similar concerns about an implementation gap in all three jurisdictions, and a number of innovations in response. For the purposes of the present report, we have taken forward only one innovation from those jurisdictions. This is the establishment of 'implementation monitors' following some inquiries in Australia, which is a distinct mechanism not found in the UK at present.

For the purposes of our research, we considered the following reports from 18 inquiries held in the UK, including some in Scotland and Northern Ireland, all of which reported between 1 January 2018 and 31 July 2025.[29] Where we give examples from our sample of UK inquiries, these examples are not meant to be exhaustive.

List of reports in our sample of UK inquiries
1. Inquiry into Hyponatraemia-related Deaths – Report (Jan 2018)
2. Anthony Grainger Inquiry – Report into the Death of Anthony Grainger (Jul 2019)
3. Grenfell Tower Inquiry – Grenfell Tower Inquiry Phase 1 Report (Oct 2019)
4. Report of the Independent Inquiry into the Issues raised by Paterson (Feb 2020)
5. Report of the Independent Public Inquiry into the Non-domestic Renewable Heat Incentive (RHI) Scheme (Mar 2020)
6. Report of the Daniel Morgan Independent Panel (Jun 2021)
7. Manchester Arena Inquiry – Volume 1: Security for the Arena (Jun 2021)
8. Jermaine Baker Public Inquiry – Report into the Death of Jermaine Baker (Jul 2022)
9. Report of the Independent Inquiry into Child Sexual Abuse ("IICSA") (Oct 2022)
10. Manchester Arena Inquiry – Volume 2: Emergency Response (Nov 2022)
11. Manchester Arena Inquiry – Volume 3: Radicalisation and Preventability (Mar 2023)
12. Brook House Inquiry – Report (Sep 2023)
13. Edinburgh Tram Inquiry – Report (Sep 2023)
14. Independent Inquiry into the issues raised by the David Fuller case – Phase 1 Report (Nov 2023)
15. Angiolini Inquiry – Part 1 Report (Feb 2024)
16. Infected Blood Inquiry – The Report (May 2024)
17. Truth Recovery Independent Panel – Interim Report (May 2024)
18. UK Covid-19 Inquiry – Module 1: The resilience and preparedness of the United Kingdom (Jul 2024)
19. Grenfell Tower Inquiry – Grenfell Tower Inquiry Phase 2 Report (Sep 2024)
20. Scottish Hospitals Inquiry – Interim Report (Mar 2025)
21. Post Office Horizon IT Inquiry – Report Volume 1 (Jul 2025)
22. Infected Blood Inquiry – Additional Report on Compensation (Jul 2025)
23. Independent Inquiry into the issues raised by the David Fuller case – Phase 2 Report (Jul 2025)

We held a workshop on 25 March 2026 which was attended by a range of stakeholders.[30] We are grateful to our panellists and to the attendees who brought a range of valuable perspectives to our discussion from across academia, parliament, campaign organisations, legal practice and inquiries, and who included some people with lived experience of inquiries. In advance of the event, we

circulated an outline paper which provided an overview of our research findings and included some discussion questions. We also circulated this afterwards to panellists and those registered to attend, as well as other key stakeholders.

The workshop was held under the Chatham House Rule and we have not published a report of the event. In this report, we draw on contributions made during the speaker presentations and the Q&A discussions, without revealing the contributors' identities or affiliations.

Part 1: Making inquiry recommendations

1.1 The number, presentation and categories of recommendations made by public inquiries

Many public inquiries will make recommendations as part of their process. It is important to recall that under Section 5 of the Inquiries Act 2005, the Minister must set out the inquiry's 'terms of reference', defined in the Act to mean "the matters to which the inquiry relates" and including, for example, "whether the inquiry panel is to make recommendations".[31] In addition, under Section 24 of the Inquiries Act 2005, the inquiry chair must deliver a report to the Minister setting out the "facts determined by the inquiry panel" and "the recommendations of the panel (where the terms of reference required it to make recommendations)".[32] In addition, the inquiry report "may also contain anything else that the panel considers to be relevant to the terms of reference (including any recommendations the panel sees fit to make despite not being required to do so by the terms of reference)".[33]

This section considers the number, presentation and categories of recommendations made by public inquiries by analysing the recommendations from our sample of UK inquiries.

1.1.1 The number and presentation of recommendations in our sample of UK inquiries

We counted 712 recommendations in our sample of 18 inquiries, across 23 reports.

The reports in our sample adopt different approaches to presentation, but in many instances the recommendations are clearly set out even where they are not labelled "Recommendation 1, Recommendation 2" etc. However, we found that a number of the inquiry reports in our sample were more difficult to navigate than others, as shown in the examples below.

We considered the **Grenfell Tower Inquiry Phase 1 report** to contain 21 recommendations. The chapter on recommendations contains 35 numbered paragraphs but not all paragraphs contain recommendations.[34] It uses the phrase "I therefore recommend" 21 times covering a range of recommendations and sub-recommendations.

The **Grenfell Tower Inquiry Phase 2 report** takes a similar approach and we considered it to contain 58 recommendations. The chapter on recommendations contains 83 numbered paragraphs, but not all paragraphs contain recommendations and some paragraphs contain multiple recommendations.[35] It uses the phrases "we therefore recommend", "we recommend" or "we also recommend" 58 times.

1.1.2 The categories of recommendations in our sample of UK inquiries

As an early exercise in our research, we attempted to provisionally classify recommendations from our sample of UK inquiries into one or more of 12 draft categories that we had developed (e.g., recommendations relating to legislative reform or relating to changes in policy, practice or culture etc). However, during the course of our research, we decided to add a further category. We have listed below the final 13 categories that we developed. This is not meant to be an exhaustive list of categories. However, we think it is helpful to highlight the types of recommendations that UK inquiries are making and so, in the Appendix, we have suggested some examples from our sample of UK inquiries for each category. It should be noted that it was not always clear into which category (or categories) a recommendation should be placed.

Category
1. Legislative reform
2. Investigation of individuals
3. Policy change
4. Culture change
5. Practice change
6. Internal review
7. Training
8. Responses to inquiry recommendations
9. Implementation monitoring
10. Implementation of a previous recommendation
11. Future inquiries
12. Compensation
13. Inspection

We would highlight several of these categories as particularly relevant to the themes of this report including the categories on responses to inquiry recommendations; implementation monitoring; and implementation of a previous recommendation. We will return to this discussion in Part 3.

1.2 How recommendations are framed and developed

In this section of the report, we consider the framing and development of recommendations. Throughout this report and, in particular in this section, we draw on a briefing prepared by expert Dr Emma Ireton for the Lampard Inquiry.[36] The briefing considers "how public inquiry recommendations are framed, implemented, and monitored" and draws on current practice, inquiry-led innovation, and proposals for reform, with a focus on increasing the likelihood that public inquiry recommendations lead to meaningful and lasting change".[37]

At the outset of this part of the report, it is important to highlight Section 17 of the Inquiries Act 2005 which provides that "Subject to any provision of this Act or of rules under section 41, the procedure and conduct of an inquiry are to be such as the chairman of the inquiry may direct".[38] This gives the chair discretion to determine the procedure and conduct of the inquiry.

1.2.1 The number of recommendations

There are concerns about the high number of inquiry recommendations and the impact this has on implementation. For example, the 2013 report of the Mid Staffordshire NHS Foundation Trust Public Inquiry alone contained 290 recommendations.[39] Commenting on the follow-up to recommendations, John O'Brien, former secretary to IICSA, told the House of Lords Statutory Inquiries Committee in 2024 that "Increasingly, we operate in an environment where three or four inquiries might be reporting in a 12 to 18-month period".[40] In his view, "We need to be practical and honest about the fact that it will sometimes not be possible for a Government to accept and deliver all those recommendations".[41]

As noted above, we counted 712 recommendations in our sample of 18 inquiries. However, we also noticed that a small number of total recommendations sometimes masks a large number of sub-recommendations, as shown in the example below.

In the **Infected Blood Inquiry Report**, the recommendations are divided into 12 themes and we counted this as 12 recommendations.[42] Theme 1 contains only one recommendation. However, themes 2-12 are made up of 39 sub-recommendations (labelled (a), (b), (c) etc). In some cases, these are further sub-divided and labelled (i), (ii), (iii) etc.

A similar approach is taken in the Infected Blood Inquiry Additional Report.[43]

Inquiry Chair Sir Brian Langstaff introduced his recommendations by commenting on the number of recommendations:

> "In the light of all the evidence available to the Inquiry, and the submissions made to it, I have a number of recommendations to make. There is a danger in inquiries making too many recommendations: it becomes difficult to see whether action is truly being taken to avoid the errors of the past being repeated. Of the many recommendations which might have followed, therefore, this Report will concentrate upon a small number. I acknowledge that some participants may regret that I may not have chosen one which is their particular concern. Some of the lessons to be learned which were set out in the previous chapter Lessons to be Learned might also have resulted in additional recommendations made formally by the Inquiry. This should not, however, prevent anyone from applying the lessons identified there, avoiding in future the mistakes which have been identified, and using the content of that chapter as a basis for taking further action, and does not diminish the importance of learning those lessons."[44]

1.2.2 The scope of recommendations

Related to concerns about the high number of recommendations is the issue of overreach. For example, Dr Ireton has emphasised that "While the breadth of evidence may reveal multiple areas of concern, issuing too many recommendations can reduce the chances of implementation" and "Similarly, recommendations that are too broad can obscure priorities, create uncertainty around responsibility, and make implementation and meaningful follow-up more difficult".[45] She noted that the discretion in Section 24 of the Inquiries Act 2005 must be "exercised with care" and recommendations "must remain within the remit of the inquiry's terms of reference, be proportionate to the issues identified, and directed at issues the inquiry is properly equipped to address".[46] Dr Ireton commented that experience from previous inquiries suggests that "a smaller number of focused, clearly directed recommendations" are more likely to be taken forward.[47]

Following on from Sir Brian's comments above, an approach of clearly demarcating recommendations, and distinguishing them from an inquiry's broader findings and comments, could go some way to containing the number and scope of recommendations in inquiry reports.

1.2.3 The presentation of recommendations

As noted above, a key observation from our research is that recommendations are not always clearly presented in inquiry reports. Clear presentation matters when it comes to accessibility. However, it was not always easy to navigate some of the inquiry reports in our sample.

For example, in the report of the **Daniel Morgan Independent Panel**, while the recommendations are clearly presented in coloured text boxes, they are distributed throughout the report (the first appears on page 374 and the last on page 1139), they are not numbered and they do not appear to be collated in one place in the report.[48]

Having a shared understanding of the number of recommendations and a shared way of identifying and referring to specific recommendations is especially crucial to implementation and to the monitoring of implementation.

We counted 169 recommendations across the three volumes of the **Manchester Arena Inquiry** report.[49] The **Manchester Arena Inquiry Recommendations Dashboard** (part of the collection of inquiry dashboards discussed below) also covers 169 recommendations.[50]

The Dashboard User Guide states that "Recommendations are numbered sequentially from 1 to 169 for easy reference".[51] However, the numbering appears to be related to listing all of the recommendations in alphabetical order rather than, for example, reflecting the order of recommendations in the inquiry reports.[52] Nor does there appear to be any cross-referencing to where the recommendations can be found in the original inquiry reports, which would help the end-user to navigate and monitor the implementation of the inquiry's various recommendations. To give one example, Recommendation 1 in the Dashboard (relating to records of student behaviour) is actually the last recommendation of Volume 3 (at paragraphs 25.110-25.111), where it is also labelled as Monitored Recommendation 26.[53]

At a minimum, we think inquiry reports should number their recommendations (and any sub-recommendations) and should present them in a dedicated section of the report.

An example of good practice in this regard is the **Covid-19 inquiry**. In its Module 1 report,[54] the recommendations are numbered (Recommendation 1, Recommendation 2 etc) and presented in coloured text boxes throughout the report. To aid the reader, a summary of the recommendations is provided in the Executive Summary and a list of the recommendations made in the report is given in an Appendix. In addition, the Covid-19 inquiry website has a page dedicated to its recommendations where they are grouped by module, they are set out in number order and the recommendation title is given, and where there is an option to read the recommendation in full.[55]

Another good example is the **Brook House Inquiry** report, where the recommendations are numbered and presented in coloured text boxes in a dedicated chapter, 'Recommendations to prevent recurrence of mistreatment'.[56] The chapter has thematic sub-headings and each recommendation has a descriptive title e.g., "Recommendation 1: Robust monitoring of contract performance".[57]

1.2.4 The categories of recommendations

As noted above, we developed 13 categories of recommendations based on analysis of our sample of UK inquiries and we have suggested examples for each category in the Appendix.

Expressly indicating the type of recommendation being made (e.g., for legislative reform, training etc.) may encourage a focus on the implementation of recommendations when they are being developed. In addition, later on, it may help those responsible for implementation to put in place an implementation plan. We have illustrated how this might work in the box below, though we acknowledge this signposting may not be suitable for all recommendations.

As noted above, the recommendations in the **Brook House Inquiry** report are very clearly presented. To give one example: "Recommendation 7: A time limit on detention – The government must introduce in legislation a maximum 28-day time limit on any individual's detention within an immigration removal centre".[58]

In this straightforward example, a small change would be to include the phrase "legislative reform" in the title: "Recommendation 7: A time limit on detention (legislative reform)".

1.2.5 Responsibility for implementing recommendations

It has been highlighted that, "Another important issue here is that not all recommendations are necessarily directed towards the Government. They are directed towards a whole series of people involved in policy networks and people at the coalface of service delivery, and we need to ensure that those recommendations are acted on and implemented as well".[59]

Dr Ireton has emphasised that "Clear assignment of responsibility is essential to ensure that inquiry recommendations are not only accepted but acted upon", and she suggested recommendations should "specify, wherever possible, the department, agency, or officeholder responsible for delivery".[60] For complex recommendations, such as those involving multiple departments or institutions, she thought "an inquiry should consider identifying a lead department or convening body to coordinate delivery and ensure accountability".[61]

An example of good practice in this regard is the **Manchester Arena Inquiry**. For example, the table of Monitored Recommendations in **Volume 1** clearly lists a "Reporter" or "Reporters" for each recommendation such as the Home Office, the National Police Chiefs' Council, Showsec, the Security Industry Authority etc.[62]

The **Jermaine Baker Public Inquiry** also uses sub-headings to clearly indicate the bodies to whom its recommendations are addressed (e.g., the Metropolitan Police Service, the College of Policing and the National Police Chiefs' Council etc).[63]

The **Phase 2 Report of the David Fuller Inquiry** presents all the recommendations from the report as a whole in a table and this includes a column titled "Organisation/body".[64]

1.2.6 Planning and evidence for recommendations

Commentators have discussed the need for inquiry teams to plan throughout the inquiry process for the development of recommendations.

For example, Dr Ireton has noted, "To be effective, the inquiry must develop its recommendations iteratively, throughout its lifespan, informed by its ongoing analysis of the evidence".[65] Dr Ireton has also emphasised that "Each recommendation must be demonstrably grounded in the evidence gathered during the inquiry process" and has stated that "When recommendations are clearly rooted in an inquiry's findings, they are more likely to be accepted, acted upon, and embedded into policy and practice, increasing the likelihood of meaningful and lasting change".[66]

1.2.7 Consultation with experts and other stakeholders

Commentators have emphasised the need for recommendations to be developed through consultation with experts and other stakeholders, including those who can provide diverse perspectives and constructive feedback.

For example, the IfG has observed that "Developing detailed recommendations for change requires a number of different skillsets that it is unrealistic to expect chairs to possess".[67] It noted that expertise and specialist knowledge of the issues before the inquiry are needed and, in addition, "some knowledge of how to construct policy recommendations in a form that is likely to have traction in government will be an aid to effectiveness".[68] The IfG recommended inquiries adopt a seminar process to involve expert witnesses when developing recommendations.[69]

In this regard, Dr Ireton has emphasised that inquiries will often "improve and refine their draft recommendations through consultation and testing with policymakers, subject-matter experts, and

other stakeholders, including those most directly affected by the events under investigation" to help "ensure the recommendations are informed by practical experience, aligned with operational realities, and informed by those with expertise in implementation and the workings of government".[70] She noted that a range of approaches, such as seminars and roundtables, have been used by inquiries to engage with external views.[71] Dr Ireton also emphasised the importance of engaging "a wide range of stakeholders during the design stage" as well as having "internal scrutiny" processes to help "ensure that all recommendations are evidence-based, coherent, proportionate, and capable of being implemented".[72]

An example of good practice as regards involving those with lived experience is the **Covid-19 Inquiry**, which has highlighted a listening exercise called "Every Story Matters". The Module 1 report notes that

> "As set out in the Terms of Reference, the Inquiry also regards it as critical to its work to listen to and carefully consider the experiences of bereaved families and others who have suffered hardship or loss as a result of the pandemic. The Inquiry will do this in a number of different ways, including through its 'listening exercise', Every Story Matters. …Sharing experiences with the Inquiry will help the understanding of events and their impact, and the development of recommendations that could reduce suffering in the future".[73]

It also has a targeted project which seeks to hear from children and young people most affected to "help inform its findings and recommendations".[74]

1.2.8 The 'implementability' of recommendations

A range of experts have stressed the need for consideration of what is 'implementable'.

For example, in evidence to the House of Lords Statutory Inquiries Committee, Mark Fisher, former secretary to the Grenfell Tower Inquiry, emphasised:

> "It is important that the Government is held to account, to a degree, for the implementation of recommendations, but then that puts an onus on the inquiry team to produce recommendations that are capable of implementation and not to produce a whole set of hundreds and hundreds of recommendations that are not capable of clean and simple implementation."[75]

Experts at King's College London have stressed that "Based on the extant research, an important success factor for inquiries is that their recommendations be feasible" and that "Recommendations stand a lower chance of success when they are politically, technically or budgetarily unfeasible".[76]

As we have noted above, recommendations should be evidence-based and developed through consultation with experts and other stakeholders. As Dr Ireton has stressed, each inquiry recommendation "must be demonstrably grounded in the evidence gathered during the inquiry process".[77] She has also emphasised that "Once inquiries have determined the areas on which they intend to make recommendations, they will often improve and refine their draft recommendations through consultation and testing with policymakers, subject-matter experts, and other stakeholders".[78] This consultation and testing process is one of the ways in which inquiries can give consideration to whether recommendations are "implementable". Once an inquiry has made recommendations, it is then a decision for the Government whether or not to accept and implement inquiry recommendations.[79]

We would also emphasise at this point the importance of keeping an eye on rejected recommendations, as well as previously accepted recommendations that are no longer being implemented, because the harms they seek to address might be repeated in future and need to be further considered. As INQUEST'S Executive Director Deborah Coles has stated, "Equally, if somebody says that a recommendation should not be implemented at a particular time for whatever reason, if you have proper oversight of recommendations, something else may happen two years later that suggests that the recommendation that was rejected should perhaps have been implemented and may need to be reconsidered".[80] We will return to this point below.

Dr Ireton has also considered the importance of internal scrutiny to strengthen recommendations and she has noted that, "Where previous inquiries have examined the same or similar issues, an early task is to review what work has already been done, what recommendations were made, and what has happened in terms of implementation".[81] Dr Ireton pointed to the Thirlwall Inquiry, which was set up to examine events at the Countess of Chester Hospital and their implications after the trial and convictions of former neonatal nurse Lucy Letby, and which reviewed recommendations from previous inquiries.[82] The Thirlwall Inquiry's terms of reference asked, among other things, "'Whether recommendations to address culture and governance issues made by previous inquiries into the NHS have been implemented into wider NHS practice? To what effect?'".[83]

The Thirlwall Inquiry Report was published on 15 September 2026, just before this report was finalised.[84] We would highlight Chapter 31 of the Thirlwall Inquiry Report which considers in some detail the implementation of recommendations of inquiries.[85] Among other things, the report explains that "The first detailed work carried out by this Inquiry was a review of all recommendations made in all inquiries into the NHS in the last 30 years" and "The review shows that, whilst some significant changes have been introduced in response to Inquiry recommendations over the last 30 years, most have not been implemented".[86] The Chair of the Inquiry, Lady Justice Thirlwall, stated, "I accept that 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. Even where recommendations are accepted, there is no mechanism to track progress or enforce implementation".[87] Chapter 31 also includes discussion of the reasons recommendations are not implemented.

More broadly, in some instances of non-implementation of recommendations there might be a question of whether the recommendations were capable of being implemented. In other cases, non-implementation might speak more to a need for greater accountability.

For example, INQUEST has stated, "The Lakanal House recommendations provided an opportunity to make crucial changes to ensure that no more lives would be lost in another tower block fire, however there was no action taken. Had several of these recommendations been prioritised and implemented, the Grenfell Tower fire may not have occurred".[88] Similarly, on the ninth anniversary of the Grenfell Tower fire, Joe Powell MP stated in Parliament:

> "I acknowledge all that progress, but there is one missing piece of the jigsaw: oversight and accountability. The online tracker for Grenfell recommendations is no doubt helpful, but 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 need a proper system of tracking and following up, not just on major inquiries that get a lot of attention here, but on all the inquests and investigations that lead to recommendations for change. That is why I continue to support the idea of a national oversight mechanism as a legacy for Grenfell." [89]

1.3. Ways forward for making inquiry recommendations

In this part of the report, we have considered the number, presentation and categories of recommendations made by public inquiries by analysing the recommendations from our sample of UK inquiries. We have also explored some wider themes relating to the framing and development of inquiry recommendations.

In this concluding section, we highlight some key messages from our workshop about making inquiry recommendations, and we suggest some ways forward.

Key messages from our workshop about making inquiry recommendations

- We heard about the need to reach back to the beginning of establishing an inquiry and designing its procedures with the recommendations function in mind.[90]
- For example, we heard about the importance of considering the development of recommendations and how to monitor them, from the outset of an inquiry.[91]
- We also heard about the central importance of recommendations in the inquiry process, with the whole inquiry heading towards the development of recommendations.[92]
- It was also emphasised that recommendations are made to achieve a purpose.[93] It was suggested that inquiries ought to give more consideration to a metric by which one can say whether a recommendation has been achieved.[94]

Ways forward for making inquiry recommendations[95]

- From the beginning, consideration should be given to the process of making recommendations and how implementation of recommendations will be monitored and scrutinised.
- Inquiries should review past inquiries on similar or the same subject matter to see what recommendations were made and which have been implemented (and to what extent).
- Recommendations should be focused in number and scope.
- Recommendations should be clearly presented and categorised.
- Responsibility for implementing recommendations should be clearly assigned.
- Recommendations should be considered throughout the inquiry process, grounded in evidence, and developed through consultation with experts and other stakeholders, including those with lived experience of the issues raised by the inquiry.
- Consideration should be given to the 'implementability' of recommendations.
- Our research did not consider whether some categories of recommendation are more amenable to implementation than others, and this could be an avenue for further research and analysis.

The next part of this report will focus on what happens to inquiry recommendations once they have been delivered. In particular, it considers approaches to responding to inquiry recommendations and reporting on progress.

Part 2: Responding to inquiry recommendations and reporting on progress

2.1 Responding to inquiry recommendations

This section considers responses to inquiry recommendations. We begin by considering the current position and then we highlight some proposed reforms.

The Inquiries Act 2005 requires the relevant minister to publish inquiry reports and lay them before Parliament.[96] The Act "does not require the Government, public bodies or other organisations to respond to inquiry recommendations, explain why any are rejected, or even formally acknowledge an inquiry's findings", which has been "widely criticised".[97]

Nonetheless, draft Cabinet Office guidance states, "The responsible minister will be expected to respond to the report and other parties may be subject to considerable media attention".[98] It also states that "The Government is not obliged to accept the inquiry's recommendations but will be expected to indicate in its response which recommendations will be accepted".[99]

In evidence to the House of Lords Statutory Inquiries Committee in April 2024, the Director of the Propriety and Ethics Team in the Cabinet Office noted that "we say as a matter of best practice that unless there is a compelling reason not to do so, departments should be responding to any inquiry's final report within six months to make sure that there is a proper and full response".[100] This was reiterated by the Deputy Director of the Propriety and Ethics Team who noted that "the government view is that, apart from in exceptional circumstances, they should be responded to within six months". [101] Referencing this, the Statutory Inquiries Committee noted that "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" and that "The wait for the Government's response and uncertainty about Government action also further protracts the suffering of victims and survivors".[102]

In 2013-2014, a House of Lords Select Committee undertook post-legislative scrutiny of the Inquiries Act 2005. [103] The Committee made several recommendations about responding to inquiry recommendations, and it is worth noting them in full.[104]

> "Recommendation 30: In the case of many inquiries, publication of the formal Government response is accompanied by a statement to both Houses. We recommend that this should be the invariable practice. If a second, more detailed, written response is produced, as [is] often the case, it should also be published. It should say exactly which recommendations are accepted."
>
> "Recommendation 31: If the inquiry specifies that particular recommendations are for implementation by particular public bodies, those bodies should have a statutory duty to say within a specified time whether they accept the recommendations, and if so, what plans they have for implementation."
>
> "Recommendation 32: We recommend that in all cases, the response should be published not more than three months after receipt of an inquiry report. Reasons should be given for not accepting recommendations. For those which are accepted, details of when and how they will be implemented are essential. The report should include an implementation plan, and a commitment to issue further reports to Parliament at 12-monthly intervals."

In June 2014, the then government responded to the Select Committee's report, and again it is worth setting out in some detail.[105]

Recommendation 30 – "The Government accepts this recommendation insofar as a formal Government response can be agreed. However, there are cases where this will conflict with other security related legislation and where, therefore, the Government will be unable to meet the requirements of this recommendation".

Recommendation 31 – "The Government accepts recommendation 31 but does not consider that there needs to be a statutory duty".

Recommendation 32 – "The Government also accepts Recommendation 32 in principle but with a more realistic timeframe given the clearances that will be required and the need to cost fully those recommendations it is considering accepting. We consider that a six month timeframe for publication of the Government's response would be more achievable".

In 2024, the House of Lords Statutory Inquiries Committee published its report 'Public Inquiries: Enhancing public trust'.[106] The 2024 Committee reiterated Recommendations 30 and 32 but it discarded Recommendation 31,[107] and this "disappointed many who hoped the introduction of a statutory duty would encourage greater transparency and accountability".[108]

In February 2025, under Keir Starmer's Labour government, a response was published to the 2024 Committee's report, which among other things set out the 2014 report recommendations and the 2024 reiterations.[109] As regards Recommendation 30, it stated that, "The Government agrees, and notes that this is already common practice. It will be reflected in the guidance on inquiries to be published".[110] As regards Recommendation 32, it stated:

> "The Government agrees that responses should be published as swiftly as possible. In practice, the design and costing of policy, and the seeking of cross-Government agreement on complex areas of reform, can take longer than three months. In response to the House of Lords 2014 report on post-legislative scrutiny of the Act, the then government suggested that six months was a more realistic timeframe. The Government can commit to publishing guidance on inquiries which will address this recommendation. The Government is also committed to providing a further update to Parliament on its intentions for any wider reforms of the frameworks around inquiries."[111]

A central theme that emerges from these recommendations is the importance of transparency. As expert Dr Emma Norris has emphasised:

> "The key is not whether they are being implemented. The key is knowledge and explanation. That is why one of the other changes that I would like to see… is a reporting duty being placed on public bodies requiring them to set out whether they plan to accept recommendations and, if not, why not. That is the crucial piece: going through the process of thinking it through, having to explain it and providing transparency …"[112]

It is particularly important that reasons are given for rejecting recommendations. It is also important that reasons are given for previously accepted recommendations no longer being implemented, and for any alternative measures being adopted. As Dr Ireton has stressed, "There may be legitimate reasons why some recommendations are rejected, or why accepted recommendations later prove impracticable. In such cases, what matters is transparency and a clear account of the reasoning which, currently, is often lacking".[113]

In this respect, the Chair of the Southport Inquiry recently emphasised:

> "Regarding the recommendations for immediate action, it is for the government to decide whether to accept them, reject them, or adopt an alternative course. I make clear, however, that in Phase 2 of the Inquiry I will expect detailed updates on the progress of all accepted recommendations, and on any alternative measures the government chooses to pursue. A consistent concern raised by the victims of the attack has been that recommendations from past reviews and inquiries have not led to meaningful change. It is therefore essential that they are informed, in concrete terms, of the action to be taken in response to the Phase 1 recommendations."[114]

Key messages from our workshop about responding to inquiry recommendations

- We heard that the timeliness and quality of responses to inquiry recommendations have been inconsistent; and that responses should be timely, transparent and supported by clear reasoning.[115]
- We heard that we presently lack transparency and clear reasoning around the reasons for rejecting recommendations or subsequently deciding they are not practical.[116]
- It was stressed that the preventative potential of the UK's investigation framework is currently being undermined due to the lack of transparency about the actions taken (or not taken) to implement what are potentially life-saving recommendations.[117]
- We also heard about the frustration at having developed important recommendations and then nothing happening.[118] The worst thing was recommendations falling into a black hole.[119]
- We heard about the importance of an implementation plan and regular reporting to Parliament to track progress of accepted recommendations.[120]
- It was also stressed that it is often the most difficult recommendations that are likely to be rejected, and we should be careful not to take our eyes off rejected recommendations because there may be repeat instances further down the line.[121]

Ways forward for responding to inquiry recommendations

- As noted above, the responsible minister will be expected to respond to an inquiry report and the Cabinet Office has noted that, unless there is a compelling reason not to do so, departments should respond to an inquiry's final report within six months.
- We agree with Recommendations 30, 31 and 32 from the 2014 Select Committee:

  "Recommendation 30: In the case of many inquiries, publication of the formal Government response is accompanied by a statement to both Houses. We recommend that this should be the invariable practice. If a second, more detailed, written response is produced, as [is] often the case, it should also be published. It should say exactly which recommendations are accepted."

  "Recommendation 31: If the inquiry specifies that particular recommendations are for implementation by particular public bodies, those bodies should have a statutory duty to say within a specified time whether they accept the recommendations, and if so, what plans they have for implementation."

  "Recommendation 32: We recommend that in all cases, the response should be published not more than three months after receipt of an inquiry report. Reasons

should be given for not accepting recommendations. For those which are accepted, details of when and how they will be implemented are essential. The report should include an implementation plan, and a commitment to issue further reports to Parliament at 12-monthly intervals."

- As regards the three-month time frame suggested in Recommendation 32, we note that the then government considered a six-month timeframe for publication of the Government's response would be more achievable. However, we would emphasise that public inquiries are set up in response to events that raise major public concern, and public inquiry recommendations can be important for addressing the harms an inquiry identifies and for preventing similar harms from occurring in future.
- In addition to giving reasons for not accepting recommendations, we believe there should be a requirement to provide reasons in relation to partial acceptance and, further down the line, there should be a requirement to give reasons for previously accepted recommendations no longer being implemented and for any alternative measures being adopted.

2.2 Reporting on progress

Some stakeholders have expressed concern about the way in which progress on the implementation of inquiry recommendations is reported. For example, in evidence to the Housing, Communities and Local Government ("HCLG") Committee, as part of its inquiry into Grenfell and building safety, journalist Peter Apps stated, "one of my roles as a journalist is trying to keep track of whether the Government are implementing the recommendations that have come from the Grenfell Tower Inquiry and other processes" and "It is extraordinarily hard to do that if all you have to go on is the Government's own word".[122]

Until recently, "there was no central public record of public inquiry recommendations, responses, or implementation progress", which "makes it extremely difficult for participants, the public, the media, and others to track progress or apply pressure when commitments are not being met".[123] For example, in 2018, the National Audit Office ("NAO") highlighted that, "Once inquiries have concluded, there is no central repository or responsibility across government for tracking whether recommendations have been implemented and ensuring that inquiries have an impact".[124] It noted that, "Individual inquiries and departments vary in the extent to which they are transparent about action taken in response to recommendations".[125]

In September 2024, the Grenfell Tower Inquiry Phase 2 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".[126] It noted in particular that "The department had no system for recording recommendations made by public bodies or keeping track of its response to them".[127] The Inquiry recommended that "it be made a legal requirement for the government to maintain a publicly accessible record of recommendations made by select committees, coroners and public inquiries together with a description of the steps taken in response" and added that "If the government decides not to accept a recommendation, it should record its reasons for doing so. Scrutiny of its actions should be a matter for Parliament, to which it should be required to report annually".[128] This has been numbered "Recommendation 25" for reporting purposes.[129]

In February 2025, under Keir Starmer's Labour government, a response to the Grenfell Tower Inquiry's Phase 2 report was published and it stated:

> "The government accepts this recommendation in principle.

> We will establish a record on GOV.UK of all recommendations made by public inquiries since 2024, and will consider making this an enduring legal requirement. The government agrees that scrutiny of its actions is a matter for Parliament, and ministers will commit to updating Parliament on progress for implementing inquiry recommendations. The government notes the recommendation of the House of Lords Statutory Inquiries Committee to establish a new committee of Parliament to improve scrutiny of government's response to inquiry recommendations. The judiciary already maintains a publicly accessible record of Prevention of Future Deaths reports made by coroners, and the government is working with the Chief Coroner to improve their transparency and availability, as well as to improve accountability for responses to them."[130]

However, in March 2025, in evidence to the HCLG Committee, INQUEST's Executive Director Deborah Coles emphasised that "it excludes pre-2024 recommendations, which risks failing to identify those patterns of repeated recommendations that we see" and "it does not draw together recommendations from inquests, inquiries and Select Committees in one place".[131] In the same evidence session, Journalist Peter Apps stressed, "You cannot leave it to Departments, Officials and Ministers to police themselves" and "the Government's proposal—as I understand it—is to effectively report to us themselves on the progress, and that relies on them telling the truth about it, which unfortunately they haven't done".[132]

In July 2025, the Cabinet Office published a webpage collection, 'Public Inquiries: Recommendations and the Government Response'.[133] This notes that "This page records public inquiry recommendations made since 2024, the government's commitments in response to these recommendations, and updates on implementation".[134] The collection currently includes pages for the Infected Blood Inquiry, Grenfell Tower Inquiry, Covid-19 Inquiry, Manchester Arena Inquiry, Post Office (Horizon) Inquiry and the Fuller Inquiry.[135]

This new collection represents a significant development and the transparency it offers will help those seeking to keep track of these recommendations. However, it has been noted that "the tracker does not capture responses from other bodies to whom recommendations are directed, and relies on self-reported data".[136] We will return to some of these issues below.

Key messages from our workshop about reporting on progress

- We heard some caution as regards the new Cabinet Office collection of inquiry dashboards, including that it is not independent of government or independently tested, and is not safeguarded against a change in departmental needs or government.[137]
- It was also emphasised that while the Cabinet Office collection provides a degree of visibility, it is not and was not meant to be a substitute for monitoring.[138]

Ways forward for reporting on progress

- The Cabinet Office webpage collection should be expanded to include all inquiries with accepted recommendations that remain to be implemented. However, it will remain the case that, as currently set up, the collection is based on self-reported data.
- Therefore, as we will discuss in more detail below, 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).

Part 3: Monitoring the implementation of inquiry recommendations

3.1 Background and definitions

As noted above, there is an 'implementation gap' between inquiry recommendations and their implementation in practice. When inquiry recommendations go unaddressed, it risks similar harms being repeated, and it risks undermining public trust and confidence in inquiries as an accountability tool. We recognise that government may have good reasons for not accepting and implementing certain recommendations. However, there is an implementation gap between accepted recommendations and their implementation in practice that goes beyond this. This problem is at the heart of our research project which explores 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.

There are several reasons for the implementation gap, some of which we have discussed above. First, the Inquiries Act 2005 "does not require the Government, public bodies or other organisations to respond to inquiry recommendations, explain why any are rejected, or even formally acknowledge an inquiry's findings".[139] Second, once an inquiry has made recommendations, it is then a decision for the Government whether or not to accept and implement inquiry recommendations.[140] Third, and perhaps most significantly, there is no "formal, independent mechanism to oversee and monitor implementation of recommendations once an inquiry has concluded".[141]

In view of the numerous accepted recommendations which remain to be implemented, many are calling for greater accountability in the UK. In particular, the organisation INQUEST has for many years called for a new oversight mechanism.[142] We will discuss INQUEST's proposal for a 'National Oversight Mechanism' further below. INQUEST's Executive Director Deborah Coles has stressed, "Bereaved families and victims tell us that they go through the inquiry process particularly in the hope of finding the truth and getting their experiences acknowledged, particularly where there has been wrongdoing or harm, but more than anything they look for these processes to result in meaningful change so that other people do not end up going through similar experiences".[143]

It is important that the implementation of every recommendation is monitored and scrutinised. However, we must also emphasise at the outset that there cannot be a one-size-fits-all approach here. As Dr Ireton has emphasised, "Given the variation in the core purpose for which public inquiries are convened, and in the technical complexity, policy fields, regulatory regimes, and institutional environments to which their recommendations relate, it does not follow that one single model can adequately monitor government responses and implementation of recommendations across all public inquiries".[144] She suggested that "Monitoring mechanisms should align with the inquiry's core purpose and the nature of its recommendations, in order to ensure proportionality and effectiveness".[145]

It is worth pausing here to consider some definitions. "Implementation monitoring" has been described as "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".[146]

Dr Ireton has noted that "Effective monitoring requires both oversight and scrutiny" which she defines as follows:

> "Oversight is a top-down mechanism for tracking implementation, requiring those responsible for implementation to report on progress. Its value lies in providing a structured framework for visibility and accountability. However, it relies heavily on

> the quality and completeness of the information received, much of which is self-reported. Where reporting is overstated, incomplete, or inaccurate, oversight alone may mask shortcomings rather than expose them. The formal acceptance of recommendations, and commitments to implement them, do not in themselves guarantee effective implementation or meaningful change in practice. Experience shows that recommendations may be accepted and implementation reported, yet the underlying matter of public concern may recur, or subsequent inquiries may identify similar failures and repeat earlier recommendations.
>
> Scrutiny, by contrast, is a bottom-up process that provides independent verification not only of whether recommendations have been implemented, but whether implementation has been done meaningfully and as intended. It involves specialist, independent examination of implementation 'on the ground' and may report directly to Parliament. In doing so, it can also prompt behaviour change and accelerate delivery. However, scrutiny is inquiry-specific. Alone, it does not provide a structured framework for tracking implementation across inquiries, nor does it ensure ongoing visibility or accountability at a systemic level."[147]

Before closing this section, we highlight two examples of ad hoc oversight groups, one established in relation to the Infected Blood Inquiry and the other established in relation to Prevention of Future Death ("PFD") reports and relevant to the Grenfell Tower Inquiry's Recommendation 25 discussed above. While the initiatives noted in the two case studies are welcome, many are calling for a joined-up approach to monitoring, overseeing and scrutinising the implementation of recommendations from inquiries and inquests.

Case study: Infected Blood Oversight and Assurance Group

The 'Infected Blood Inquiry Oversight and Assurance Group' was established in 2024 to oversee delivery of recommendations from the Infected Blood Inquiry which are to be implemented by either the Scottish Government, NHS Scotland or other associated organisations in Scotland.[148] Its membership includes a range of stakeholders including, for example, representatives from the Scottish Government, Scottish Infected Blood Forum, Haemophilia Scotland, Scottish National Blood Transfusion Service, the NHS, and others.[149]

Case study: Prevention of Future Deaths Oversight Working Group

In the 'Grenfell Tower Inquiry Phase 2 Report Government Response: Annual Report 2026', as part of a wider discussion about work relevant to Recommendation 25 from the Inquiry, the Government noted that it had established "a cross-government PFD Oversight Working Group bringing together all departments that routinely receive PFDs".[150] The report stated that the group "shares best practice and helps tackle any barriers that hinder timely dissemination, learning, and implementation" and noted that the initiative is "designed to strengthen internal structures within government departments and public bodies for handling PFD reports, ensuring they can respond effectively and consistently to concerns raised".[151]

3.2 Legal challenges concerning the response to recommendations

At the outset, we note that "Decisions made by ministers and the chair or inquiry panel during the convening, and course, of a public inquiry may be challenged by way of judicial review" and it has been observed that "In the context of public inquiries, the most frequent judicial review challenges have related to decisions by a minister not to convene a public inquiry".[152]

However, inquiry recommendations are not legal binding and, as noted above, once an inquiry has been established and made recommendations, it is then a decision for the Government whether or not to accept and implement inquiry recommendations.[153] Indeed, in evidence to the 2014 Select Committee, the law firm Eversheds commented that, in their experience, the 2005 Act "does not ensure that recommendations are adequately implemented" and that "other than facing potential public criticism, there is no recourse if Government fail to implement recommendations or fail to explain their reasons for non-implementation".[154]

It is against this backdrop, that this section highlights some recent examples of legal challenges concerning the response to recommendations. The first two cases involve unsuccessful challenges.

Sarah Phillipa Rennie & Ors v Secretary of State for the Home Department (2023) – Grenfell Tower Inquiry

This claim concerned the Defendant's response to two recommendations from the Grenfell Tower Inquiry Phase 1 Report relating to personal emergency evacuation plans ("PEEPs").[155] The claim was dismissed and, among other things, the Court concluded, "This was essentially a political decision for the defendant to take and was not in breach of the requirements of public law and procedural fairness".[156] It added, "It must have been desperately disappointing for the claimants and many others that the carefully considered PEEPs recommendations contained in the Phase 1 report have not been implemented, but it was not an unlawful decision".[157]

D1914 & Anor, R (on the application of) v Secretary of State for the Home Department (2025) – Brook House Inquiry

The Claimants sought permission to challenge the Defendant's response to the Brook House Inquiry report.[158] AAA was refused permission to apply for judicial review due to lack of standing; D1914 was granted permission to apply for judicial review on several of the grounds, but the claim for judicial review was dismissed.[159]

It is beyond the scope of this report to set out the Court's findings in full. However, it is interesting to highlight that, in its conclusions, the Court accepted "the Defendant's submission that there is no legal obligation upon the Defendant to comply with the BHI recommendations", adding that "They are recommendations, not directions. The BHI had no power to compel the Defendant to implement its recommendations".[160] It also stated that "Whilst the Defendant has responded to the BHI report and recommendations, both formally and informally, there is no express legal obligation on her to do so".[161] Later, the Court stated that "The IA 2005 does not include any express or implied obligation on a minister to implement inquiry recommendations" and "Parliament did not mandate whether, how and to what extent any recommendations should be implemented".[162]

A piece for law firm Burges Salmon commented that the D1914 judgment "reminds us that inquiries cannot directly enforce their recommendations" and "makes clear that the Inquiry's powers are investigative only and the court will not intervene to compel a body or organisation to implement the recommendations of an Inquiry Chair".[163] The law firm Eversheds Sutherland noted that the case "adds to the wider ongoing discussion around inquiry recommendations being ignored, delayed, or perhaps not implemented in the way that others expect".[164] It concluded, "The right balance needs to be struck between respecting the Government's discretion to respond to Inquiry recommendations, and ensuring that, where recommendations are accepted, effective mechanisms are in place to ensure their implementation".[165]

The D1914 case highlights two further issues. First, as noted above, AAA was refused permission to apply for judicial review due to lack of standing, with the Court commenting, among other things, that "Any causative link between AAA's experiences at Colnbrook and the Defendant's response to the recommendations in the BHI report is very tenuous indeed".[166] It has been commented that "This further underlines the difficulties of using the courts as a means for ensuring the implementation of the kind of systemic learning frequently required by independent reports and inquiries so that incidents of public concern do not happen again in similar sites, be they other detention centres, residential tower blocks, or care homes".[167]

Second, the Court ruled that a ministerial statement made by the Defendant in November 2019 was inadmissible on grounds of parliamentary privilege, in light of which D1914 decided not to pursue one of his grounds (relating to legitimate expectation) at the hearing.[168] It has been commented that "The scope for transforming learning to lawyering is therefore highly dependent on the vagaries of where and how promises of action are made, with a clear precedent set for legally canny ministers to only make promises for action within the confines of the House of Commons, on the basis that to do so might reduce their long-term exposure to legal accountability".[169]

The next two cases involve successful challenges, though we note that strictly speaking these do not relate to public inquiries as such. The Windrush Lessons Learned Review ("WLLR") was an independent review by Wendy Williams,[170] and the Independent Review of Criminal Legal Aid was chaired by Sir Christopher Bellamy QC.[171]

Trevor Donald, R (on the application of) v Secretary of State for the Home Department (2024) – Windrush Lessons Learned Review

The Claimant challenged the former Home Secretary's decision not to proceed with certain recommendations (Recommendations 3, 9 and 10) from the Windrush Lessons Learned Review ("WLLR").[172] The Home Office had published a "Comprehensive Improvement Plan" ("CIP") in September 2020 which set out the Defendant's response to each of the WLLR's recommendations.[173]

It is beyond the scope of this report to set out the Court's findings in full. Briefly, we note that two of the grounds of challenge were dismissed; and all grounds of challenge relating to Recommendation 3 were dismissed.[174] However, the Court concluded that the decisions not to proceed with the responses indicated in the CIP in relation to Recommendations 9 and 10 (1) breached a "procedural legitimate expectation that the Defendant would consult with relevant stakeholders, including representatives of the Windrush community, and with Wendy Williams" before substantially changing the response to the recommendations that was set out in the CIP; (2) amounted to "indirect discrimination, given the particular impact on Windrush victims as compared to the rest of the population at large and that the Defendant had not shown that these policy decisions were a proportionate means of achieving a legitimate aim"; and (3) breached the public sector equality duty.[175]

One commentator has noted, "it was not a contentious point between the claimant and defendant in this case that the scandal's victims fell within groups protected by Article 14 or the public sector equality duty", however, "other potential claimant groups affected by other kinds of government maladministration may find these preconditions to be a barrier to repeating the same success where the equality dimensions are not as overt as in Donald".[176]

Law Society of England and Wales, R (on the application of) v The Lord Chancellor (2024) – Criminal Legal Aid Independent Review

In this case, the Law Society challenged two aspects of the response to the 'Criminal Legal Aid Independent Review' Report.[177] The claim for judicial review was granted in part and the Court stated that a declaration would be granted in the following terms:

> "It is declared that:
>
> (1) The Lord Chancellor's failure, during the decision-making process, to ask whether fee increases at lower levels than the 15% recommended in the CLAIR Report would, or might, still deliver the aims and objectives of the CLAIR Report, was irrational and breached his Wednesbury duty.
>
> (2) The Lord Chancellor's failure to undertake any modelling to ascertain whether the aims and objectives of the CLAIR Report, in particular ensuring the sustainability of criminal legal aid, would be furthered if fee uplifts lower than the 15% recommended by the CLAIR Report were implemented, was irrational and breached his Tameside duty of sufficient enquiry."[178]

It has been commented that the Law Society judgment "represents the high-water mark of judicial intervention".[179] In particular, it has been suggested that "It is difficult to see where this approach ends or how government can carry out its complex tasks if it is to be micromanaged by the courts and if considerable resources have to be expended on defending itself in court. It will lead to even more caution and delay by officials and also discourage ministers from establishing the kind of independent review carried out … by Lord Bellamy".[180]

Concluding remarks

Looking ahead, we understand the High Court has granted permission for The Maggie Oliver Foundation to challenge "the Government on its failure to implement" the recommendations of IICSA.[181] It will be interesting to see the approach of the court in this case.

From this brief exploration of some recent cases, we see the limitations of legal challenges in this area. It is, therefore, clear that we need 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.

3.3 The role of Parliament

3.3.1 Background and the role of Parliament

Writing in 2011, leading expert on public inquiries, Jason Beer KC, emphasised that one of the most significant changes brought about by the Inquiries Act 2005 was the repeal of the Tribunals of Inquiry (Evidence) Act 1921 and "the removal of the direct role of Parliament in establishing inquiries".[182] He noted, however, that the Act still ensures a role for Parliament, including, for example, the requirement to lay a copy of the inquiry report before Parliament.[183] In addition, inquiry reports can

also be debated in Parliament, though Jason Beer KC commented that the "nature and extent of debate of inquiry reports has varied enormously".[184]

Notes from our sample of UK inquiries

UK Covid-19 Inquiry

- There was a debate in the House of Commons on 19 July 2024,[185] and a debate in the House of Lords on 3 September 2024.[186] These related to the Module 1 Report.
- There have also been a number of written questions tabled (and answered) about the Covid-19 inquiry including, for example, questions about the total public cost so far of the Covid-19 Inquiry;[187] about steps being taken to implement specific recommendations from the Inquiry;[188] about the planned timeframe for implementing recommendations from the Inquiry;[189] about whether the Minister for the Cabinet Office will assess the merits of establishing an oversight mechanism to monitor the implementation of the Inquiry's recommendations;[190] and about the steps being taken to ensure that the Inquiry's findings and recommendations are incorporated into pandemic planning and preparedness exercises.[191]

Independent Inquiry into the Issues raised by Paterson

- There was a debate in the House of Commons on 4 February 2020,[192] and a debate in the House of Lords on 4 February 2020.[193]

Daniel Morgan Independent Panel

- There was a debate in the House of Commons on 15 June 2021,[194] and a debate in the House of Lords on 22 June 2021.[195]

It is also important to emphasise at the outset that it is "the responsibility of Government to respond in a timely and transparent manner to inquiry recommendations, to give clear reasons where recommendations are not accepted, and to oversee and support effective and timely implementation in addressing the matter of public concern" and, importantly for present purposes, it is "for Parliament to hold the executive to account in this respect".[196]

Indeed, in February 2026, in written evidence to the Public Administration and Constitutional Affairs Committee ("PACAC") as part of its Inquiry into the recommendations of the Infected Blood Inquiry, the Cabinet Office stated that "The Government has recognised that the monitoring of public inquiry recommendations is currently insufficient" and that "too often inquiry recommendations have been made and accepted, but not implemented".[197] The Cabinet Office acknowledged that "There are clearly further improvements required to scrutiny in this area" and "Parliament is the constitutionally appropriate body to hold the Government to account for the implementation of inquiry recommendations".[198] It also emphasised that "The Government supports an enhanced role for Parliament in monitoring implementation".[199]

In the remainder of this section we will focus on the role of Parliamentary select committees as well as proposals for a new public inquiries committee.

3.3.2 Parliamentary select committees

Some of the inquiries in our sample have called for (specific) parliamentary committees to monitor the implementation of their recommendations.

Notes from our sample of UK inquiries

Sir John Saunders, chair of the **Manchester Arena Inquiry**, suggested that the Intelligence and Security Committee of Parliament could monitor the recommendations in the closed Volume 3 report.[200] The Committee agreed "with Sir John that it is important his recommendations must be implemented, and that an appropriate form of monitoring is essential to ensure that this happens" but concluded that "it is not the right body to monitor [the recommendations] proposed by Sir John's Inquiry".[201]

Recommendation 12 of the **Infected Blood Inquiry Report** called for "(d) The Public Administration and Constitutional Affairs Committee ("PACAC") should review both the progress towards responding to the Inquiry's recommendations and, to the extent that they are accepted, implementing those recommendations".[202] We understand that PACAC has agreed to take forward recommendation 12(d).[203]

Parliamentary committees have considered some of the inquiries in our sample.

Notes from our sample of UK inquiries

In 2025, the **Home Affairs Committee** held evidence sessions on the implementation of the findings of **IICSA**, and recent policy developments.[204] This process included, for example, considering "how far the recommendations of the report have been implemented".[205]

In 2024, the **Home Affairs Committee** held a one-off evidence session on the **Brook House Inquiry** and it noted that "The Government has now published its response, and this session will examine the Government's proposed reforms and progress made".[206]

The **HCLG Committee** has a current inquiry into **Grenfell and Building Safety** which opened in March 2025 and it has noted that "The Committee is examining the Government's response to the Grenfell Inquiry recommendations, and exploring progress on the wider programme of work around building and fire safety and remediation".[207]

As noted above, in 2013-2014, a House of Lords Select Committee undertook post-legislative scrutiny of the Inquiries Act 2005.[208] Among other things, the Committee concluded that Commons Departmental Select Committees were "best placed to monitor the implementation of inquiry recommendations".[209] However, the 2024 House of Lords Statutory Inquiries Committee also considered monitoring by Parliament and it commented that, "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".[210] It cited the IfG's 2017 report which 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" and which stressed that "Parliament can and should play a more significant role in holding ministers to account".[211]

At the time, the IfG recommended that the Liaison Committee consider adding a "core task to the guidance that steers select committee work: scrutinising the implementation of inquiry findings".[212] However more recently, in evidence to the Statutory Inquiries Committee in 2024, Emma Norris (then Deputy Director of the IfG) noted that the organisation's view had since evolved.[213] She noted that while there is "still an important role there for them… the Select Committee model should be combined with another independent body".[214] She noted that "expecting them to do in-depth monitoring of recommendations and whether they are being implemented feels like a relatively tall order" and suggested that another body, such as the National Oversight Mechanism proposed by

INQUEST, could do this and pass on areas of concern to the relevant Select Committee.[215] We will discuss INQUEST's proposal for a National Oversight Mechanism further below.

Others have expressed similar concerns. For example, Dr Ireton has noted that "inquiry recommendations often span multiple departments and may not align neatly within the remit of a single parliamentary committee".[216] She has also commented that "Capacity, resources, and turnover amongst committee memberships can also affect continuity and effectiveness".[217] Similarly, INQUEST has recently emphasised that "Select committees already have a high number of areas to investigate and it is questionable whether they would have the capacity to effectively follow-up on inquiry recommendations".[218] It recommended that the "Government should set up a dedicated and independent organisation that can work alongside Parliament to ensure scrutiny of recommendations that is comprehensive, thorough and sustained".[219] As noted above, we will discuss INQUEST's proposal further below.

Finally, it is interesting to highlight that the Cabinet Office has suggested several ways in which Parliament might play a greater role here:

> "Practical steps could include inviting the relevant minister or, if appropriate, a suitable senior official, to appear before PACAC or the relevant Select Committee shortly after the Government publishes its response to an inquiry. This would allow for immediate scrutiny of how the department intends to absorb and implement lessons learned. …
>
> Additionally, Committees may find it beneficial to invite Inquiry Chairs to give evidence following the publication of their reports. This would provide an opportunity for the Chair to discuss their recommendations in greater detail and clarify their intent, aiding Parliament in its subsequent scrutiny of the Government's delivery."[220]

3.3.3 A new public inquiries committee

The 2024 report of the House of Lords Statutory Inquiries Committee emphasised that 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".[221]

The Committee's recommendation was that "formal implementation monitoring should be undertaken by a new, joint, select committee of Parliament: the Public Inquiries Committee" or should "a new joint committee not be desired, then it should be a sessional committee of the House of Lords".[222] In the Committee's view, a new committee should be given the resources to perform 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." [223]

However, as Dr Ireton has commented, "While such a committee would offer formal top-down oversight, it would rely on self-reported evidence, with the limitations that brings".[224] She did suggest that "Its work, however, could be combined with other mechanisms, such as implementation monitors, to strengthen scrutiny".[225] We will consider the role of implementation monitors further below. Dr Ireton has also emphasised that "its proposed role would require access to expertise spanning diverse and highly technical fields, as well as substantial staffing and research capacity, beyond current committee resourcing arrangements" and this is "likely to require it to prioritise some inquiries over others, with the risk of uneven and inconsistent oversight".[226]

In February 2025, under Keir Starmer's Labour government, a response was published to the 2024 Committee's report.[227] Regarding the recommendation for a new Public Inquiries Committee, it stated that "This recommendation is for Parliament. The Government is committed to providing a further update to Parliament on its intentions for any wider reforms of the frameworks around inquiries".[228]

3.3.4 Ways forward for the role of Parliament

Key messages from our workshop about the role of Parliament

- We heard at the workshop that there is a strong case for involving parliamentary committees in overseeing implementation, but that it does not follow that one committee will be suitable for all inquiries.[229]
- We also heard, for example, that the Infected Blood Inquiry's recommendations spanned multiple committees, meaning it made sense for one committee to monitor them all, but again it does not follow that one committee will be suitable for all inquiries.[230]
- In addition, it was emphasised that parliamentary committees are well-suited to formal, top-down oversight.[231] Without subject-matter expertise in terms of scrutiny, parliamentary committees could inadvertently focus on the wrong issues and could miss shortcomings on implementation.[232] So, we need a combination of oversight and independent scrutiny.[233]

Ways forward for the role of Parliament

- We have highlighted above some examples from our sample of UK inquiries of parliamentary debates about inquiry reports. Given the public importance of inquiries, we suggest this should be routine for all inquiry reports.
- We have also highlighted above some examples of inquiries in our sample calling for (specific) parliamentary committees to monitor the implementation of their recommendations. This approach should be considered by future inquiries, where appropriate.
- More broadly, 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.
- As we will discuss in more detail below, 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.

- As Dr Ireton has commented, "Whilst there is a strong argument for parliamentary committee involvement in formal top-down oversight, scrutiny of implementation is a different task" and "Parliamentary oversight can, however, be effectively combined with independent scrutiny by individuals or bodies with relevant subject-matter expertise and experience in policy implementation".[234]
- In addition, the suggestion from Emma Norris, noted above, that the select committee model should be combined with another independent body, such as the National Oversight Mechanism proposed by INQUEST, also emerges as a strong proposal from the research.

3.4 The role of inquiries

3.4.1 Background and monitoring by the inquiry chair

Under the Inquiries Act 2005, an inquiry usually comes to an end after the delivery of the inquiry report when the chair notifies the Minister that the inquiry has fulfilled its terms of reference.[235] There are "no formal rules for when a non-statutory inquiry should conclude" and "According to the Cabinet Office's Inquiries Guidance, the submission of the report should generally mark the end of the inquiry".[236]

Commenting on monitoring by the inquiry chair, Dr Ireton has noted that "The formal role of an inquiry chair ends when the final report is submitted and the chair notifies the minister that the inquiry has fulfilled its terms of reference" and at this point "the chair's legal powers cease and there is no statutory mechanism for them to remain involved in monitoring implementation".[237] Dr Ireton has commented that those who are serving judges "do not engage in post-report monitoring due to the risk of being drawn into political debate and undermining perceptions of the impartiality and independence of the judiciary".[238] She also observed that most non-judicial chairs "also conclude their involvement once the final report is published for reasons of availability and the fact that the role and skills required for scrutinising policy delivery and institutional change are different to those for chairing an inquiry".[239] However. Dr Ireton did highlight the example of the reconvening of the Soham Inquiry.

The Bichard Inquiry

- The Bichard Inquiry Report was published in 2004.[240] The Inquiry, also known as the 'Soham Inquiry', was set up to look into child protection measures, record keeping, vetting and information sharing in Humberside Police and Cambridgeshire Constabulary.[241]
- In the covering letter for that report, the Chair stated, "I aim to reconvene my Inquiry in six months' time to assess progress on those recommendations which the Government chooses to accept".[242]
- Indeed, the Bichard Inquiry Final Report (described as a "Report by Sir Michael Bichard's reconvened Inquiry to establish progress on delivering the recommendations made in his original report") was published in 2005.[243]
- The Final Report details progress on recommendations made in the original report, and a summary of the Chair's latest recommendations.[244]
- Dr Ireton has noted that the "This informal reconvening enabled the chair to report on progress directly to Parliament and helped maintain momentum and public visibility" though she added that "this model depends heavily on ministerial agreement and the chair's availability and willingness to remain involved".[245]

It is interesting to note at this point that, in its written opening statement to the ongoing Lampard Inquiry, INQUEST discussed recommendations and it urged the Inquiry "to consider, from the outset any steps that can be taken to provide ongoing monitoring of recommendations made, in light of the current lack of any suitable structure to oversee implementation".[246] In particular, INQUEST stated, "In light of the critical nature of apparent failings in Essex, the urgent need for actions to be taken in order to prevent future deaths, and the history of institutional inability or unwillingness on the part of the relevant trusts to effect necessary changes, it is submitted that this Inquiry should reconvene after publication of any final report in order to monitor the implementation of its recommendations".[247] It remains to be seen whether this suggestion will be followed.

The House of Lords Select Committee, which undertook post-legislative scrutiny of the Inquiries Act 2005 in 2013-2014, also considered the question of whether the inquiry chair should be responsible for following-up their own recommendations.[248] In its detailed examination, it noted in particular that "We consider that a serving judge who has chaired an inquiry not concerned with the practice or procedure of the courts should play no further part after submitting his report, leaving this to ministers, others to whom the recommendations are addressed, and Parliament".[249] The Committee also considered other chairmen (by which it meant "chairmen who are retired judges or who are not part of the judiciary") and noted that it agreed "with the majority of our witnesses that inquiry chairmen and panels are not responsible for the implementation of their recommendations when the inquiry has reported".[250] Again, it highlighted the Soham/Bichard Inquiry in this context, which we discuss above. Finally, in its discussion about overseeing implementation, the Committee noted that "We agree that overseeing the implementation of recommendations is not within the remit of an inquiry" and "To reconvene the inquiry group when the inquiry is over and the chairman and other members may have moved on to other areas of work seems impractical and onerous".[251] Ultimately, as we discussed above, the Committee believed that Commons Departmental Select Committees "are best placed to monitor the implementation of inquiry recommendations".[252]

The 2024 report of the House of Lords Statutory Inquiries Committee also considered monitoring by the inquiry chair.[253] After some discussion, it commented that "informal implementation by inquiry chairs is not a generally viable model".[254] Later, the Committee considered the option of formalising monitoring by the chair.[255] It noted that "Implementation monitoring by inquiry chairs after reporting could be put on a formal basis by amending the Inquiries Act 2005".[256] It concluded that "this option (and inquiry-level monitoring generally) is not the Committee's first preference".[257]

Notes from our sample of UK inquiries

Manchester Arena Inquiry

- The Manchester Arena Inquiry published three volumes of reports, with the last being published in March 2023.[258]
- The closure notice from the Inquiry Chair, Sir John Saunders, is dated 1 August 2023.[259]
- It is interesting to observe that, almost two years later, in May 2025, it was reported that Sir John was due to meet with MI5 to "discuss his recommendations".[260]

3.4.2 Making recommendations that are relevant to responses and implementation

In Part 1, we saw that inquiries are making recommendations that are particularly relevant to the themes of this report including the categories on responses to inquiry recommendations; implementation monitoring; and implementation of a previous recommendation. In the Appendix, we have suggested some examples from our sample of UK inquiries for each of these three categories.

An important recent example of an inquiry recommendation which focuses on giving effect to the recommendations of the inquiry is Recommendation 12 from the Infected Blood Inquiry Report, which we set out in full in the box below.

Infected Blood Inquiry Report: Recommendation 12:

> **"Giving effect to Recommendations of this Inquiry –**
>
> (a) Within the next 12 months, the Government should consider and either commit to implementing the recommendations which I make, or give sufficient reason, in sufficient detail for others to understand, why it is not considered appropriate to implement any one or more of them.
> (b) During that period, and before the end of this year – the Government should report back to Parliament as to the progress made on considering and implementing the recommendations.
> (c) This timetable should not interfere with earlier consideration and response to the Recommendations of the Second Interim Report of the Inquiry
> (d) The Public Administration and Constitutional Affairs Committee ("PACAC") should review both the progress towards responding to the Inquiry's recommendations and, to the extent that they are accepted, implementing those recommendations
> (e) PACAC should accept the role in respect of any future statutory inquiry of reviewing government's timetable for consideration of recommendations, and of its progress towards implementation of that inquiry's recommendations."[261]

As can be seen from the quote above, in points (d) and (e), the Infected Blood Inquiry makes suggestions not only about reviewing progress towards implementing the Inquiry's own recommendations, but also the recommendations of "any future statutory inquiry".

Sir Brian made some remarks on publication day and, among other things, he noted:

> "My final recommendation considers the question of implementing the recommendations I have set out. I've written to the minister to tell him that I cannot as yet notify him that the Inquiry has fulfilled its terms of reference. Those terms include the nature, adequacy and timeliness of the response of government. As I've said repeatedly in public, delay not only causes frustration but it compounds the harm and suffering many of those infected and affected have endured. In the context of this Inquiry, perhaps beyond all other, it is unconscionable to allow a state of affairs to exist in which people's fears that the lessons and recommendations of this Inquiry will collect dust on a Cabinet Office shelf are realised.
>
> I'm satisfied that I must do what I properly can within my powers to try to ensure that that does not happen. Now, it's for the government to respond as it will but I intend to use my position, as far as I properly can, to prevent any unreasonable delay in its doing so.
>
> I hope to be able to say soon that the Inquiry's work is completed."[262]

Dr Ireton has highlighted Recommendation 12 from the Infected Blood Inquiry as part of her discussion of public inquiry requests for responses and implementation plans, in which she commented that "In the absence of a statutory requirement to respond to inquiry recommendations, UK public inquiries are increasingly issuing their own formal requests for published responses and implementation plans from the Government and other bodies".[263]

It is interesting to consider at this point **IICSA's concluding report** and the approach set out in the concluding paragraph of the chapter summarising the Inquiry's recommendations:

> "The Inquiry expects the UK government, the Welsh Government and the specified institutions to act upon its recommendations promptly. In the interests of transparency and openness, the Inquiry asks that each institution publish details of the steps they will take in response to each recommendation in this report, including the timetable involved, within six months of the publication of this report. It is anticipated that, in due course, implementation of, or compliance with, the Inquiry's recommendations will be regularly monitored and reported upon by the Child Protection Authorities for England and for Wales, and that pending the establishment of these agencies the Minister for Children and the equivalent minister in Wales will undertake the same role. It is the hope and expectation of the Inquiry that reporting should happen at least annually, in order to ensure the focus and prioritisation of the improvements necessary better to protect children in England and Wales from sexual abuse."[264]

3.4.3 Interim recommendations

A. Publishing interim reports and making interim recommendations

The House of Lords Statutory Inquiries Committee considered the issue of regular reporting by inquiries.[265] It noted that IICSA, the Grenfell Tower Inquiry and the Manchester Arena Inquiry, for example, published interim reports.[266] Interestingly, the Committee noted that "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)" and it noted that "Whether or not publishing an interim report was permitted depended on the inquiry's specific terms of reference".[267] It stated that "Inquiries should provide regular, public, updates on their work—both administrative activities, as well as public hearings" and that "Longer inquiries should, where appropriate, publish interim reports".[268] It recommended, among other things, that "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".[269]

Dr Ireton considered the use of interim recommendations in her Lampard Inquiry briefing and she noted that they can "play an important role in public inquiries, particularly where urgent risks are identified or early action is needed to prevent further harm".[270] She also noted that they may "help to maintain public engagement and momentum, particularly in long-running inquiries." [271] However, she stressed that "issuing interim recommendations is not always practical or appropriate", and inquiries "that adopt a modular or phased structure are generally better placed to issue interim recommendations, as they are more likely to reach defined points where sufficient evidence has been gathered to support early action on specific issues". [272]

B. Monitoring interim recommendations

The House of Lords Statutory Inquires Committee noted that "If inquiries publish interim recommendations … then it is possible for chairs to undertake implementation monitoring before the inquiry publishes its final report and ceases to exist".[273] It noted that the Chair of the Manchester Arena Inquiry "undertook interim implementation monitoring" during the inquiry.[274] The Committee emphasised that "we encourage the publication of interim reports, and if inquiries can begin monitoring implementation of these interim recommendations immediately, then this is helpful".[275] It acknowledged that "this will not be possible for every inquiry; for example, inquiries with short timeframes are less suited to interim reports" and also "this style of monitoring is only possible for interim recommendations as the chair ceases to hold their position once the final report is submitted". [276]

Dr Ireton also considered the monitoring of interim recommendations, and noted that "Where recommendations are made, some inquiries have adopted innovative procedures to monitor compliance during the lifetime of the inquiry" and "These may include setting deadlines for progress reports, requesting implementation plans, and publishing updates".[277] However, she noted that "internal monitoring only works while an inquiry is in progress" and once the final report is delivered and the Chair gives notification that the inquiry has fulfilled its terms of reference, "the inquiry comes to an end and has no continuing power or resources to oversee implementation".[278]

Interestingly, as part of her discussion about monitoring interim recommendations, Dr Ireton noted that "the decision whether or not to hold hearings on implementation progress falls within the discretion of the chair under section 17 of the Inquiries Act 2005 to determine the procedure and conduct of any inquiry as they see fit".[279] She noted that approaches have varied, and for example, the Grenfell Tower Inquiry chair "declined a request to take evidence on implementation of its first report's recommendations, despite the fact that approach had been taken by the Manchester Arena Inquiry, on the basis there were no express powers to do so under the Inquiries Act 2005".[280] There are other considerations to be taken into account here and she added that, "Where the chair is a serving judge, a further consideration is the risk of being drawn into political debate through involvement with monitoring implementation, and the potential impact on perceptions of judicial impartiality and independence".[281]

In the boxes below, we consider some examples from our sample of UK inquiries of inquiries monitoring the implementation of some of their recommendations during the lifetime of the inquiry.

UK Covid-19 Inquiry

The Inquiry's terms of reference are available on its website.[282]

The work of the Inquiry is ongoing and reports on Modules 1-5 (out of 10) have already been published.[283] Here we focus on the Module 1 Report which was published on 18 July 2024 and which contains 10 recommendations.[284]

The inquiry website states, "The Chair expects that all recommendations are acted upon and implemented within the time frames set out in the recommendations. The Inquiry will be monitoring the implementation of the recommendations during its lifetime".[285]

The webpage for Module 1 sets out the recommendations as well as the government responses and government implementation updates.[286]

The webpage about inquiry recommendations contains a section titled 'Monitoring of Inquiry Recommendations' which states:

> "The Chair expects that all accepted recommendations are acted upon and implemented in a timely manner.
>
> In the interest of transparency and openness, the Inquiry requests that the institution responsible for each recommendation publishes the steps they will take in response and the timetable for doing so.
>
> Unless otherwise stated, institutions should do this within six months of the recommendation being published. The Inquiry has agreed an internal process to ensure effective monitoring of recommendations, which is detailed below".[287]

The webpage then sets out a process which is divided into sections (three months, six months, nine months and 12 months after report publication) and it is worth noting that the process seems to relate to asking the relevant institution to publish its response.)[288]

The webpage also notes that "The UK Government and devolved administrations will publish updates detailing their progress in implementing the Inquiry's recommendations on a twice-yearly basis" and "Each update will include progress across all modules that have reported, provided that a minimum of five months has passed between the initial Government response deadline and the next scheduled May/November cycle".[289]

The Angiolini Inquiry

There are terms of reference for each of the three Parts of the Angiolini Inquiry.[290]

The work of the Inquiry is ongoing and, so far, two major reports have been published. The Part 1 Report was published on 29 February 2024 and makes 16 recommendations.[291] The Part 2 First Report was published on 2 December 2025 and provides an update on the recommendations made in the Part 1 Report and makes a further 13 recommendations.[292]

Interestingly, in the Part 2 First Report, Chapter 1 is titled 'Implementation of recommendations from Part 1 Report' and Inquiry Chair Lady Elish Angiolini stated:

> "In order to ensure that the recommendations I make during Part 2 are relevant, and reflect the current position in policing, it is therefore important that I consider the extent to which my Part 1 recommendations have been implemented. This Report … seeks to do that, the Inquiry having gathered information from relevant stakeholders about the progress that has been made".[293]

Lady Elish Angiolini also noted:

> "The section below summarises the information provided by the Home Office, the National Police Chiefs' Council and the College of Policing (as those named in the recommendations) on steps taken to implement each of the recommendations as of 24 September 2025, and their view of the result of those steps and any outstanding actions. I have not provided an assessment of progress made against each of the individual recommendations or measured purported outcomes against evidence gathered for Part 2 of the Terms of Reference (which is ongoing): I am not charged with holding policing accountable for their actions – that role belongs to Police and Crime Commissioners and, ultimately, the Home Secretary. Instead, this section shines a light on what has been done, what remains to be done and the remaining challenges in between".[294]

In concluding Chapter 1, Lady Elish Angiolini emphasised:

> "I will provide a further update on progress on the implementation of the Part 1 recommendations, as well as the recommendations arising from this Report, in my next published report. I hope to see greater progress, and where policing determines that it will not implement recommendations it previously accepted, that position should be explained to the public and those who hold policing to account".[295]

It is also notable that the recommendations in the Part 1 Report provide for commencement or completion dates, such as "With immediate effect" or "By September 2024" etc.[296] The Part 2 First Report takes a similar approach.[297]

The Manchester Arena Inquiry

The Manchester Arena Inquiry has now concluded and the closure notice is dated 1 August 2023.[298] The Inquiry's terms of reference are available on its website.[299]

The Manchester Arena Inquiry published three volumes of reports: Volume 1 was published in June 2021, Volume 2 in November 2022 and Volume 3 in March 2023.[300]

All three volumes contained some "monitored recommendations", and Inquiry Chair Sir John Saunders made clear that he intended "to monitor" the monitored recommendations.[301]

On 10 and 11 January 2022, the Inquiry heard evidence regarding the monitored recommendations made in Volume One; from 5 to 7 June 2023, the Inquiry heard evidence regarding the monitored recommendations made in Volumes Two and Three.[302]

In the Inquiry Closure Notice, Sir John stated:

> "I have published my findings on the evidence I heard in three open volumes and also in a closed volume which had two parts. Across those volumes, I made more than 150 open recommendations and a number of closed recommendations. Where there was a particular need, I indicated a wish to monitor a number of those recommendations. I have held hearings to consider updates on implementing my open monitored recommendations and the reason for any delays in progressing them. I firmly believe that these hearings have made a difference, both to ensure my recommendations were acted upon quickly and to scrutinise publicly the reason for any delays in doing so.
>
> I am particularly concerned to ensure, now the Inquiry has come to an end, the continuation of the monitoring of the recommendations I made. There have been reports of occasions when an inquiry has made detailed findings and recommendations only for that work to be side-lined and the important learning from that inquiry lost, until another disaster or tragedy leading to another inquiry causes the same issues to be examined again … I have been determined that does not happen here. It was an important reason for monitoring recommendations during the course of this Inquiry and doing so publicly." [303]

In evidence to the Statutory Inquiries Committee, Sir John commented:

> "I and the inquiry, having made recommendations in the different volumes as they came along, followed up. We had a hearing after three months. The purpose of that was twofold. First, it was to make sure that something was being done—that people were not just saying, 'Oh, we'll do that sometime', but were getting on with it. Secondly, it was to see whether there was anyone saying, 'These recommendations won't work. We can't do them', which would allow us time to change them".[304]

In his 'General Observations on the Conclusion of the Inquiry', Sir John noted:

> "In relation to Volumes 1 and 2 of my Report and the open Volume 3, I have been able to monitor the recommendations. I was able to do that as the Inquiry was still in existence. That monitoring was in order to ensure that steps were being taken to action those recommendations or, if there were problems with them, I could be told. This ensured that these issues were raised publicly, that I had the opportunity to discuss what could be done about them and, if necessary, amendments could be made to the recommendations. The monitoring needs to be continued until the recommendations are fully implemented.
>
> On 5th, 6th and 7th June 2023 I held a public hearing to see what progress had been made on implementing the recommendations I had made in the Volume 2 and open Volume 3 Report. That revealed that in relation to some recommendations a great deal of work had been done and, in relation to others the work was only getting started. It was apparent that work would not have started at all if we had not had a public hearing to see what was going on."[305]

We note that the June 2023 hearings were held after the Volume 3 report was published in March 2023 (though before the inquiry closure notice dated 1 August 2023).

IICSA

IICSA closed under section 14 of the Inquiries Act 2005 on 31 March 2023.[306] The Inquiry's terms of reference are available on its website.[307]

IICSA produced regular publications,[308] and it is possible to view recommendations and responses grouped by report on the inquiry website.[309]

IICSA published its concluding report on 20 October 2022, and an annex to the concluding report notes:

> "Since its establishment in 2015, the Independent Inquiry into Child Sexual Abuse has made 107 recommendations to 33 specified State and non-State institutions … as well as a number of other organisations and settings such as political parties and religious organisations. The table below includes a summary of each recommendation and whether it has been accepted or rejected by the receiving institution. It also sets out the action taken to date based on information that was provided to the Inquiry by the receiving institution, which can also be found on the Inquiry website".[310]

In written evidence to the House of Lords Statutory Inquiries Committee, IICSA Chair Prof Alexis Jay OBE commented among other things:

> "The lack of provision in the Act for follow up to recommendations made by public inquiries is often cited as the major weaknesses of the present process. I agree. In the case of my Inquiry, not only did it mean no structured accountability, but the expectations of victims, survivors and other interested parties had been raised with the nature of the recommendations made, and the initial positive government response from the then Home Secretary.
>
> In my inquiry, we had already taken our own steps to increase public accountability for recommendations made. As we had determined to publish individual reports including recommendations, as we proceeded with the public hearings, I took the decision that we should follow up recommendations made in each report.

> This involved making contact with the organisations we required to implement recommendations every six months, to report on progress, which we considered a reasonable time to have taken some form of action. This was then publicly reported on the Inquiry website. This meant there was some degree of accountability during the Inquiry's lifetime. We also published a progress report on the final position as at December 2022. The final, twentieth report, made 20 recommendations, which were repeated from earlier reports since we had concluded the responses to these recommendations were inadequate."[311]

There is also a webpage which sets out the 'Process for monitoring responses to Inquiry recommendations' which states:

> "The Inquiry expected that, where recommendations were addressed to an institution, the institution would act upon those recommendations.
>
> In the interest of transparency and openness, the Inquiry expected institutions to publish the steps they will take in response. They should also publish the timetable for doing so. Unless otherwise stated, institutions should do this within six months of the recommendation being published.
>
> The Inquiry monitored the responses of institutions through the following formal process. Responses were monitored up until December 2022".[312]

The webpage then sets out a process which is divided into sections (after three months, six months, seven months, nine months and 12 months) and it is worth noting that the process seems to relate to asking the relevant institution to publish its response to the Inquiry's recommendation.)

As we conclude this section, there are some aspects which are particularly worth highlighting. First, we would draw attention to the structured processes set out on the websites of both the UK Covid-19 Inquiry and IICSA, which seem to relate to asking the relevant institution to publish its response.[313] Second, the Chair of the Angiolini Inquiry stressed, among other things, that where it is decided that previously accepted recommendations will not be implemented, that position should be explained publicly.[314] As we noted above, it is important to keep an eye on rejected recommendations, as well as previously accepted recommendations that are no longer being implemented, because the harms they seek to address might be repeated in future and need to be further considered. Third, the Chair of the Manchester Arena Inquiry explained that monitoring some of the inquiry's recommendations during its lifetime sought to ensure that, if necessary, amendments could be made to the recommendations.[315]

Related to this last point, it has been suggested that "perhaps the best way to increase the chance that government will implement inquiry recommendations is to ensure that it is wholly engaged in the inquiry process and has full opportunity to set out any objections to the inquiry's proposals before the recommendations are made".[316] As discussed above, recommendations are often developed through consultation with experts and other stakeholders. This consultation and testing process is one of the ways in which inquiries can give consideration to whether recommendations are "implementable". However, an inquiry's recommendations should be evidence-based. Once an inquiry has made recommendations, it is then a decision for the Government whether or not to accept and implement inquiry recommendations.[317]

3.4.4 Ways forward for the role of inquiries

Key messages from our sample of UK inquiries

- We would like to highlight, in particular, the approach suggested by Sir John Saunders, Chair of the Manchester Arena Inquiry, of "early monitoring by the inquiry team… followed by monitoring by a named individual who will report periodically to the public on progress which has been made",[318] which in that case appeared to focus minds and generate action on the inquiry's recommendations.
- Indeed, as noted above, Sir John reflected on the public hearings he held in June 2023 and he noted "That revealed that in relation to some recommendations a great deal of work had been done and, in relation to others the work was only getting started. It was apparent that work would not have started at all if we had not had a public hearing to see what was going on".[319] He added, "it did demonstrate to me the value of having early monitoring carried out by me to ensure that systems were being put in place to carry out the implementation of recommendations".[320]
- Sir John also commented that, "The evidence at that hearing made clear that the monitoring process needs to continue after the Inquiry has finished", and he noted that a senior civil servant had been appointed "to continue that job of monitoring".[321]
- Sir John also stressed the importance of public accountability, noting that, "It is important for the public and, in this case particularly the bereaved families, that reports on progress are made in a public forum. Whether that is to a select committee of Parliament as has been suggested or, in a report which is made public, there has to be public accountability".[322]
- INQUEST's Executive Director Deborah Coles has commented on the Manchester Arena Inquiry's approach: "Not only did it provide meaning to the victims, but it incentivised action from the recipients of recommendations by scheduling those official monitoring sessions".[323]

Ways forward for the role of inquiries

- In Part 1 of this report, we noted our view that, from the beginning, consideration should be given to the process of making recommendations and how implementation of recommendations will be monitored and scrutinised.
- In Part 1, and above, we saw that inquiries are making recommendations that are particularly relevant to the themes of this report including the categories on responses to inquiry recommendations; implementation monitoring; and implementation of a previous recommendation. We suggest this approach should be considered by future inquiries, where appropriate.
- Above, we considered the use of interim recommendations and we looked at some examples of inquiries monitoring the implementation of some of their recommendations during the lifetime of the inquiry. We suggest this approach should be considered by future inquiries, where appropriate.
- As noted above, using interim recommendations may not always be practical or appropriate, and it will depend on the particular circumstances of an inquiry. Where interim recommendations are made, consideration should be given to whether it would be appropriate for the inquiry to monitor them during its lifetime.
- For example, for the Covid-19 Inquiry, it is explained that "The scale of the pandemic was unprecedented; the Inquiry has a huge range of issues to cover" and so it was "decided to address this challenge by dividing its work into separate investigations known as modules".[324] In Baroness Hallet's opening statement for the

Covid-19 Inquiry, she explained further why she would be adopting a modular approach:

"I know many people will wonder how long they will have to wait to hear about my conclusions and recommendations. By running the Inquiry through modules, I will be able to produce regular reports. … Where I make recommendations to people or organisations, I expect them to consider and respond to them quickly, to ensure that the UK is as well prepared as it can be to respond to the next pandemic and to protect the lives of its people. The Inquiry will monitor implementation of the recommendations it makes during its lifetime".[325]

3.5 The role of other mechanisms

3.5.1 The Cabinet Office Inquiries Unit

In its 2024 report, the House of Lords Statutory Inquiries Committee noted that the Cabinet Office has run an Inquiries Unit since 2019 and, among other things, noted that the Inquires Unit maintains a 'Guide for Inquiry Chairs and Secretaries'.[326] One of the points emphasised by the Committee was that "Sharing best practice between inquiries and learning from past inquiries is essential" and the "Inquiries Unit should more effectively engage expert opinion on inquiries and share this across Government departments and the Civil Service".[327] Elsewhere, the Committee noted that some witnesses suggested that monitoring functions be conferred on the Inquiries Unit either in its current form or as a new independent body, but it noted that 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".[328] Finally, at the end of its report, the Committee also set out some "specific examples of good practice in running an inquiry". These do not explicitly cover the development or monitoring of inquiry recommendations, though the report does note, for example, that "There should be more efforts to engage those affected by a public disaster" and also that "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".[329]

The IfG has recommended that the Cabinet Office "should be more proactive in gathering and analysing evidence on what works" and that the Inquiry Unit "should publish an Inquiries Handbook to share best practice, developed through the research and engagement, with chairs, secretaries and inquiry teams as well as officials in sponsoring department inquiry teams".[330] In March 2026, the then Parliamentary Secretary for the Cabinet Office confirmed that "the Cabinet Office will publish The Inquiry Practitioners' Handbook in due course".[331]

3.5.2 Existing audit institutions

In its 2024 report, the House of Lords Statutory Inquiries Committee noted that "Monitoring can be undertaken by a country's supreme audit institution".[332] It gave the example of the Independent Public Inquiry into the Non-domestic RHI Scheme, which was monitored by the Northern Ireland Audit Office (the "NIAO").[333]

Independent Public Inquiry into the Non-domestic RHI Scheme: Recommendation 44:

"The recommendations for change made here, to the extent they are adopted, will take time to implement; they may indeed not even be sufficient to address the range of shortcomings revealed by the Inquiry. The Inquiry therefore recommends a role in future for the Northern Ireland Audit Office in assessing and validating the extent

of progress in implementing the lessons learned from the NI RHI scheme and implementing these recommendations, including reporting on such progress periodically to the Northern Ireland Assembly and the people of Northern Ireland. The Inquiry further recommends that the Northern Ireland Audit Office is provided with sufficient additional resources so as to enable it to perform such a role."[334]

The Statutory Inquiries Committee noted that "This is a reasonable approach and is appropriate for inquiries like RHI, which made highly technical recommendations about public finance".[335] However, the Committee suggested that requiring the UK's NAO to engage in implementation monitoring for non-financial inquiries would "constitute a radical shift in the expertise required of it and require the recruitment of new teams".[336] It also noted that, "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".[337]

As noted above, the Thirlwall Inquiry Report was published on 15 September 2026, just before this report was finalised.[338] It is worth highlighting in this part of our report that Recommendation 17 ("Implementation of recommendations") provides that, "A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office" and that "Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027".[339] In a statement to Parliament following the Thirlwall Inquiry Report, the Health Secretary stated, "Lady Justice Thirlwall highlights problems with past inquiry recommendations not being implemented. So, my 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. But we will work with the Cabinet Office now on improvements in this area to respond to this inquiry".[340]

3.5.3 The media

There is a role for the media in raising awareness and maintaining visibility of inquiry findings and recommendations. Dr Ireton has described the media's "significant role in sustaining public visibility of inquiry findings and exposing failures to implement recommendations once a public inquiry has formally concluded".[341] She has also noted that the media can help "maintain public pressure on government departments, public bodies, and other organisations to act on accepted recommendations" and can provide "a platform for victims, survivors, and advocacy groups to challenge inaction, demand transparency, and mobilise public support for reform".[342]

Notes from our sample of UK inquiries

In September 2024, an article in the Guardian called IICSA "Perhaps the most striking example of recommendations not being implemented", noting that "more than two years on from publication of the final report none have been implemented".[343]

In September 2024, the BBC reported the Brook House Inquiry Chair's assessment that the Government had agreed to only one of the inquiry's 33 recommendations.[344]

In February 2025, an ITV News Central report on the Paterson Inquiry's recommendations emphasised that "Half a decade on, it seems that little progress has been made on the recommendations suggested for public safety".[345]

3.5.4 Advocacy groups, the public and those with lived experience of inquiries

It is often victims, families and advocacy groups who play a key role in campaigning for an inquiry to be established. For example, in a statement to the Lampard Inquiry, INQUEST stressed that "Without the families' courage, persistence and determination, this Inquiry would not have come into existence".[346] However, as INQUEST added, "it should not fall to bereaved families alone to ensure that such serious and repeated state failings are properly investigated".[347] In addition, Dr Ireton has emphasised that, later in the inquiry process, "In the absence of a formal mechanism for post-inquiry oversight, the burden of monitoring implementation often falls to victims, survivors, bereaved families, and advocacy groups".[348] However, as Dr Ireton has noted, "The expectation, whether external or self-imposed, that they will play a central role in ensuring that recommendations are acted upon, can place considerable pressure on them".[349] The House of Lords Statutory Inquiries Committee also recognised this burden and commented that "Victims and survivors may have already experienced significant stress and trauma when campaigning for and giving evidence to an inquiry" and, therefore, "it is unfair to burden them further with the expectation that they should be the sole source of follow-up scrutiny".[350]

Notes from our sample of UK inquiries

We understand that **campaign group 'ACT on IICSA'** was established in the new year of 2023, three months after the final report was published.

ACT on IICSA is described as "an independent campaign group made up of key leaders from the Independent Inquiry into Child Sexual Abuse (IICSA) and CEOs from across the sexual violence sector" and it is noted that "Together, we are united in holding the UK Government to account for fully implementing all 20 of IICSA's final recommendations and delivering the systemic change needed to prevent child sexual abuse, protect children, and transform the response to survivors".[351]

In particular, "ACT on IICSA monitors government action and inaction in response to the Inquiry's recommendations, engages directly with departments … and provides transparent public updates on progress. We meet with ministers responsible for implementing IICSA's recommendations to encourage action without further delay".[352]

The organisation INQUEST has reported several changes that the families it works alongside would like to see. INQUEST's Executive Director Deborah Coles has emphasised that:

> "It is important for those most affected to have a much more transparent and accountable system. Families who INQUEST works with tell us that very often it is the families who are the drivers of change. They are the ones who will try to pursue different government bodies to try to find out what has changed, because there is nowhere to go to find that information. Corporations and public authorities tend not to tell bereaved people, in our case anyway, what they have done to implement change. Reports and recommendations literally sit on a shelf gathering dust until, sadly, the next time…"[353]

'Family Listening Days' can be an important way of hearing the views of those most affected.[354] For example, in the 2019 report of the Grenfell Family Consultation Day it is noted that, "There was recognition of the need for a duty on the Government to implement recommendations made by the Inquiry and systematic monitoring and follow up on implementation".[355] In the 2025 report of the Hillsborough Law Family Listening Day it is noted that families recommended the establishment of a "National Oversight Mechanism to monitor the implementation of recommendations made

following investigations, inquests and inquiries".[356] We will discuss INQUEST's proposal for a National Oversight Mechanism further in the next section of this report.

3.5.5 Ways forward for the role of other mechanisms

Key messages from our workshop about the role of other mechanisms

- We heard at the workshop that the Cabinet Office Team's remit does not include monitoring implementation of recommendations nor capturing policy lessons learned in a systemic way across inquiries.[357]
- We also heard about the need for guidance for inquiry chairs about how to run their inquiries and the hope that the Cabinet Office Inquiries Unit would publish good practice guidelines soon.[358]
- We heard at the workshop that while the RHI Inquiry recommended the NIAO to scrutinise implementation, there were very technical recommendations in that case relating to public finance, and it does not follow that it could be used elsewhere.[359]
- Throughout the workshop, we heard about the important role played by those with lived experience of the issues raised by public inquiries, and that the issues before us were not only matters of law, governance and accountability, but were also personal.[360]
- It was emphasised that responsibility for responding to inquiry recommendations and securing implementation rests with government subject to parliamentary scrutiny, and this responsibility should not be shifted onto inquiries themselves, nor onto survivors, the bereaved and campaign groups.[361]
- However, in the absence of a formal mechanism for monitoring implementation of inquiry recommendations, survivors, victims and the bereaved may feel they need to remain involved and play a key role in ensuring recommendations are acted upon, which is a significant and unreasonable burden.[362]
- We also heard at the workshop about the need for more research on the experience of those involved with inquiries and how that experience could be improved.[363]

Ways forward for the role of other mechanisms

- The Cabinet Office Inquiries Unit should share best practice from inquiries and other experts. In particular, there should be a focus on sharing best practice about the process of making recommendations and how implementation of recommendations will be monitored and scrutinised.
- Inquiry chairs should consider whether there may be a role for the NAO or other existing bodies in monitoring and scrutinising implementation of their recommendations.
- Our research did not consider in detail the role of the media in tracking the extent of progress in implementing inquiry recommendations, nor the risks of relying on the media rather than institutional mechanisms in this regard, and this could be an avenue for further research and analysis.
- Consideration should be given to the form(s) of monitoring, oversight and scrutiny those with lived experience of the issues raised by inquiries would like to see, which as noted above, include support for INQUEST's proposal for a National Oversight Mechanism, and we will turn to this in the next section of our report.

3.6 A National Oversight Mechanism

3.6.1 Proposals for a National Oversight Mechanism

At various points in our report, we have noted INQUEST's proposals for a National Oversight Mechanism, which it describes as "an independent public body responsible for collating, analysing and following-up on recommendations arising from four post-death processes: Investigations; Inquests; Public Inquiries; Official reviews".[364] INQUEST has stressed that "A National Oversight Mechanism is the missing link between recommendations being made and meaningful change happening" and that "Independent of government and informed by bereaved families and survivors, it would bring together recommendations from inquests, inquiries and other investigations, track whether action has been taken, identify recurring risks, and escalate related concerns".[365] The campaign for a National Oversight Mechanism is supported by over 70 organisations including, for example, Covid-19 Bereaved Families for Justice, Grenfell United, Hillsborough Law Now Campaign and Tainted Blood, and also the Institute for Government, JUSTICE, Liberty and the Public Law Project.[366]

One of the key reasons INQUEST believes a National Oversight Mechanism should be established is the impact of the current accountability gap on bereaved families. It has stressed that "Bereaved families report that they participate in protracted, intrusive, and distressing processes following a death in the hope of establishing the truth about how their loved one died, holding those responsible to account, and for there to be learning to prevent other deaths in the future", however, the "gap in accountability – from recommendations made to actions completed – is a disservice and insult to bereaved families seeking change".[367] The 2025 report of the Hillsborough Law Family Listening Day noted that "Many felt that with a national independent oversight body in place, there would be a greater onus on the implementation of recommendations, resulting in lasting change".[368]

The need for a National Oversight Mechanism or similar body has wide public acknowledgement.[369] However, in its response to the HCLG Committee's Grenfell and Building Safety Inquiry, the Government did not commit to this and stated that, "We have heard calls for a National Oversight Mechanism from members of the Grenfell community and others affected by state related deaths. The Cabinet Office is leading work to consider how oversight of inquiry recommendations can be improved more broadly".[370] This was criticised by the HCLG Committee's Chair, who stated, "'It is crucial that Government is properly held to account for implementing the recommendations of the Grenfell inquiry, and disappointing that they have yet to commit to introducing an independent mechanism which would apply to the implementation of the recommendations of all public inquiries'".[371]

We saw some relevant parliamentary initiatives in the last session of Parliament. For example, Carla Denyer MP (Green Party) proposed a Private Members' Bill, 'State-related Deaths (National Oversight Mechanism) Bill'.[372] In addition, 27 members signed an early day motion which, among other things, urged the government to "create a national oversight mechanism to ensure that these recommendations are routinely monitored by an independent body to help enact learning and prevent future deaths".[373] Importantly, in the last session of Parliament, the issue of a National Oversight Mechanism was also raised during various stages of the Public Office (Accountability) Bill. For example, during Committee stage, Edward Daffarn from Grenfell United emphasised that "It is the families, eight and a half years afterwards, who are having to try and hold the Government to account to implement those recommendations; and it is not just us. In every inquiry, the recommendations seem to be buried. It seems to be left to the families to chase them up, and there is no way that that can be right".[374] He suggested "a Grenfell law could be a national oversight mechanism that would ensure that no family ever has to go through what we have had to go through in the last eight and a half years to try and hold the Government to account".[375]

As noted above, the Public Office (Accountability) Bill has been carried over into the new parliamentary session and the Bill was reintroduced in the House of Commons on 14 May 2026.[376] During the debate on 14 July 2026, the need for a National Oversight Mechanism was raised several times.[377] The Bill is now before the House of Lords and the need for a National Oversight Mechanism was raised during the Second Reading stage on 1 September 2026.[378] Committee stage in the House of Lords is scheduled to take place from 12 October 2026.[379]

Some have pointed out possible shortcomings with a National Oversight Mechanism. For example, Dr Ireton has noted: "Like other oversight mechanisms, the NOM may face limitations where it relies on self-reported information. However, it could, for example, work in conjunction with implementation monitors, to strengthen its scrutiny. As with other possible mechanisms, challenges around funding and long-term sustainability remain".[380] We will turn to implementation monitors in the next section of the report.

Finally, a new report, 'Public Inquiries: are they fit for purpose?', commissioned by the Nuffield Foundation and authored by Prof Andrew Williams, offers "a different vision for public inquiry, one that would position it as a key component of a public right to justice".[381] Prof Williams states that "Implementation of recommendations to amend policy and institutional practice to deal with root causes of harm and to protect against repetition, requires proper administration", and "Government bear primary responsibility for this and Parliament should contribute to holding it to account".[382] In particular, he notes that "Achieving that through the oversight of a national independent mechanism, as INQUEST have promoted, could avoid charges of political control and bureaucratic inertia" and an independent, permanent "Council of Inquiry with powers, as proposed, might fulfil that role too".[383]

3.6.2 Ways forward for a National Oversight Mechanism

Key messages from our workshop about a National Oversight Mechanism

- We heard at the workshop that public inquiries are often called due to a failure to heed warnings and make changes following previous inquests or investigations.[384] Looking at inquests, reviews and inquiries in isolation from each other can miss crucial parts of the picture.[385] A National Oversight Mechanism would consider recommendations made following inquests, inquiries, investigations and other official reviews.[386]
- We heard at the workshop that concerns about self-reported information could be ameliorated by the National Oversight Mechanism addressing progress on the ground, and the importance of implementation monitors was highlighted in this context.[387]
- It was also noted that the National Oversight Mechanism would need a close and formalised working relationship with select committees to share information arising from investigations.[388]
- As regards the cost of a National Oversight Mechanism, it was emphasised that the costs of inquests, inquiries and investigations are massive.[389] Failure to learn and inaction mean that these costly and time-consuming processes keep happening.[390]
- We also heard concerns at the workshop that a National Oversight Mechanism is to an extent a one-size-fits-all in an area where many inquiries are really very different.[391]

Ways forward for a National Oversight Mechanism

- In our view, establishing an independent National Oversight Mechanism or similar body, possibly supported by independent scrutiny from implementation monitors,

emerges as a strong proposal. We will consider implementation monitors in the next section of our report.

- As Dr Ireton has commented, "The National Oversight mechanism (NOM), proposed by INQUEST, as an independent body to oversee implementation of recommendations from inquests, public inquiries and official reviews into state related deaths, would face similar challenges as parliamentary committees when relying on self-reported information on progress. However, it could also operate in conjunction with independent implementation monitors to strengthen scrutiny".[392]

3.7 Implementation monitors

At various points in our report, we have noted that 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), for example, to support Parliament's role and/or to support an independent National Oversight Mechanism.

Dr Ireton has commented on implementation monitors in her written evidence to PACAC as part of its Inquiry into the recommendations of the Infected Blood Inquiry. She noted that "Another approach is the appointment of inquiry-specific implementation monitors by government" and she commented that "Pioneered in Australia, this model has demonstrated significant success in scrutinising implementation, strengthening accountability, and improving implementation rates".[393]

In evidence to the House of Lords Statutory Inquiries Committee, expert Dr Alastair Stark similarly emphasised that "we saw great success in Australia with attaching a temporary independent office to monitor the implementation".[394] In particular, he noted that, "We have found in Australia that not only do implementation monitors lead to a 100% success rate in implementation when they are used, but they are a good source of co-design and co-constitution" and "They end up working with the implementation agencies in certain ways to adapt, shape and fit recommendations so that they can travel and be implemented".[395]

It is helpful to highlight Dr Ireton's overview of this type of mechanism here:

> "Implementation monitors are individuals or small teams appointed on short, Government-funded fixed-term contracts, typically around four years, and selected for their technical expertise and experience in policy delivery within the specific subject matter of the inquiry. Rather than relying on written or oral updates, and self-reported assurances from implementing bodies, they verify progress independently, on the ground, through direct engagement and site visits. This enables them to engage with the technical detail; identify delay, partial implementation, or misunderstanding and challenge implementing bodies where necessary.
>
> They operate independently of both Government and implementing bodies, report directly to Parliament to inform parliamentary oversight, and publish their reports. In Australia, they are increasingly regarded as one of the most effective means of combining oversight and scrutiny and to support meaningful change. They offer a valuable model for strengthening scrutiny of UK public inquiry recommendations."[396]

It has been suggested that the "mechanism has been used extensively in Australia, with the first recorded case being the Equine Influenza Inquiry," though it is also noted that the "implementation

monitor role was subsequently used in a much more formal way in both the Hazelwood Mine Fire Inquiry and the Victorian Bushfire Royal Commission".[397]

As set out in the box below, in Australia, for example, implementation monitors have recommended by inquiries into bushfires, family violence, police informants, and child safety.

Recommendation 66 of the 2009 Victorian Bushfires Royal Commission: "The State appoint an independent monitor or the Victorian Auditor-General to assess progress with implementing the Commission's recommendations and report to the Parliament and the people of Victoria by 31 July 2012." [398]

Recommendation 199 of the Royal Commission into Family Violence: "The Victorian Government establish an independent statutory Family Violence Agency [by 1 July 2017] to: monitor and report on implementation of the Commission's recommendations and of the Statewide Family Violence Action Plan…"[399]

Recommendation 108 of the Royal Commission into the Management of Police Informants: "That the Victorian Government, within three months, appoints an independent Implementation Monitor to monitor the implementation of the Commission's recommendations until implementation is completed." [400]

Recommendation 22.1 of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings: "The Tasmanian Government should introduce legislation to establish and fund an independent Child Sexual Abuse Reform Implementation Monitor to: a. monitor and report to Parliament annually on the implementation of i. the recommendations of this Commission of Inquiry; ii. any recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse that were accepted by the Tasmanian Government and have not been implemented; iii. the recommendations of the Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse; b. undertake independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations identified above, especially the impact on the safety and wellbeing of children in government and government funded institutions and victim-survivors of child sexual abuse in institutional contexts."[401]

It is helpful to consider the perspective of one of these implementation monitors.

Focus on the Victorian Bushfires Royal Commission

In evidence to the Statutory Inquiries Committee, Neil Comrie (Australian Implementation Monitor) described that the Bushfires Royal Commission in Victoria made a specific recommendation for an independent monitor.[402] Mr Comrie noted that he was appointed as the monitor and over the next four years submitted an annual report to the Parliament of Victoria, and the report was also made publicly available.[403]

Among other things, Mr Comrie emphasised that "It is important that the Government formally accept the recommendations so that everyone, particularly the bureaucracy, is aware that the Government want the recommendations to be implemented" and the Government "should then appoint nominated officials in each relevant department who are responsible for developing an implementation plan for each of the recommendations".[404] He stressed that the plan should state who is responsible for implementing each action item, and that a "firm timeline should also be set for the action item to be completed".[405]

Mr Comrie stated that, "It is important to appoint an implementation monitor to independently monitor the progress of each of those implementation action items and to report, at least annually to Parliament on the progress of that work".[406]

Mr Comrie stressed that implementation monitors "must be truly independent" and that it is "also important that they have a strong background in the area in which they are reporting so that they have the ability to recognise some of the technical issues that may be associated with the implementation of some of the recommendations and to challenge… some of the assertions being made".[407]

Mr Comrie also discussed the central importance of verification, noting that "It is that approach of 'Don't tell me. Show me what you're doing'. It comes back to the individual experience and credibility of the monitor to be able to do that and to judge whether what has been done is effective. That is important. There is a risk in simply accepting written assurances that things have been done without looking for further evidence to confirm that they have been done".[408]

Finally, as part of this discussion, it is important to highlight the role of the "Inspector-General for Emergency Management" ("IGEM"). It has been commented about implementation monitors that "these time-limited roles often cease prior to long-running recommendations being implemented" and that in such situations "Inspector-Generals for Emergency Management have taken charge of overseeing the reform process".[409] The role of Inspector-General was established in July 2014 under the Emergency Management Act 2013, and they are "an independent statutory officer appointed by the Governor in Council".[410] One aspect of their work involves monitoring the implementation of recommendations from major inquiries and reviews.[411] From August 2014, the Inspector-General monitored implementation of the remaining recommendations and actions from the Victorian Bushfires Royal Commission.[412]

Australian commentary has noted, for example, that in Victoria we have seen "the creation of statutory implementation monitors, who report publicly on the government's implementation of Royal Commission recommendations, increasing accountability and, ultimately, the value derived from the inquiries".[413] It has also been commented that a "notable feature of implementation of inquiry recommendations in Victoria is the use of a formal mechanism for monitoring implementation of recommendations", and that the "formal infrastructure for monitoring implementation of recommendation[s] is also praiseworthy because it puts in place an accountability mechanism and lack of progress towards implementation of recommendations (where relevant) will be highlighted, or in relevant cases justified".[414]

Ways forward for the role of implementation monitors

- The House of Lords Statutory Inquiries Committee considered the role of independent implementation monitors in its 2024 report, noting that "Implementation monitors are an effective and trusted part of the governance structure for public inquiries in Australia".[415] However, it cautioned that "they work on individual inquiries and are not able to complete meta-analysis based on multiple inquiries".[416]
- This is correct. The role of implementation monitors is inquiry-specific. As Dr Ireton has noted, "Implementation monitors are inquiry-specific and do not carry out thematic analysis across inquiries. Their role is focused on ensuring that the recommendations of a particular inquiry are delivered in practice. They can also be used to complement broader oversight mechanisms".[417] For example, Dr Ireton suggested implementation monitors could support a new parliamentary committee and/or a National Oversight Mechanism.[418]

- Indeed, in our discussions above, we have suggested that implementation monitors could be used to support Parliament and/or a National Oversight Mechanism.
- Combining inquiry-specific implementation monitors with other mechanisms that take an overarching view could also help to ensure that meta-analysis across inquiries can be conducted, and learning can be transferred from inquiry to inquiry.
- It will depend on the particular circumstances of an inquiry whether it is appropriate to recommend the appointment of an implementation monitor, and this should be considered on an inquiry-by-inquiry basis.

Appendix: Examples of categories of recommendations in our sample of UK inquiries[419]

(1) Legislative reform

Brook House Inquiry: Recommendation 7: "The government **must introduce in legislation** a maximum 28-day time limit on any individual's detention within an immigration removal centre."

Daniel Morgan Independent Panel: Recommendation 17: "The Panel recommends the **creation of a statutory duty of candour**, to be owed by all law enforcement agencies to those whom they serve, subject to protection of national security and relevant data protection legislation."

Jermaine Baker Public Inquiry: Recommendation 15.21: "There should be **an amendment to the Criminal Procedure Rules** which govern the process in applications for a firearms presence in court – a requirement for witness statements, sworn evidence and the taping of proceedings should all be included."

(2) Investigation of individuals

Inquiry into Hyponatraemia-related Deaths: Recommendation 7: "Trusts should monitor compliance and **take disciplinary action** against breach."

Independent Inquiry into the Issues raised by Paterson: Recommendation 12: "We recommend that if, **when a hospital investigates a healthcare professional's behaviour**, **including the use of an HR process**, any perceived risk to patient safety should result in the suspension of that healthcare professional. If the healthcare professional also works at another provider, any concerns about them should be communicated to that provider."

(3) Policy change

IICSA: Recommendation 17: "The Inquiry recommends that the UK government directs the Information Commissioner's Office to **introduce a code of practice** on retention of and access to records known to relate to child sexual abuse."

Post Office Horizon IT Inquiry Report Volume One: Recommendation 10: "The Department shall issue **a supplementary document/announcement clarifying the meaning and intent of the "best offer" principle in the Horizon Shortfall Scheme Appeal ("HSSA") process** demonstrating how it is intended to operate in practice with appropriate examples, if thought necessary."

(4) Culture change

Angiolini Inquiry Part 1 Report: Recommendation 14: "With immediate effect, every police force **should commit publicly to being an anti-sexist, anti-misogynistic, anti-racist organisation** in order to address, understand and eradicate sexism, racism and misogyny, **contributing to a wider positive culture** to remove all forms of discrimination from the profession. This includes properly addressing – and taking steps to root out – so-called 'banter' that often veils or excuses malign or toxic behaviour in police ranks."

UK Covid-19 Inquiry Module 1: Recommendation 3: "The UK government and devolved administrations should work together on developing a **new approach to risk assessment** that moves away from a reliance on single reasonable worst-case scenarios towards an approach that…"

Independent Inquiry into the Issues raised by Paterson: Recommendation 14: "We recommend that when things go wrong, boards **should apologise at the earliest stage of investigation and not hold back from doing so for fear of the consequences** in relation to their liability."

(5) Practice change

Manchester Arena Inquiry Volume 2-II: Recommendation 8: "Greater Manchester Police should **ensure that its role cards are always immediately accessible** to the officers who are to perform those roles."

Scottish Hospitals Inquiry Interim Report: Recommendation 2: "A **risk assessment is required** if there is a change in the arrangements for funding a project."

(6) Internal review

Jermaine Baker Public Inquiry: Recommendation 15.6: "The NPCC should commission a **national review** of the frequency with which this strategic option is used and its efficacy. The NPCC **should consider** whether contain and call out is being given meaningful consideration in the planning of armed deployments."

Manchester Arena Inquiry Volume 2-II: Recommendation 7: "British Transport Police should **reflect on its approach** to record-making during and immediately following a Major Incident, with a view to improving the current practice."

Infected Blood Inquiry Report: Recommendation 4a(ii): "The operation of the duties of candour in healthcare in Scotland and in Wales **should be reviewed**, as it is being in England, to assess how effective its operation has been in practice. Since the duty was introduced in 2023 in Wales, the review there need not be immediate, but should be no later than the end of 2026."

Inquiry into Hyponatraemia-related Deaths: Recommendation 5: "Trusts should **review their contracts of employment, policies and guidance** to ensure that, where relevant, they include and are consistent with the duty of candour."

Independent Public Inquiry into the Non-domestic RHI Scheme: Recommendation 38: "The Northern Ireland Assembly **should consider what steps are needed to strengthen its scrutiny role**, particularly as conducted by Assembly Committees, in the light of lessons from the RHI. While it will be for the Assembly itself to decide, the Inquiry recommends that **such a consideration might include** significantly increasing the resources available to statutory committees and, generally, identifying what steps are needed to improve the effective scrutiny of Departments and their initiatives, whether in Assembly Committees or in the Assembly Chamber itself."

Manchester Arena Inquiry Volume 1: Monitored Recommendations 7, 8 and 9:

- "The requirement that only those monitoring CCTV under a contract for services need to hold an SIA licence **should be reviewed**."
- "**Consideration should be given** to whether contractors who carried out security services should be required to be licenced."

- "BTP and all Home Office Police Services **should conduct a review** of the areas in which their jurisdictions overlap. In the case of areas which have a significant footfall by members of the public which are not part of the railway estate, a review should be conducted by both BTP and the Home Office Police Services. Following the review, agreement as to primacy should be reached and recorded in writing."

Daniel Morgan Independent Panel: Recommendation 21: "In order to avoid most of the delays and difficulties inherent in this case, and in so many other unsolved cases, there is a need for **a review of the processes for archiving historic material** with a view to creating a system which can produce national and local documents as required."

(7) Training

Brook House Inquiry: Recommendation 8: "The Home Office (in collaboration with NHS England as required) must ensure that **comprehensive training** on Rule 34 and Rule 35 of the Detention Centre Rules 2001 is rolled out urgently across the immigration detention estate. Staff must be subject to refresher training, at least annually."

Grenfell Tower Inquiry Phase Two: Recommendation 16: "In order to speed up the creation of a body of professional fire engineers we also recommend that the government take urgent steps to **increase the number of places on high-quality masters level courses** in fire engineering accredited by the professional regulator."

(8) Responses to inquiry recommendations

Post Office Horizon IT Inquiry Report Volume One: Recommendation 1: "HM Government and/or the Department and where appropriate the Post Office and Fujitsu shall provide **written responses to my recommendations** by 10 October 2025".

Report Infected Blood Inquiry: Recommendation 12: "(a) Within the next 12 months, the Government should consider and either commit to implementing the recommendations which I make, or give sufficient reason, in sufficient detail for others to understand, why it is not considered appropriate to implement any one or more of them. (b) During that period, and before the end of this year – the Government should report back to Parliament as to the progress made on considering and implementing the recommendations. (c) This timetable should not interfere with earlier consideration and response to the Recommendations of the Second Interim Report of the Inquiry (d) The Public Administration and Constitutional Affairs Committee ("PACAC") should review both the progress towards responding to the Inquiry's recommendations and, to the extent that they are accepted, implementing those recommendations (e) PACAC should accept the role in respect of any future statutory inquiry of reviewing government's timetable for consideration of recommendations, and of its progress towards implementation of that inquiry's recommendations."

Anthony Grainger Inquiry: Recommendation 1: "A national policing body should manage a national register of recommendations relating to armed policing, **and the response to such recommendations**, arising from Independent Office for Police Conduct ("IOPC") reports, prevention of future death reports made in the course of inquests, and statutory inquiries concerning fatal police shootings."

(9) Implementation monitoring

Independent Public Inquiry into the Non-domestic RHI Scheme: Recommendation 44: "The recommendations for change made here, to the extent they are adopted, will take time to implement; they may indeed not even be sufficient to address the range of shortcomings revealed by the Inquiry. The Inquiry therefore recommends **a role in future for the Northern Ireland Audit Office in assessing and validating the extent of progress in implementing the lessons learned from the NI RHI scheme and implementing these recommendations, including reporting on such progress periodically to the Northern Ireland Assembly and the people of Northern Ireland**. The Inquiry further recommends that the Northern Ireland Audit Office is provided with sufficient additional resources so as to enable it to perform such a role."

David Fuller Inquiry Phase Two Report: Recommendation 75: "The government should **take responsibility for the implementation of all the recommendations** we make in this Report, regardless of the primary organisation they are directed at, **and make arrangements to monitor the progress of their implementation**".

(10) Implementation of a previous recommendation

IICSA: Recommendation 20: "The Inquiry recommends (as originally stated in its The Internet Investigation Report, dated March 2020) that the **UK government introduces legislation** requiring providers of online services and social media platforms to implement more stringent age verification measures."

Daniel Morgan Independent Panel: Recommendation 9: "The Government should act on its stated intention in 2013 to require licensing measures, introduce legislation to ensure the creation and use of standards, and **implement the recommendation in the 2016 review concerning the regulation of private investigators**."

(11) Future inquiries

Truth Recovery Independent Panel Interim Report: Recommendation 1: "The Panel **asks Ministers to consider the early appointment of the Chair of the Public Inquiry**. This will allow the Panel to support the work of the Public Inquiry more effectively. It will also enable the Chair to engage in foundational planning for the Public Inquiry. In hindsight, providing a similar opportunity for the Panel's Co-Chairs to take up post ahead of the rest of the Panel would have enabled them to oversee planning for the Panel's most significant workstreams. This could have included: securing access to institutional records before the Panel began its work; ensuring processes had been completed to recruit testimony facilitators early in the Panel's work; and securing administrative support and suitable accommodation for the taking of testimonies."

Manchester Arena Inquiry Volume 3: Recommendation 25.98: "I recommend that the Crown Prosecution Service establish **a written protocol in relation to its approach to any application from an inquiry Chairman** for a section 35 prosecution to be taken over under section 6(2) of the Prosecution of Offences Act 1985."

Edinburgh Tram Inquiry: Recommendation 2: "In any event Scottish Ministers should not appoint as the sponsor of **any public inquiry** any department, agency or other government organisation where it, or any of its employees, has had any involvement in the project or other event giving rise to the establishment of the public inquiry."

Infected Blood Inquiry Report: Recommendation 11: "(a) that a minister should retain the power to call an inquiry as the minister sees fit, in accordance with the Inquiries Act 2005 – but where a minister does not choose to do so, then: (b) if there is sufficient support from within Parliament for there to be an inquiry, the question whether there should be one should be referred to PACAC for it to consider the question. (c) If it appears to PACAC that there is sufficient concern to justify a public inquiry, either because what happened and why has caused concern (as the committee sees it) or there are likely to be lessons learned which may prevent similar concerns arising in future, the committee may recommend to an appropriate minister that there be an inquiry. (d) If the minister disagrees with the recommendation, they must set out in detail and publish reasons for this disagreement which are sufficient to satisfy PACAC that the matter has been carefully and properly considered."

(12) Compensation

IICSA: Recommendation 19: "The Inquiry recommends that **the UK government establishes a single redress scheme in England and Wales**, taking into account devolved responsibilities. The detailed rules of, and funding for, this redress scheme should reflect the following core elements."

Infected Blood Inquiry Report: Recommendation 1: "My principal recommendation remains that **a compensation scheme should be set up** now."

(13) Inspection

Grenfell Tower Inquiry Phase Two Recommendation 1: "We are aware that in the period since the Grenfell Tower fire Parliament has passed the Building Safety Act 2022 to regulate work on higher-risk buildings, to impose particular duties on those involved in the construction and refurbishment of such buildings and to establish a Building Safety Regulator responsible for building control and for overseeing standards of competence. However, responsibility for the range of functions identified above remains dispersed. We therefore recommend that **the government draw together under a single regulator all the functions relating to the construction industry** to which we have referred."

Anthony Grainger Inquiry: Recommendation 2: "Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services ("HMICFRS") **should conduct a thematic inspection or inspections** concerning: (i) the selection and training of officers authorised to use weapons requiring special authorisation (paragraph 2.3.1(b) of the Code of Practice on Police use of Firearms and Less Lethal Weapons); (ii) the selection and training of officers authorised to command incidents involving the use of weapons requiring special authorisation (paragraph 2.3.1(b) of the Code); (iii) the selection and training of officers authorised to provide tactical advice relating to the use of weapons requiring special authorisation (paragraph 2.3.1(b) of the Code); (iv) compliance with the Code and/or the Armed Policing module of Authorised Professional Practice ("APP") relating to the police use of firearms (paragraph 2.3.1(c) of the Code); and (v) compliance with the Code and/or APP concerning the procurement and use of special munitions."

Manchester Arena Inquiry Volume 2-II: Recommendation 98: "Local resilience forums have a vital role in the preparation for the response to any Major Incident. The Cabinet Office and the Home Office should consider implementing an **independent inspection regime** for local resilience forums."

David Fuller Inquiry Phase Two Report: Recommendation 3: "All NHS trusts **should routinely audit** the access data of all facilities used to store deceased people."

Endnotes

[1] House of Commons Library, 'Public inquiries' (November 2025) at page 7.
[2] House of Commons Library, 'Public inquiries' (November 2025) at pages 11. See also Inquiries Act 2005.
[3] House of Commons Library, 'Public inquiries' (November 2025) at pages 5 and 12.
[4] House of Commons Library, 'Public inquiries' (November 2025) at pages 12-13.
[5] See https://lampardinquiry.org.uk/non-statutory-phase-of-the-inquiry/.
[6] See https://lampardinquiry.org.uk/non-statutory-phase-of-the-inquiry/ . See also discussion in Lampard Inquiry, 'Written Opening Statement on Behalf of INQUEST' (21 August 2024).
[7] House of Commons Library, 'Public inquiries' (November 2025) at pages 13-14. See also Manchester Arena Inquiry report, 'Volume 2: Emergency Response: Volume 2:II' (November 2022) at page 27.
[8] See Institute for Government, 'Explainer: Public Inquiries' (last updated 15 September 2026).
[9] Emma Ireton, 'Public inquiries: irreconcilable interests and the importance of managing expectations', Journal of Social Welfare and Family Law 45(3), 212–233 at page 215.
[10] Emma Ireton, 'Public inquiries: irreconcilable interests and the importance of managing expectations', Journal of Social Welfare and Family Law 45(3), 212–233 at page 215.
[11] See bill page here https://bills.parliament.uk/bills/4019. See also 'Public Office (Accountability) Bill (Carry-Over)' (27 April 2026).
[12] See Explanatory Notes accompanying the Bill as reintroduced in the House of Commons on May 2026, available at https://publications.parliament.uk/pa/bills/cbill/59-02/0007/en/260007en.pdf.
[13] See Clause 1 of the Public Office (Accountability) Bill as reintroduced at report stage, available at https://publications.parliament.uk/pa/bills/cbill/59-02/0007/260007.pdf.
[14] See Patrick Roche, 'Hillsborough Law, at last', Garden Court Chambers (26 September 2025).
[15] INQUEST, 'Hillsborough Law: Why legal aid is essential for bereaved families' (18 December 2025).
[16] See Public Accounts Committee, 'Government compensation schemes: update'.
[17] See Public Accounts Committee, 'System failure in govt compensation schemes - PAC joins victims in call for change' (9 September 2026).
[18] See Public Accounts Committee, 'Government Compensation Schemes' (September 2026) at page 4.
[19] See Institute for Government, 'Explainer: Public Inquiries' (last updated 15 September 2026).
[20] See Institute for Government, 'Explainer: Public Inquiries' (last updated 15 September 2026).
[21] See Institute for Government, 'Explainer: Public Inquiries' (last updated 15 September 2026).
[22] See Institute for Government, 'Explainer: Public Inquiries' (last updated 15 September 2026).
[23] INQUEST, 'No More Deaths: Learning, action, and accountability: the case for a National Oversight Mechanism' (undated) at page 11.
[24] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Deborah Coles (Director, INQUEST) at Q77.
[25] See e.g., Baroness Hallett's comments as reported here 'UK Covid-19 Inquiry officially underway as Terms of Reference are received' (28 June 2022).
[26] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at page 3.
[27] See e.g., House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) and e.g., INQUEST's campaign for a National Oversight Mechanism.
[28] See e.g., Institute for Government, 'How public inquiries can lead to change' (December 2017) at page 31.
[29] While we are aware of more recent inquiry reports published since July 2025 and reference them on occasion in this report, our analysis focused on those listed here.

[30] See Bingham Centre events, 'Promoting More Effective Oversight of the Implementation of Recommendations Made by Public Inquiries in the UK' (25 March 2026).
[31] Inquiries Act 2005, Section 5.
[32] Inquiries Act 2005, Section 24.
[33] Inquiries Act 2005, Section 24.
[34] See Volume 4 at pages 771-780
[35] See Volume 7 at pages 231-248.
[36] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025).
[37] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at page 4.
[38] Inquiries Act 2005, Section 17.
[39] See Volume 3 of the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' (February 2013).
[40] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 19 February 2024', John O'Brien (former secretary to the Independent Inquiry into Child Sexual Abuse (IICSA)) at Q25.
[41] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 19 February 2024', John O'Brien (former secretary to the Independent Inquiry into Child Sexual Abuse (IICSA)) at Q25.
[42] See 'Infected Blood Inquiry: The Report' (May 2024) Volume 1 at pages 284-291.
[43] See 'Infected Blood Inquiry: Additional Report on Compensation' (July 2025) at pages 202-205
[44] See 'Infected Blood Inquiry: The Report' (May 2024) Volume 1 at page 221.
[45] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.5.
[46] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.5.
[47] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.5.
[48] See 'Report of the Daniel Morgan Independent Panel' (June 2021). The recommendations are however extracted here https://www.gov.uk/government/publications/daniel-morgan-independent-panel-report-metropolitan-police-service/daniel-morgan-independent-panel-recommendations-annex-accessible-version.
[49] Available at https://www.gov.uk/government/collections/manchester-arena-inquiry-reports. This includes the 9 Monitored Recommendations from Volume 1, 149 recommendations from Volume 2 and 11 recommendations from Volume 3.
[50] See https://www.gov.uk/government/publications/manchester-arena-inquiry-recommendations. We have not checked that the 169 recommendations in the dashboard align with our counting of 169 recommendations from the reports.
[51] See https://www.gov.uk/government/publications/manchester-arena-inquiry-recommendations.
[52] See the complete dataset available to download here https://mainquiry.dac.grid.civilservice.gov.uk.
[53] Available at https://www.gov.uk/government/collections/manchester-arena-inquiry-reports.
[54] See 'UK Covid-19 Inquiry Module 1: The resilience and preparedness of the United Kingdom' report (July 2024).
[55] See https://covid19.public-inquiry.uk/inquiry-recommendations/.
[56] See 'Brook House Inquiry Report' (September 2023).
[57] See 'Brook House Inquiry Report' (September 2023).
[58] See 'Brook House Inquiry Report' (September 2023).

[59] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 26 February 2024', Dr Nathan Critch (Teaching Associate, University of Birmingham) at Q33.
[60] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.4.
[61] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.4.
[62] See Volume 1 at pages 168-169, available at https://www.gov.uk/government/collections/manchester-arena-inquiry-reports.
[63] 'Report into the Death of Jermaine Baker' (July 2022) at pages 219-223.
[64] See 'Independent Inquiry into the issues raised by the David Fuller case: Phase 2 Report' at pages 263-279.
[65] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.2.1.
[66] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.2.2.
[67] Institute for Government, 'How public inquiries can lead to change' (2017) at page 33.
[68] Institute for Government, 'How public inquiries can lead to change' (2017) at page 33.
[69] Institute for Government, 'How public inquiries can lead to change' (2017) at page 33.
[70] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.3.
[71] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.3.
[72] Dr Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.3.
[73] See 'UK Covid-19 Inquiry Module 1: The resilience and preparedness of the United Kingdom' report (July 2024) at para A1.8.
[74] See 'UK Covid-19 Inquiry Module 1: The resilience and preparedness of the United Kingdom' report (July 2024) at para A1.8.
[75] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 19 February 2024', Mark Fisher (former secretary to the Grenfell Tower Inquiry) at Q16.
[76] King's College London, 'Learning the Right Lessons for the Next Pandemic: How to Design Public Inquiries into the UK Government's Handling of COVID-19' (2020) at page 23.
[77] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.2.2.
[78] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.3.
[79] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 3.1.
[80] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Deborah Coles (Director, INQUEST) at Q77.
[81] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.3.2.

[82] See https://thirlwall.public-inquiry.uk/2024/05/17/review-of-previous-recommendations-published/.
[83] See https://thirlwall.public-inquiry.uk/document/review-by-the-thirlwall-inquiry-legal-team-of-the-implementation-of-recommendations-made-by-previous-inquiries-into-healthcare-issues/.
[84] See https://thirlwall.public-inquiry.uk/2026/09/15/inquiry-report-finds-profound-failure-of-management-governance-and-safeguarding/.
[85] See https://thirlwall.public-inquiry.uk/final-report-chapter/volume-iii/part-two/chapter-31/.
[86] See https://thirlwall.public-inquiry.uk/final-report-chapter/volume-iii/part-two/chapter-31/ at paras 31.1 and 31.2.
[87] See https://thirlwall.public-inquiry.uk/final-report-chapter/volume-iii/part-two/chapter-31/ at para 31.5.
[88] INQUEST, 'No More Deaths: Learning, action, and accountability: the case for a National Oversight Mechanism' (undated) at page 8.
[89] See House of Commons, 'Grenfell Tower Fire: Ninth Anniversary', Volume 787: debated on 11 June 2026.
[90] Workshop notes on file with authors.
[91] Workshop notes on file with authors.
[92] Workshop notes on file with authors.
[93] Workshop notes on file with authors.
[94] Workshop notes on file with authors.
[95] See Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025).
[96] See Sections 25 and 26 of the Inquiries Act 2005.
[97] See Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 3.2.
[98] Cabinet Office, 'Draft Inquiries Guidance' at page 14.
[99] Cabinet Office, 'Draft Inquiries Guidance' at page 15.
[100] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 22 April 2024', Simon Madden (Director, Propriety and Ethics Team, Cabinet Office) at Q129.
[101] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 22 April 2024', Luke Hughes (Deputy Director, Propriety and Ethics Team, Cabinet Office) at Q135.
[102] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 83.
[103] House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014).
[104] House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014) at paras 287-289 and repeated at page 95.
[105] Ministry of Justice, 'Government Response to the Report of the House of Lords Select Committee on the Inquiries Act 2005' (2014) at paras 85-90
[106] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024).
[107] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024), Appendix 4.
[108] See Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 3.2.
[109] 'Government Response to the House of Lords Statutory Inquiries Committee report: Enhancing public trust' (2025), Annex A.
[110] 'Government Response to the House of Lords Statutory Inquiries Committee report: Enhancing public trust' (2025), Annex A.
[111] 'Government Response to the House of Lords Statutory Inquiries Committee report: Enhancing public trust' (2025), Annex A.

[112] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Emma Norris (Deputy Director, Institute for Government) at Q72.
[113] See 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).
[114] 'The Southport Inquiry Report, Volume 2' (April 2026) at page 461.
[115] Workshop notes on file with authors.
[116] Workshop notes on file with authors.
[117] Workshop notes on file with authors.
[118] Workshop notes on file with authors.
[119] Workshop notes on file with authors.
[120] Workshop notes on file with authors.
[121] Workshop notes on file with authors.
[122] Housing, Communities and Local Government Committee, 'Oral evidence: Grenfell and Building Safety, Tuesday 18 March 2025', Peter Apps (Journalist and author) at Q5.
[123] See Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.2.1.
[124] National Audit Office, Report by the Comptroller and Auditor General, 'Investigation into government-funded inquiries' (May 2018) at para 3.17.
[125] National Audit Office, Report by the Comptroller and Auditor General, 'Investigation into government-funded inquiries' (May 2018) at para 3.17.
[126] 'Grenfell Tower Inquiry: Phase 2 Report' (September 2024), Volume 7 at para 113.40.
[127] 'Grenfell Tower Inquiry: Phase 2 Report' (September 2024), Volume 7 at para 113.40.
[128] 'Grenfell Tower Inquiry: Phase 2 Report' (September 2024), Volume 7 at para 113.40.
[129] See e.g., https://www.gov.uk/government/publications/grenfell-tower-inquiry-government-progress-report-may-2026/progress-report-may-2026-implementation-timeline-for-grenfell-tower-inquiry-recommendations.
[130] 'Grenfell Tower Inquiry Phase 2 Report: Government response' (February 2025), recommendation 25 notes.
[131] Housing, Communities and Local Government Committee, 'Oral evidence: Grenfell and Building Safety, Tuesday 18 March 2025', Deborah Coles (Executive Director, INQUEST) at Q5.
[132] Housing, Communities and Local Government Committee, 'Oral evidence: Grenfell and Building Safety, Tuesday 18 March 2025', Peter Apps (Journalist and author) at Q5.
[133] 'Public Inquiries: Recommendations and the Government Response'.
[134] 'Public Inquiries: Recommendations and the Government Response'.
[135] 'Public Inquiries: Recommendations and the Government Response'.
[136] See Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.2.1.
[137] Workshop notes on file with authors.
[138] Workshop notes on file with authors.
[139] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 3.2.
[140] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 3.1.
[141] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.2.
[142] See e.g., INQUEST, 'Learning from Death in Custody Inquests: A New Framework for Action and Accountability' (November 2012); and INQUEST, 'INQUEST calls for new mechanism for oversight on recommendations in response to the Grenfell Tower Inquiry' (October 2019). See

also e.g., Lampard Inquiry, 'First Witness Statement of Deborah Coles on Behalf of INQUEST' (1 April 2025) at para 80.
[143] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Deborah Coles (Director, INQUEST) at Q67.
[144] See 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).
[145] See 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).
[146] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 80.
[147] See 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).
[148] See https://www.gov.scot/groups/infected-blood-oversight-and-assurance-group/.
[149] See https://www.gov.scot/groups/infected-blood-oversight-and-assurance-group/.
[150] See 'Grenfell Tower Inquiry Phase 2 Report Government Response: Annual Report 2026' (February 2026) at para 140.
[151] See 'Grenfell Tower Inquiry Phase 2 Report Government Response: Annual Report 2026' (February 2026) at para 140.
[152] Isabelle Mitchell, Peter Watkin Jones, Sarah Jones and Emma Ireton, 'The Practical Guide to Public Inquiries' (Bloomsbury 2020) at page 280.
[153] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 3.1.
[154] See 'Eversheds – Written Evidence' at para 42 contained within 'Select Committee on the Inquiries Act 2005: Written and corrected oral evidence' (published 11 March 2014).
[155] Rennie & Ors v SSHD [2023] EWHC 1794 (Admin) at para 1.
[156] Rennie & Ors v SSHD [2023] EWHC 1794 (Admin) at paras 171 and 172.
[157] Rennie & Ors v SSHD [2023] EWHC 1794 (Admin) at para 171.
[158] R (D1914 & Anor) v SSHD [2025] EWHC 1853 (Admin) at para 1. We note that Claim 1, filed by D1914 and AAA, was linked for case management and hearing with Claim 2, filed by AVY. We focus here on Claim 1.
[159] R (D1914 & Anor) v SSHD [2025] EWHC 1853 (Admin) at paras 293 and 294.
[160] R (D1914 & Anor) v SSHD [2025] EWHC 1853 (Admin) at para 265.
[161] R (D1914 & Anor) v SSHD [2025] EWHC 1853 (Admin) at para 267.
[162] R (D1914 & Anor) v SSHD [2025] EWHC 1853 (Admin) at para 289.
[163] Gemma Ludgate, 'The High Court rules on the enforcement of an inquiry's recommendations', Burges Salmon (28 August 2025).
[164] Eversheds Sutherland, 'Brook House Detainees' Judicial Review: the Duty to Investigate and the Limits of Government Accountability' (27 October 2025).
[165] Eversheds Sutherland, 'Brook House Detainees' Judicial Review: the Duty to Investigate and the Limits of Government Accountability' (27 October 2025).
[166] R (D1914 & Anor) v SSHD [2025] EWHC 1853 (Admin) at para 95.
[167] Jonathan Collinson, 'From learning to Lawyering: When Can Political Accountability Have Legal Consequences?', UK Constitutional Law Association Blog (11 September 2025).
[168] R (D1914 & Anor) v SSHD [2025] EWHC 1853 (Admin) at paras 7 and 8.
[169] Jonathan Collinson, 'From learning to Lawyering: When Can Political Accountability Have Legal Consequences?', UK Constitutional Law Association Blog (11 September 2025).
[170] See https://www.gov.uk/government/publications/windrush-lessons-learned-review. See also 'Windrush Lessons Learned Review: Question for Home Office' (UIN HL15568, tabled on 16 March 2026, answered on 27 March 2026) which notes, among other things, that "Given that

there have been numerous reviews we do not believe a public inquiry would add to the scrutiny and understanding of the Home Office Windrush Scandal...".
[171] See https://www.gov.uk/government/groups/independent-review-of-criminal-legal-aid.
[172] R (Donald) v SSHD [2024] EWHC 1492 (Admin) at para 1.
[173] R (Donald) v SSHD [2024] EWHC 1492 (Admin) at paras 3 and 289.
[174] R (Donald) v SSHD [2024] EWHC 1492 (Admin) at paras 289-294. See also Garden Court Chambers, 'High Court finds Home Office decision to abandon key Windrush recommendations discriminatory' (19 June 2024) and Temple Garden Chambers, 'Judgment handed down in judicial review of the Home Secretary's decision not to proceed with three Windrush recommendations' (20 June 2024).
[175] R (Donald) v SSHD [2024] EWHC 1492 (Admin) at paras 289-294.
[176] Jonathan Collinson, 'From learning to Lawyering: When Can Political Accountability Have Legal Consequences?', UK Constitutional Law Association Blog (11 September 2025).
[177] R (Law Society of England and Wales) v The Lord Chancellor [2024] EWHC 155 (Admin) at para 2. See also Bindmans, 'The Law Society succeeds in its judicial review claim against 'irrational' Legal Aid decision making by the Lord Chancellor' (31 January 2024).
[178] R (Law Society of England and Wales) v The Lord Chancellor [2024] EWHC 155 (Admin) at paras 246 and 247.
[179] Graham Zellick KC, 'A Judgment Too Far', New Law Journal (8 March 2024).
[180] Graham Zellick KC, 'A Judgment Too Far', New Law Journal (8 March 2024).
[181] See The Maggie Oliver Foundation, 'High Court Grants Historic Permission for the Maggie Oliver Foundation to Challenge Government on Failure to Act on Child Sexual Abuse and Exploitation' (17 March 2026).
[182] Jason Beer QC, 'Public Inquiries' (James Dingemans QC and Richard Lissack QC consultant editors) (Oxford University Press 2011) at para 1.64. See also Section 49 of the Inquiries Act 2005.
[183] Jason Beer QC, 'Public Inquiries' (James Dingemans QC and Richard Lissack QC consultant editors) (Oxford University Press 2011) at para 1.64. See also Section 26 of the Inquiries Act 2005.
[184] Jason Beer QC, 'Public Inquiries' (James Dingemans QC and Richard Lissack QC consultant editors) (Oxford University Press 2011) at para 10.61.
[185] See House of Commons, 'Covid-19 Inquiry', Volume 752: debated on 19 July 2024.
[186] See House of Lords, 'Covid-19 Inquiry', Volume 839: debated on 3 September 2024.
[187] 'Covid-19 Inquiry: Costs: Question for Cabinet Office' (UIN 124125, tabled on 26 March 2026, answered on 21 April 2026).
[188] 'Covid-19 Inquiry: Question for Department for Education' (UIN 5679, tabled on 1 June 2026, answered on 9 June 2026).
[189] 'Covid-19 Inquiry: Question for Department of Health and Social Care' (UIN 5128, tabled on 10 September 2024, answered on 17 September 2024).
[190] 'Covid-19 Inquiry: Question for Cabinet Office' (UIN 2069, tabled on 29 July 2024, answered on 9 September 2024).
[191] 'Covid-19 Inquiry: Question for Department of Health and Social Care' (UIN 97697, tabled on 5 December 2025, answered on 15 December 2025).
[192] See House of Commons, 'Paterson Inquiry', Volume 671: debated on 4 February 2020.
[193] See House of Lords, 'Paterson Inquiry', Volume 801: debated on 4 February 2020.
[194] See House of Commons, 'Daniel Morgan Independent Panel Report', Volume 697: debated on 15 June 2021.
[195] See House of Lords, 'Daniel Morgan Independent Panel Report', Volume 813: debated on 22 June 2021.
[196] See 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).

[197] See 'Written evidence from the Cabinet Office (IBI0005)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1) at para 11.
[198] See 'Written evidence from the Cabinet Office (IBI0005)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1) at para 11.
[199] See 'Written evidence from the Cabinet Office (IBI0005)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1) at para 11.
[200] See 'Manchester Arena Inquiry: General Observations on the Conclusion of the Inquiry' (4 July 2023).
[201] See Intelligence and Security Committee of Parliament, 10 July 2023 news item available at https://isc.independent.gov.uk/news/.
[202] See 'Infected Blood Inquiry: The Report' (20 May 2024) at page 291.
[203] See 'Letter from Rt Hon. Nick Thomas-Symonds MP, Minister for the Cabinet Office and HM Paymaster General on Infected Blood Inquiry' (21 July 2025).
[204] See Home Affairs Committee, 'Implementation of Independent Inquiry into Child Sexual Abuse'.
[205] See Home Affairs Committee, 'Alexis Jay to be questioned on child sexual abuse report' (10 January 2025).
[206] See Home Affairs Committee, 'One off evidence session: the Brook House Inquiry'.
[207] See Housing, Communities and Local Government Committee, 'Grenfell and Building Safety'.
[208] House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014).
[209] House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014) at para 290.
[210] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 93.
[211] Institute for Government, 'How public inquiries can lead to change' (December 2017) at page 4.
[212] Institute for Government, 'How public inquiries can lead to change' (December 2017) at page 4.
[213] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Emma Norris (Deputy Director, Institute for Government) at Q77.
[214] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Emma Norris (Deputy Director, Institute for Government) at Q77.
[215] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Emma Norris (Deputy Director, Institute for Government) at Q77.
[216] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.8.
[217] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.8.
[218] See 'Written evidence from INQUEST (IBI0006)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1) at para 15.
[219] See 'Written evidence from INQUEST (IBI0006)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1) at para 14.
[220] See 'Written evidence from the Cabinet Office (IBI0005)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1) at paras 12 and 13.

[221] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 104.
[222] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 116.
[223] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 116.
[224] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.8.
[225] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.8.
[226] 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).
[227] 'Government Response to the House of Lords Statutory Inquiries Committee report: Enhancing public trust' (10 February 2025).
[228] 'Government Response to the House of Lords Statutory Inquiries Committee report: Enhancing public trust' (10 February 2025).
[229] Workshop notes on file with authors.
[230] Workshop notes on file with authors.
[231] Workshop notes on file with authors.
[232] Workshop notes on file with authors.
[233] Workshop notes on file with authors.
[234] 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).
[235] Inquiries Act 2005, Section 14.
[236] House of Commons Library, 'Public inquiries' (November 2025) at page 24. See also Cabinet Office, 'Draft Inquiries Guidance' at page 15.
[237] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.7.
[238] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.7.
[239] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.7.
[240] See 'The Bichard Inquiry Report' available at https://dera.ioe.ac.uk/id/eprint/6394/1/report.pdf.
[241] See 'The Bichard Inquiry Report' available at https://dera.ioe.ac.uk/id/eprint/6394/1/report.pdf.
[242] See 'The Bichard Inquiry Report' available at https://dera.ioe.ac.uk/id/eprint/6394/1/report.pdf.
[243] See 'The Bichard Inquiry Final Report' available at https://image.guardian.co.uk/sys-files/Society/documents/2005/03/15/Bichardfinalreport.pdf.
[244] See 'The Bichard Inquiry Final Report' available at https://image.guardian.co.uk/sys-files/Society/documents/2005/03/15/Bichardfinalreport.pdf.
[245] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.7.
[246] Lampard Inquiry, 'Written Opening Statement on Behalf of INQUEST' (21 August 2024) at para 84.

[247] Lampard Inquiry, 'Written Opening Statement on Behalf of INQUEST' (21 August 2024) at para 87. Underline added.
[248] House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014) at paras 268-278.
[249] House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014) at para 270.
[250] House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014) at paras 273 and 278.
[251] House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014) at para 283.
[252] House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: post-legislative scrutiny' (2014) at para 290.
[253] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at paras 87-92.
[254] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 91.
[255] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at paras 95-98.
[256] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 95.
[257] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 98.
[258] Available at https://www.gov.uk/government/collections/manchester-arena-inquiry-reports.
[259] See 'Letter from Chairman for the Manchester Arena Inquiry – S.14 Notice' (1 August 2023).
[260] See Lauren Hirst, 'Arena inquiry chairman to meet MI5 over progress', BBC News (22 May 2025). See also, Roger Johnson, 'Arena bomb inquiry was 'ground-breaking' - chairman' BBC News (10 September 2025).
[261] 'Infected Blood Inquiry Report' (20 May 2024) Volume 1 at page 291.
[262] See transcript at pages 29-30, available at https://www.infectedbloodinquiry.org.uk/reports/inquiry-report/publication-day. Underline added.
[263] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 3.3.
[264] 'IICSA Report' (October 2022) at page 354. Underline added.
[265] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at paras 60-63.
[266] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 60.
[267] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 61.
[268] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 62.
[269] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 63.
[270] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.6.
[271] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.6.
[272] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 2.6.

[273] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 92.
[274] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 92.
[275] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 92.
[276] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 92.
[277] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.1.
[278] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.1.
[279] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.1.
[280] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.1. See also 'Inquest calls on Grenfell Tower Inquiry Chair To Ensure Phase One Recommendations Are Enacted' (12 August 2020).
[281] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.1.
[282] See https://covid19.public-inquiry.uk/documents/terms-of-reference/.
[283] See https://covid19.public-inquiry.uk/structure-of-the-inquiry/.
[284] See https://covid19.public-inquiry.uk/modules/resilience-and-preparedness/#recommendations.
[285] See https://covid19.public-inquiry.uk/reports/module-1-report-in-brief-summary-the-resilience-and-preparedness-of-the-united-kingdom/. Underline added.
[286] See https://covid19.public-inquiry.uk/modules/resilience-and-preparedness/#recommendations.
[287] See https://covid19.public-inquiry.uk/inquiry-recommendations/.
[288] See https://covid19.public-inquiry.uk/inquiry-recommendations/.
[289] See https://covid19.public-inquiry.uk/inquiry-recommendations/.
[290] See https://www.angiolini.independent-inquiry.uk/the-angiolini-inquiry-terms-of-references/.
[291] See https://www.angiolini.independent-inquiry.uk/reports/.
[292] See https://www.angiolini.independent-inquiry.uk/reports-2/the-angiolini-inquiry-part-2-first-report-prevention-of-sexually-motivated-crimes-against-women-in-public/.
[293] See 'Angiolini Inquiry Part 2 First Report' (December 2025) at para 1.2. Underline added.
[294] See 'Angiolini Inquiry Part 2 First Report' (December 2025) at para 1.7. Underline added.
[295] See 'Angiolini Inquiry Part 2 First Report' (December 2025) at para 1.61. Underline added.
[296] See 'Angiolini Inquiry Part 1 Report' (February 2024) at pages 8-16.
[297] See 'Angiolini Inquiry Part 2 First Report' (December 2025) at pages 12-20.
[298] See 'Letter from Chairman for the Manchester Arena Inquiry – S.14 Notice' (1 August 2023).
[299] See https://webarchive.nationalarchives.gov.uk/ukgwa/20231101054836mp_/https://files.manchesterarenainquiry.org.uk/live/uploads/2019/11/18090347/MAI-Terms-of-Reference-17-Sept-2020.pdf.
[300] See https://www.gov.uk/government/collections/manchester-arena-inquiry-reports.
[301] See e.g., Volume 1 report at paras 8.1-8.5 and paras 8.122-8.125, Volume 2:2 at paras 21.39-21.47, and Volume 3 at para 25.3.

[302] See https://webarchive.nationalarchives.gov.uk/ukgwa/20231101051353/https:/manchesterarenainquiry.org.uk/transcripts-by-hearing-date/.
[303] See 'Letter from Chairman for the Manchester Arena Inquiry – S.14 Notice' (1 August 2023) at pages 1-2. Underline added.
[304] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 12 February 2024', Sir John Saunders (Chair, Manchester Arena Inquiry) at Q12. Underline added.
[305] 'Manchester Arena Inquiry: General Observations on the Conclusion of the Inquiry' (4 July 2023). Underline added.
[306] See 'Public Inquiries: Question for the Home Office' (UIN 96290, tabled on 2 December 2025, answered on 9 December 2025.)
[307] See https://www.iicsa.org.uk/about-us/terms-reference.html.
[308] See https://www.iicsa.org.uk/reports-recommendations/publications.html.
[309] See https://www.iicsa.org.uk/recommendations.html.
[310] 'IICSA Report' (October 2022) at Annex 3. Underline added.
[311] See 'Written evidence from Alexis Jay (STI0026)' to the Statutory Inquiries Committee (23 April 2024). Underline added.
[312] See https://www.iicsa.org.uk/reports/process-monitoring-responses-inquiry-recommendations.html.
[313] See https://covid19.public-inquiry.uk/inquiry-recommendations/ and https://www.iicsa.org.uk/reports/process-monitoring-responses-inquiry-recommendations.html.
[314] See 'Angiolini Inquiry Part 2 First Report' (December 2025) at para 1.61.
[315] See 'Manchester Arena Inquiry: General Observations on the Conclusion of the Inquiry' (4 July 2023).
[316] Rob Harland, 'Public Inquiries and their Recommendations: Prospects for Reform', 5 Essex Chambers (30 May 2025).
[317] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 3.1.
[318] See 'Manchester Arena Inquiry: General Observations on the Conclusion of the Inquiry' (4 July 2023).
[319] See 'Manchester Arena Inquiry: General Observations on the Conclusion of the Inquiry' (4 July 2023).
[320] See 'Manchester Arena Inquiry: General Observations on the Conclusion of the Inquiry' (4 July 2023).
[321] See 'Manchester Arena Inquiry: General Observations on the Conclusion of the Inquiry' (4 July 2023).
[322] See 'Manchester Arena Inquiry: General Observations on the Conclusion of the Inquiry' (4 July 2023).
[323] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Deborah Coles (Director, INQUEST) at Q70.
[324] See https://covid19.public-inquiry.uk/reports/module-1-report-in-brief-summary-the-resilience-and-preparedness-of-the-united-kingdom/.
[325] See https://www.covid19.public-inquiry.uk/chair-statements/baroness-halletts-opening-statement/.
[326] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at paras 127 and 135.
[327] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 138.
[328] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 103.
[329] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at Appendix 5.

[330] Institute for Government, 'Public Inquiries: How can the government ensure inquiries are set up to succeed' (December 2025) at page 6.
[331] 'Public Inquiries: Question for Cabinet Office' (UIN HL15917, tabled on 24 March 2026, answered on 27 March 2026).
[332] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 100.
[333] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 100.
[334] 'Report of the Independent Public Inquiry into the Non-domestic RHI Scheme' Volume 3 (March 2020). Underline added.
[335] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 100.
[336] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 100.
[337] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 100.
[338] See https://thirlwall.public-inquiry.uk/2026/09/15/inquiry-report-finds-profound-failure-of-management-governance-and-safeguarding/.
[339] See https://thirlwall.public-inquiry.uk/final-report-chapter/volume-iii/part-three/recommendations/#toc-heading-implementation-of-recommendations.
[340] See https://www.gov.uk/government/speeches/government-response-to-the-thirlwall-inquiry.
[341] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.10.
[342] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.10.
[343] Haroon Siddique, 'Do public inquiries work? What comes after Grenfell and other UK disasters', The Guardian, (6 September 2024).
[344] Tom Symonds, 'Only one change made at 'toxic' migrant centre', BBC News (18 September 2024).
[345] Hannah Bechelet, 'Recommendations from Ian Paterson inquiry not all implemented, five years since they were made', ITV News Central (4 February 2025).
[346] Lampard Inquiry, 'Written Opening Statement on Behalf of INQUEST' (21 August 2024) at para 6.
[347] Lampard Inquiry, 'Written Opening Statement on Behalf of INQUEST' (21 August 2024) at para 7.
[348] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.6.
[349] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.6.
[350] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 86.
[351] See https://thesurvivorstrust.org/act-on-iicsa/.
[352] See https://thesurvivorstrust.org/act-on-iicsa/.
[353] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Deborah Coles (Director, INQUEST) at Q68. Underline added.
[354] See https://inquest.org.uk/about-us/family-listening-days/.
[355] INQUEST, 'Family reflections on Grenfell: No voice left unheard: INQUEST report of the Grenfell Family Consultation Day' (2019) at page 8.
[356] INQUEST, '"All or Nothing" A report on the Hillsborough Law Family Listening Day' (April 2025) at page 7.

[357] Workshop notes on file with authors.
[358] Workshop notes on file with authors.
[359] Workshop notes on file with authors.
[360] Workshop notes on file with authors.
[361] Workshop notes on file with authors.
[362] Workshop notes on file with authors.
[363] Workshop notes on file with authors.
[364] INQUEST, 'No More Deaths: Learning, action, and accountability: the case for a National Oversight Mechanism' (undated) at page 4.
[365] See https://www.inquest.org.uk/no-more-deaths-campaign.
[366] See https://inquest.org.uk/campaigning-for-change/campaigns/no-more-deaths/campaign-supporters/.
[367] INQUEST, 'No More Deaths: Learning, action, and accountability: the case for a National Oversight Mechanism' (undated) at page 11.
[368] INQUEST, '"All or Nothing" A report on the Hillsborough Law Family Listening Day' (April 2025) at page 24.
[369] INQUEST, 'No More Deaths: Learning, action, and accountability: the case for a National Oversight Mechanism' (undated) at page 24. See also e.g., discussion in 'JUSTICE, 'When Things Go Wrong: The response of the justice system' (2020)'.
[370] 'Government Response to Grenfell and Building Safety Inquiry: Findings and Recommendations' (July 2025), Annex A.
[371] 'Housing Committee Chair presses Government on independent national oversight mechanism to ensure Grenfell inquiry recommendations are implemented' (10 September 2025).
[372] State-related Deaths (National Oversight Mechanism) Bill (Private Members' Bill (Presentation Bill), session 2024-26) available at https://bills.parliament.uk/bills/3837.
[373] See 'National oversight mechanism' EDM 867 tabled on 27 February 2025 (session 2024-26) available at https://edm.parliament.uk/early-day-motion/63235/national-oversight-mechanism.
[374] Compilation of all committee debate sittings so far, 'Public Bill Committee: Public Office (Accountability) Bill' (2 December 2025), at pages 48-49.
[375] Compilation of all committee debate sittings so far, 'Public Bill Committee: Public Office (Accountability) Bill' (2 December 2025), at pages 48-49.
[376] See https://bills.parliament.uk/bills/4019/stages.
[377] See https://hansard.parliament.uk/commons/2026-07-14/debates/42BA911A-DD0E-429B-BB99-60AADA6C8F69/PublicOffice(Accountability)Bill.
[378] See https://hansard.parliament.uk/lords/2026-09-01/debates/35777C3F-9FEB-4300-97CB-468C299BDEC8/PublicOffice(Accountability)Bill.
[379] See https://bills.parliament.uk/bills/4019/stages.
[380] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.9.
[381] Prof Andrew Williams, 'Public inquiries: are they fit for purpose?', Nuffield Foundation (July 2026) at page 4.
[382] Prof Andrew Williams, 'Public inquiries: are they fit for purpose?', Nuffield Foundation (July 2026) at page 37.
[383] Prof Andrew Williams, 'Public inquiries: are they fit for purpose?', Nuffield Foundation (July 2026) at pages 4-5 and 37.
[384] Workshop notes on file with authors.
[385] Workshop notes on file with authors.
[386] Workshop notes on file with authors.
[387] Workshop notes on file with authors.
[388] Workshop notes on file with authors.
[389] Workshop notes on file with authors.
[390] Workshop notes on file with authors.
[391] Workshop notes on file with authors.

[392] See 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).
[393] See 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).
[394] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 26 February 2024', Dr Alastair Stark (Associate Professor, University of Queensland) at Q32.
[395] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 26 February 2024', Dr Alastair Stark (Associate Professor, University of Queensland) at Q32.
[396] See 'Written evidence from Dr Emma Ireton (IBI0008)' to the Public Administration and Constitutional Affairs Committee Inquiry into the recommendations of the Infected Blood Inquiry (Stage 1).
[397] Alastair Stark and Duc Le, 'Public inquiry design choices: what ideas should be adopted from past inquiries around the world?', International Public Policy Observatory (18 January 2022). See also 'Equine Influenza Inquiry – the Government's response' available at https://www.agriculture.gov.au/biosecurity-trade/pests-diseases-weeds/animal/eiimplementation.
[398] See Recommendation 66 of the 2009 Victorian Bushfires Royal Commission final report summary (July 2010) available at http://royalcommission.vic.gov.au/Commission-Reports/Final-Report/Summary.html.
[399] See Recommendation 199 of the Royal Commission into Family Violence report summary and recommendations (March 2016) available at http://rcfv.archive.royalcommission.vic.gov.au/Report-Recommendations.html.
[400] See Recommendation 108 of the Royal Commission into the Management of Police Informants final report summary and recommendations (November 2020) available at https://rcmpi.archive.royalcommission.vic.gov.au.
[401] See Recommendation 22.1 of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings full report (August 2023) available at https://www.commissionofinquiry.tas.gov.au/report.
[402] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Neil Comrie (Australian Implementation Monitor) at Q68.
[403] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Neil Comrie (Australian Implementation Monitor) at Q68. For a discussion of interim work done by Mr Comrie in 2009 and 2010, see the 'Annual Report' of the Bushfires Royal Commission Implementation Monitor (July 2014) at pages 9-11.
[404] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Neil Comrie (Australian Implementation Monitor) at Q68.
[405] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Neil Comrie (Australian Implementation Monitor) at Q68.
[406] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Neil Comrie (Australian Implementation Monitor) at Q68.
[407] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Neil Comrie (Australian Implementation Monitor) at Q68.
[408] Statutory Inquiries Committee, 'Corrected oral evidence: statutory inquiries, Monday 18 March 2024', Neil Comrie (Australian Implementation Monitor) at Q68.
[409] Alastair Stark and Duc Le, 'Public inquiry design choices: what ideas should be adopted from past inquiries around the world?', International Public Policy Observatory (18 January 2022).
[410] See https://www.igem.vic.gov.au/index.php/about-us/about-the-inspector-general-for-emergency-management.
[411] See https://www.igem.vic.gov.au/index.php/our-work/implementation--monitoring.
[412] See https://www.igem.vic.gov.au/index.php/our-work/implementation-monitoring/past-implementation-monitoring-activities.
[413] See Jared Heath, 'Key trends and lessons from Australian Royal Commissions and inquiries', Corrs Chambers Westgarth (19 July 2017).

[414] Anita Mackay, 'Chapter 4: Developments in Victoria since the commencement of the Inquiries Act 2014', in Scott Prasser (Ed) 'New Directions in Royal Commissions and Public Inquiries' (Connor Court Publishing 2023), at pages 97 and 98.
[415] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 99.
[416] House of Lords Statutory Inquiries Committee, 'Public Inquiries: Enhancing Public Trust' (2024) at para 99.
[417] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at section 4.4.
[418] Dr Emma Ireton, 'Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing' (Contextual briefing commissioned by the Lampard Inquiry, September 2025) at sections 4.8 and 4.9.
[419] Not all recommendations are quoted in full.

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