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Framing, Implementing, and Monitoring Public Inquiry Recommendations: A Contextual Briefing

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1. Introduction

This is a research-based contextual briefing on how public inquiry recommendations are framed, implemented, and monitored. It 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.

The emphasis is on practical insights and application: what has worked, what has been proposed, and what challenges remain. The analysis is based on practice-focused UK documentary sources, including evidence submitted to parliamentary select committees, select committee reports, Hansard transcripts, inquiry reports, government responses, and policy-focused publications. Contributors to those sources include inquiry chairs, leading UK inquiry practitioners, and policy makers, whose insights have shaped both current practice and proposals for reform. These UK sources are complemented by comparative insights shared by senior inquiry practitioners in Australia.¹

2. Recommendations: Purpose and Framing

2.1. Statutory Basis and Purpose of Inquiry Recommendations

Not all public inquiries are required to make recommendations. Where recommendations are made, they can play a vital role in preventing recurrence of serious matters of public concern; informing public policy, legislative reform, and institutional change; and reinforcing standards of accountability.

Under section 24 of the Inquiries Act 2005, the chair of a statutory inquiry must set out in the inquiry's report:

- (a) the facts determined by the inquiry; and
- (b) the recommendations of the inquiry, where the terms of reference require it.²

The Lampard Inquiry's terms of reference require it to make recommendations to improve the provision of mental health inpatient care, with investigations focusing on the trusts. The chair may also make national recommendations where she considers it appropriate'.³ While the Inquiry must remain within its terms of reference, section 24 of the Inquiries Act 2005 provides scope for discretion, allowing the chair to include other recommendations, even where not explicitly required to do so by the terms of reference.

¹ I am extremely grateful to the Hon Marcia Neave AO and the Hon Jennifer Coate AO, Royal Commissioners and inquiry chairs; and Gail Furness SC and the Hon Justice Melinda Richards, Counsel Assisting (Counsel to the Inquiry) in Australia, who shared their expertise and perspectives, which contributed significantly to the development of this contextual briefing and informed its evidence base.

² <<https://www.legislation.gov.uk/ukpga/2005/12/section/24>>.

³ Department of Health and Social Care, 'Terms of Reference for the Lampard Inquiry' (GOV.UK, 22 April 2025) <<https://www.gov.uk/government/publications/lampard-inquiry-terms-of-reference/terms-of-reference-for-the-lampard-inquiry>> accessed 9 July 2025.

2.2. Framing recommendations – developing and grounding in evidence

Recommendations are often regarded as the most enduring legacy of a public inquiry. When they are implemented, they can have a lasting impact well beyond the life of the inquiry. But their value lies not only in what they propose, but in how effectively they are implemented. To maximise the chances of implementation and positive impact, recommendations should be:

- Realistic in scope;
- Grounded in the evidence; and
- Constructed with implementation in mind.

2.2.1 Evidential analysis informing the iterative development of recommendations

Recommendations should not be treated as a mere drafting exercise confined to the final stage of an inquiry. To be effective, the inquiry must develop its recommendations iteratively, throughout its lifespan, informed by its ongoing analysis of the evidence.

As the inquiry progresses, it should continually refine its understanding of the emerging evidence and identify any additional material needed to inform its recommendations. This includes identifying recurring themes and patterns, assessing how they relate to the terms of reference, and evaluating the risks or systemic weaknesses they expose. Particular attention should be given to emerging issues and concerns which, if substantiated, may justify formal comment or recommendations. Implementation should also be a key consideration throughout this process.

2.2.2 Ensuring recommendations are evidenced and credible

Each recommendation must be demonstrably grounded in the evidence gathered during the inquiry process. This helps ensure that the recommendations are not perceived as being speculative, agenda-driven, or misaligned with the inquiry's work. The link between findings and recommendations should be explicit, i.e. 'with respect to this issue, the inquiry found x and y and therefore recommends z'.

This evidentiary link is essential. Without it, recommendations risk being challenged, dismissed, or ignored. 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.

2.3. Consultation and testing emerging recommendations

Effective recommendations are rarely developed in isolation. 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, including those most directly affected by the events under investigation. This helps 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.

Inquiries have used a range of methods to engage with external perspectives, including roundtables, seminars, and targeted discussions with relevant agencies and bodies. These approaches allow emerging recommendations to be tested for feasibility, refined in response to feedback, and adjusted to improve their chances of being accepted and implemented.

Recommendations should be designed to work together as a complementary and coherent framework. Early, informal, consultation can help identify potential tensions or conflicts between recommendations and allow these to be addressed before recommendations are finalised.⁴ It also assists in identifying witnesses to call to test the inquiry's proposals and assess their viability in public hearings.

2.3.1 Broad engagement in design; focused responsibility in delivery

Engaging a wide range of stakeholders during the design stage of recommendations ensures that they are informed by a wide range of perspectives and tailored to the contexts in which they will be implemented. However, effective implementation then often requires the opposite approach. Concentrating responsibility for implementation within a small number of departments, agencies, or bodies reduces complexity, avoids fragmentation, and supports clearer lines of accountability. This focused approach improves consistency in delivery and increases the likelihood of a more successful outcome.⁵

2.3.2 Internal scrutiny to strengthen recommendations

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. The Thirlwall Inquiry offers a notable example of this, having produced a comprehensive review of previous healthcare-related recommendations and their outcomes.⁶

An inquiry's own recommendations should be subject to rigorous internal scrutiny. Inquiry teams should establish internal mechanisms, such as working groups, peer review processes, or structured challenge sessions, to ensure that proposed recommendations are:

- Clearly traceable to and supported by the evidence;
- Proportionate to the inquiry's findings;
- Informed by engagement with relevant agencies or delivery bodies;
- Anticipate foreseeable barriers to implementation; and
- Aligned with the inquiry's terms of reference and with broader public interest.

This scrutiny should not be left until the final stages of reporting but should be iterative and embedded throughout the inquiry process. Internal scrutiny acts as a safeguard against recommendations that may otherwise appear premature, excessive, or disconnected from the inquiry's core purpose. By applying internal scrutiny at key points during the inquiry process, it helps ensure that all recommendations are evidence-based, coherent, proportionate, and capable of being implemented in real world settings.

⁴ Alastair Stark and Sophie Yates, *Public Inquiries and Policy Design* (Cambridge University Press 2024).

⁵ *Ibid.*

⁶ Thirlwall Inquiry Legal Team, *Review of Implementation of Recommendations Made by Previous Inquiries into Healthcare Issues* (Thirlwall Inquiry, 16 May 2024) <<https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-documents/Table-of-Inquiries-Reviews-and-Recommendations-made-and-whether-they-were-implemented.pdf>> accessed 4 August 2025.

2.4. Assigning responsibility for actioning recommendations.

Clear assignment of responsibility is essential to ensure that inquiry recommendations are not only accepted but acted upon. Ambiguity around who is responsible risks recommendations being overlooked, diluted, or lost in the complexity of the organisations to whom they are addressed. Recommendations should avoid generic phrasing such as ‘the Government should consider...’ and instead specify, wherever possible, the department, agency, or officeholder responsible for delivery. This may include:

- Government departments or ministers;
- Statutory agencies or regulators;
- Local authorities or service providers;
- Non-governmental organisations or professional bodies; and
- Private or voluntary organisations.

Some recommendations are complex. They may require coordination across multiple departments, affect more than one policy area, or span institutional boundaries. In such cases, an inquiry should consider identifying a lead department or convening body to coordinate delivery and ensure accountability.

2.5. Avoiding overreach - realistic number and scope.

While the breadth of evidence may reveal multiple areas of concern, issuing too many recommendations can reduce the chances of implementation. Similarly, recommendations that are too broad can obscure priorities, create uncertainty around responsibility, and make implementation and meaningful follow-up more difficult.

Section 24 of the Inquiries Act 2005 allows inquiries to make ‘any recommendations the panel sees fit to make despite not being required to do so by the terms of reference’.⁷ However, this discretion must be exercised with care. 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.

The number of recommendations made by public inquiries varies widely. The Mid Staffordshire NHS Foundation Trust Inquiry made 290 recommendations, the Bichard Inquiry 31, and the Independent Jersey Care Inquiry made 8.⁸ Experience from past inquiries suggests that a smaller number of focused, clearly directed recommendations is more likely to be accepted and acted upon.

The operational context of those to whom recommendations are directed must be taken into account. The 2024 report of the Health Services Safety Investigations Body highlights that recommendations aimed at improving quality and safety in healthcare are issued by multiple stakeholders, both within and outside the system, often in high volume and without coordination. This creates ‘noise’ that makes it difficult for providers to prioritise and implement actions, particularly where recommendations duplicate, contradict one another, or lack costings. In systems operating under significant pressure, recommendations must be

⁷ <<https://www.legislation.gov.uk/ukpga/2005/12/section/24>>.

⁸ Isabelle Mitchell, Peter Watkin Jones, Sarah Jones and Emma Ireton, *The Practical Guide to Public Inquiries* (Hart Publishing 2020).

realistic, clearly scoped, and tailored to the capacity and responsibilities of the receiving organisation.⁹

2.6. The use of interim recommendations.

Interim recommendations can play an important role in public inquiries, particularly where urgent risks are identified or early action is needed to prevent further harm.¹⁰ They allow inquiries to respond to time-sensitive issues without waiting for the final report and can support phased implementation and early engagement by those responsible for delivery. Interim recommendations may also help to maintain public engagement and momentum, particularly in long-running inquiries.

Recent inquiries have increasingly adopted this approach. However, issuing interim recommendations is not always practical or appropriate and the following issues may arise.

Insufficient evidentiary foundation: Recommendations must be grounded in evidence that is sufficiently developed to support early action. Premature recommendations risk being incomplete or misdirected.

Fragmented subject matter: Inquiries dealing with complex, interdependent systems may find it difficult to isolate issues suitable for interim action. Where issues are closely connected, issuing recommendations in isolation may undermine their ability to function as part of a complementary and coherent framework.

Time and resource constraints: Drafting and publishing interim recommendations may not be feasible for inquiries operating under tight deadlines or limited capacity and resource. In such cases, maintaining momentum across a complex and evolving evidence base may need to take priority.

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.

3. Implementation

3.1. Recommendations are non-binding

It is the Government's role to address matters of public concern. Public inquiries are convened by a minister to find facts, analyse those facts, and produce a report to inform policy decisions. They are not courts and do not have the power to determine civil or criminal liability or impose sanctions.¹¹

⁹ Health Services Safety Investigations Body, Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare (16 September 2024). <https://www.hssib.org.uk/patient-safety-investigations/recommendations-but-no-action-improving-the-effectiveness-of-quality-and-safety-recommendations-in-healthcare/report/> accessed 14 August 2025

¹⁰ House of Lords Statutory Inquiries Committee, *Public inquiries: Enhancing public trust*, HL Paper 9 (HL 2024–25).

¹¹ Inquiries Act 2005, s 2. See also Emma Ireton, 'Public Inquiries: Irreconcilable Interests and the Importance of Managing Expectations' (2023) 45(3) *Journal of Social Welfare and Family Law* 212.

Inquiry recommendations are not legally binding. This is deliberate: it ensures that responsibility for decision-making remains with democratically elected officials, accountable to Parliament and the public. While recommendations may carry significant political and moral weight, inquiries cannot compel changes to government policy. Decisions about whether to accept and implement recommendations rest with the Government, which must also consider wider political, financial, and practical considerations.

Where recommendations are accepted, responsibility for implementation rests with the relevant bodies, such as government departments, statutory agencies, and other institutions, who must translate accepted recommendations into concrete policy, operational, or legislative changes, and ensure those changes are carried out effectively.

There may be good reasons why some recommendations are not accepted, or why some accepted recommendations later become unimplementable. In such cases, transparency and clear reasoning are essential.¹²

3.2. No requirement to respond formally to inquiry recommendations

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. This has been widely criticised.¹³

The 2024 House of Lords Statutory Inquiries Committee ('2024 HLSC') reaffirmed the recommendation of its predecessor, the 2014 House of Lords Select Committee on the Inquiries Act 2005 ('the 2014 HLSC report'), that the Government should publish a formal response within three months of an inquiry report. This response should clearly state which recommendations are accepted, explain how they will be implemented, and include an implementation plan. It should also provide reasons for any recommendations that are not accepted. It also recommended annual progress reports to Parliament.

Unlike its predecessor, the 2024 HLSC did not propose a statutory duty for public bodies to respond to recommendations directed at them. Instead, it recommended the creation of a new Public Inquiries Committee to, *inter alia*, oversee responses and monitor implementation through parliamentary scrutiny rather than legislation (see 4.8 below).¹⁴ This disappointed many who hoped the introduction of a statutory duty would encourage greater transparency and accountability.¹⁵

In its response to the 2024 report, the Government accepted the need to respond 'as swiftly as possible' but concluded that a six-month timeframe was more realistic.¹⁶ It committed to

¹² Emma Norris, *Oral evidence to the House of Lords Select Committee on the Statutory Inquiries Act 2005* Q 77 (House of Lords, 18 March 2024)

<<https://committees.parliament.uk/oralevidence/14719/pdf/>> accessed 6 August 2025.

¹³ Emma Norris and Marcus Shephard, *How Public Inquiries Can Lead to Change* (Institute for Government, December 2017) <https://www.instituteforgovernment.org.uk/publication/report/how-public-inquiries-can-lead-change> accessed 14 August 2025.

¹⁴ (n10).

¹⁵ (n12).

¹⁶ UK Government, *Government Response to the House of Lords Select Committee on the Inquiries Act 2005: 'The Inquiries Act 2005: Post-Legislative Scrutiny'*, (Cm 8127 2011), response to Recommendation 32.

publishing guidance to reflect this approach¹⁷ but it did not revisit the earlier recommendation for a statutory duty, nor the proposed parliamentary committee.¹⁸

Calls for a statutory duty to respond to inquiry recommendations are ongoing.

Summary of the current position on formal responses and implementation plans:

- There is no statutory requirement to respond to public inquiry recommendations.
- Current convention is that government responses should be published as swiftly as possible, typically within six months, except in exceptional circumstances.¹⁹
- Responses should clearly state which recommendations are accepted and rejected, explain how accepted recommendations will be implemented, and include an implementation plan.
- Progress reports on implementation should be issued to Parliament annually.
- The proposed parliamentary Public Inquiries Committee has not yet been established.
- The Government has committed to issuing guidance on responding to inquiry recommendations but that has not yet been published.

3.3. Public inquiry requests for responses and implementation plans

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. These requests typically specify a timeframe and outline expectations for transparency and follow up.

The Mid Staffordshire NHS Foundation Trust Public Inquiry

The Inquiry recommended that:

- Recipients of inquiry recommendations should promptly announce the extent to which they accept the recommendations and how they intend to implement them, and make annual progress reports;
- The Department of Health, in addition to its own response, should collate and publish a progress report on other organisations at least annually; and
- The House of Commons Health Select Committee should consider reviewing how organisations accountable to Parliament have acted on the report's recommendations.²⁰

¹⁷ *Ibid.*

¹⁸ Which is a matter for Parliament, not the Government.

¹⁹ (n16) and (n10).

²⁰ The Mid Staffordshire NHS Foundation Trust Public Inquiry, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Volume 3* (HC 898-III, 2013) 1675 (Recommendation 1).

The Infected Blood Inquiry

The Inquiry recommended that:

- The Government should, within 12 months, either commit to implementing the recommendations or provide detailed reasons for any it does not intend to implement;
- During that period, and before the end of the year, the Government should report to Parliament on progress in considering and implementing the recommendations;
- This timetable should not delay earlier consideration or responses to interim recommendations;
- The Public Administration and Constitutional Affairs Committee (PACAC) should review both the responses to the recommendations and implementation of those accepted; and
- PACAC should take a continuing role of scrutinising responses and implementation for any future statutory inquiries.²¹

4. Monitoring implementation

4.1. Monitoring interim recommendations

Where recommendations are made, some inquiries have adopted innovative procedures to monitor compliance during the lifetime of the inquiry. These may include setting deadlines for progress reports, requesting implementation plans, and publishing updates.

However, internal monitoring only works while an inquiry is in progress. Once the final report is delivered and the chair notifies the minister 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.²²

Manchester Arena Inquiry: interim monitoring

The Manchester Arena Inquiry introduced a system of ‘monitored recommendations’ for those where substantial progress could be made before the conclusion of the Inquiry.²³

Implementing bodies were required to submit written progress updates approximately three months after publication of the report, and formal witness statements were required from named individuals in each reporting organisation approximately three months later. These were published on the inquiry website and live evidence was subsequently taken from selected witnesses in public hearings. This approach enabled scrutiny of progress and allowed the inquiry to refine its recommendations where necessary.²⁴

²¹ Infected Blood Inquiry, *Final Report*, vol 1 (Overview and Recommendations) (HC 1167, 2024) 291 (Recommendation 12).

²² Inquiries Act 2005, s14(1).

²³ Details of the process are set out in *The Manchester Arena Inquiry: Emergency Response, Volume 2-II* (HC 757-II, 2022) paras 21.41- 21.4. The Module 3 report was published on 2 March 2023. Manchester Arena Inquiry Volume 3: Radicalisation and Preventability (HC 1137, 2023). The last monitored recommendations hearing was on 8 June 2023 for modules 2 and 3.

²⁴ John Saunders, *Oral evidence to the House of Lords Select Committee on Statutory Inquiries* (House of Lords 12 February 2024) <<https://committees.parliament.uk/oralevidence/14346/pdf/>> accessed 6 August 2025.

Notably, 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 an inquiry as they see fit. Approaches to this discretion have varied. For example, the chair of the Grenfell Tower Inquiry 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 2005.²⁵ 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 (see 4.7 below).

The Independent Inquiry into Child Sexual Abuse (IICSA)

IICSA adopted a structured process for monitoring institutional responses to its recommendations during the course of the Inquiry. Institutions were required to publish implementation plans, including timelines, within six months of a recommendation being made. Where responses were not forthcoming, the Inquiry escalated its approach, issuing formal requests under rule 9 of the Inquiry Rules 2006 and, if necessary, compelling witness statements under section 21 of the Inquiries Act 2005, a power which carries criminal sanctions for non-compliance.

The inquiry maintained a public online database of all its recommendations and responses and tracked implementation until publication of its report in October 2022. A final implementation progress report was published by the Inquiry in December 2022. The database remains publicly accessible via the inquiry's recommendations web page.²⁶

Following conclusion of the Inquiry, the chair, Professor Alexis Jay, proposed the creation of a small, independent group, potentially including herself and representatives of victims and survivors, to continue monitoring and publicly reporting on implementation progress. The Government did not respond.²⁷ However, whilst not the independent group envisaged, the Government later announced it would set up a new victims and survivors panel to work with the inter-ministerial group, 'to guide them on the design, delivery and implementation of new proposals and plans not just on IICSA but on wider work around child sexual exploitation and abuse'.²⁸

²⁵ Deborah Coles, *Oral evidence to the House of Lords Select Committee on the Statutory Inquiries Act 2005* Q76 (House of Lords 18 March 2024) <<https://committees.parliament.uk/oralevidence/14719/pdf/>> accessed 6 August 2025, Qs 79-80.

²⁶ Independent Inquiry into Child Sexual Abuse, 'Recommendations' (IICSA) <<https://www.iicsa.org.uk/recommendations>> accessed 11 August 2025.

²⁷ Alexis Jay, *Written evidence to the House of Lords Select Committee on Statutory Inquiries* (House of Lords, 15 April 2024) <<https://committees.parliament.uk/writtenevidence/129929/pdf/>> accessed 5 August 2025.

²⁸ HC Deb 6 January 2025, vol 759 col 632.

4.2. Lack of oversight and monitoring after inquiry comes to an end

The absence of a formal, independent mechanism to oversee and monitor implementation of recommendations once an inquiry has concluded is a significant weakness of the current public inquiry framework. Without such a mechanism, there is no structured way of ensuring that recommendations are followed up, nor any guarantee of transparency or accountability in how they are taken forward.

It is not uncommon for inquiry recommendations to be accepted in principle but for implementation to be partial, diluted, delayed, or forgotten. This is widely criticised, given the significant investment of time and public funds and the vital role of public inquiries in preventing recurrence of matters of public concern. It also risks compounding the trauma of survivors and the bereaved who have engaged with the inquiry process in the hope that their experiences will lead to meaningful change, only to see that hope frustrated when recommendations are not acted upon.

A frequently cited example of the consequences of failing to implement inquiry recommendations is the Bristol Royal Infirmary Inquiry. Its proposals to improve patient-centred care and strengthen NHS safety systems were echoed a decade later in the Mid Staffordshire NHS Foundation Trust Public Inquiry. Had the earlier inquiry's recommendations been fully implemented, many of the systemic failures identified in Mid Staffordshire might have been avoided.

Particularly in the case of healthcare inquiries, we see successive inquiries making similar recommendations due to repeated failures to implement those made previously. There is no formal recourse if the Government, or other bodies to whom recommendations are addressed, fail to respond or fail to implement recommendations that have been accepted, beyond public criticism and political pressure. This has prompted repeated calls for a formal oversight mechanism, but there is no consensus on what form such a mechanism should take (see below).²⁹

It does not follow that there is a one-size-fits-all solution for overseeing and monitoring recommendations. Every inquiry differs in its subject matter, terms of reference, and scale. Inquiries themselves may play a valuable role in informing the most appropriate approach to post-report accountability.

Implementation may span multiple political cycles. Ministers, advisers, and senior civil servants move between roles or leave. Priorities shift with changing administrations. Over time, this turnover and loss of institutional memory can undermine the delivery of change, particularly in the absence of long-term planning, oversight, and accountability mechanisms.³⁰

²⁹ House of Lords Select Committee on the Inquiries Act 2005, *The Inquiries Act 2005: Post-legislative Scrutiny* (HL 2013–2014 143) and (n14).

³⁰ (n10).

4.2.1 Central public record

Until very recently, there was no central public record of public inquiry recommendations, responses, or implementation progress. This makes it extremely difficult for participants, the public, the media, and others to track progress or apply pressure when commitments are not being met. However, in response to a recommendation made by the Grenfell Tower Inquiry, the Government committed to publishing a central record of recommendations made by public inquiries since 2004, as well as those made by future inquiries, alongside the Government's responses.³¹ This record is now live, though still in the early stages of development.³² Once fully populated, it will be updated quarterly. While the tracker does not capture responses from other bodies to whom recommendations are directed, and relies on self-reported data, it does nonetheless represent an important step towards greater transparency and public accountability.

4.3. Oversight vs scrutiny

Oversight refers to mechanisms that require those responsible for implementation to report on progress and that track delivery. It provides a structured framework for visibility and accountability, but its effectiveness depends heavily on the quality and completeness of the information received. A key limitation of oversight alone is its reliance on self-reported data. Where reporting is overstated, incomplete, or inaccurate, oversight alone may offer limited value and risk obscuring failings rather than exposing them.

Scrutiny, by contrast, is a bottom-up process involving independent verification of whether recommendations have been implemented as intended. It tests and verifies whether implementation has been meaningful in practice and can prompt behaviour change and accelerate delivery. However, scrutiny is inquiry-specific and does not, in itself, support thematic or systemic learning across inquiries.

Effective monitoring should therefore combine both oversight and scrutiny. Oversight provides the structure for tracking and follow up; scrutiny adds rigour and credibility, helping to ensure that follow up is not only visible but meaningful. There is also a need for mechanisms capable of analysing themes emerging across multiple inquiries, to identify recurring failures and support systemic reform.

4.4. Implementation monitors

In its report, an inquiry may choose to include a recommendation that the Government appoint an independent implementation monitor to scrutinise and oversee the implementation of its recommendations. Pioneered in Australia,³³ this mechanism has demonstrated significant success in improving implementation rates and accountability. In

³¹ HL Deb 25 April 2025, vol 843, col 969.

³² Cabinet Office, 'Public Inquiries: Recommendations and the Government Response' (GOV.UK, 21 July 2025) <<https://www.gov.uk/government/collections/public-inquiries-recommendations-and-the-government-response>> accessed 12 August 2025.

³³ With its introduction in the Victorian Bushfires Royal Commission; the Royal Commission into the Management of Police Informants; and Royal Commission into Family Violence (Victoria) and subsequent adoption in later Royal Commissions and inquiries.

some cases, it has led to 100% implementation of accepted recommendations.³⁴ In Australia, it is increasingly regarded as one of the most effective ways to combine oversight and scrutiny to ensure that recommendations result in meaningful change. This approach is now gaining interest in the UK and offers a valuable model for UK public inquiries to consider.

Implementation monitors are appointed for a fixed term, typically around four years. They may be an individual or a small team, depending on the scale and complexity of the recommendations. They operate independently of government and those to whom recommendations are directed. Crucially, they are selected for their subject matter expertise and experience in policy delivery, which enables them to engage with the technical detail of implementation; identify delays, partial implementation or misunderstanding; and challenge implementation bodies where necessary.

Implementation monitors assess not only whether action has been taken in a timely manner but whether the intended outcomes are being achieved.³⁵ Rather than relying on written updates and self-reported assurances, implementation monitors adopt a 'don't tell me, show me' approach, verifying progress on the ground through direct engagement and site visits.³⁶ They report directly to Parliament, at least annually. Their findings are made publicly available, reinforcing transparency and accountability.

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.

Bushfires Royal Commission (Vic Aus): implementation monitor

Following the 2009 Victorian bushfires, the Bushfires Royal Commission was the first to recommend the appointment of an independent implementation monitor to oversee delivery of its recommendations and to report annually to the Parliament of Victoria over a four-year period. This model has since been adopted by other Australian Royal Commissions and inquiries.

The implementation monitor operated with a small team of four and worked directly with senior liaison officers appointed by each government department and agency with implementation responsibilities. This approach helped to reduce delays and bureaucracy. Progress was monitored through site inspections and direct engagement, with an emphasis on building a cooperative working relationship with implementing bodies to encourage co-design and improve operational responsiveness. Where timelines were not

³⁴ Neil Comrie, *Oral evidence to the House of Lords Select Committee on the Statutory Inquiries Act 2005* (House of Lords 18 March 2024) <<https://committees.parliament.uk/oralevidence/14719/pdf/>> accessed 6 August 2025; and Alastair Stark, *Oral evidence to the House of Lords Statutory Inquiries Committee, Q32* (House of Lords 26 February 2024) <<https://committees.parliament.uk/oralevidence/14356/pdf/>> accessed 6 August 2025.

³⁵ Neil Comrie, *Oral evidence to the 2024 HLSC Ibid.*

³⁶ *Ibid.*

met, the monitor raised concerns directly with the nominated representative, seeking prompt corrective action to avoid having to report negatively on progress to Parliament.³⁷

4.5. Existing permanent bodies as implementation monitors

The Renewable Heat Incentive Inquiry recommended that implementation of its recommendations be monitored by the Northern Ireland Audit Office (NIAO), an existing statutory body with investigatory powers and public accountability functions.³⁸ The NIAO offered proactive, rigorous, bottom-up scrutiny and oversight in a model similar to that of an independent implementation monitor described above. The recommendation was accepted and the NIAO is currently monitoring implementation and reporting publicly on progress to the Northern Ireland Assembly.

The 2024 HLSC subsequently endorsed the approach of using the UK's audit institutions for inquiries involving highly technical recommendations about public finances. However, it cautioned that audit bodies would not be suitable for non-financial inquiries without a significant shift in its expertise base, remit, and resources.³⁹

4.6. Monitoring by victims, survivors, and bereaved families

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. These individuals and groups have frequently been the driving force behind the establishment of the public inquiry.

Where there has been positive and constructive engagement between them and an inquiry, many choose to remain actively involved and continue to push for implementation. However, some feel a continued sense of responsibility or pressure to remain engaged, particularly where they fear that, without their involvement, momentum for change may be lost. 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.

Implementation of recommendations should be scrutinised and overseen by an appropriate formal mechanism. The 2024 HLSC recognised that relying on this group of people, who have already experienced significant stress and trauma in campaigning for and participating in the inquiry, as the sole source of independent oversight and monitoring is 'an unfair burden'.⁴⁰ This burden may be eased where an inquiry addresses the issue of formal scrutiny and oversight of its recommendations within its report.

4.7. Monitoring by the chair

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.⁴¹ At that point, the

³⁷ *Ibid.*

³⁸ Independent Public Inquiry into the Non-Domestic Renewable Heat Incentive Scheme, *Report* (13 March 2020) https://cain.ulster.ac.uk/issues/politics/docs/rhi/2020-03-13_RHI-Inquiry_Report-V1.pdf> accessed 9 August 2025.

³⁹ (n10) para 100.

⁴⁰ (n10) para 86.

⁴¹ Inquiries Act 2005, s14.

chair's legal powers cease and there is no statutory mechanism for them to remain involved in monitoring implementation.

Inquiry chairs 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.⁴² 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.

However, there have been some exceptions where non-judicial chairs have wished to remain involved in some capacity, for example, where they have particular, relevant subject-matter or institutional expertise. Sir Robert Francis, chair of the Mid Staffordshire NHS Foundation Trust Public Inquiry, took an active role in advocating for, and raising awareness of, the Inquiry's recommendations after it had come to an end. Some other chairs have offered to assist in reviewing implementation. Responses to such offers have been inconsistent. Having initially been against any involvement after the conclusion of the Manchester Arena Inquiry, the Home Office has since engaged with Sir John Saunders as part of its oversight of implementation.⁴³ However, several other chairs have expressed their disappointment at the reluctance of the Government and sponsoring departments to accept, or even acknowledge, offers of continued involvement.⁴⁴

The Soham Inquiry: informal reconvening to assess progress:

Following publication of the Bichard report, the chair, Sir Michael Bichard, announced his intention to reconvene the inquiry six months later to assess progress on implementation. He wrote to the relevant parties to require a report on progress. Although this approach had no formal basis, it was accepted by government.

This informal reconvening enabled the chair to report on progress directly to Parliament and helped maintain momentum and public visibility.⁴⁵ However, this model depends heavily on ministerial agreement and the chair's availability and willingness to remain involved.

The Infected Blood Inquiry: postponing closure pending response from the Government:

Sir Brian Langstaff, chair of the Infected Blood Inquiry, took the unusual step of delaying the formal closure of the Inquiry following publication of its final report, by withholding the

⁴² (n10) para 34.

⁴³ (n24).

⁴⁴ For example see written evidence of John Saunders and Kate Eves, *Oral evidence to the House of Lords Select Committee on Statutory Inquiries* (House of Lords 12 February 2024)

<<https://committees.parliament.uk/oralevidence/14346/pdf/>> accessed 14 August 2025.

⁴⁵ HC Deb 28 February 2007, vol 457, cols 288WH–289WH.

statutory notification under section 14(1)(a) of the Inquiries Act 2005 and citing the inquiry's terms of reference, which specifically include consideration of 'the nature, adequacy and timeliness of the response of Government'.⁴⁶

He emphasised that 'delay not only causes frustration, but it compounds the harm and suffering many of those infected and affected have endured'.⁴⁷ He announced his intention therefore to remain in post for a period, to use his position 'as far as I properly can, to prevent any unreasonable delay'. Once that response is received, he will confirm the inquiry is complete. He also recommended that the Public Administration and Constitutional Affairs Committee should then review both progress on the Government's response to the recommendations and, if those recommendations are accepted, their implementation.⁴⁸

4.8. Parliamentary scrutiny and monitoring:

Several inquiries have recommended oversight by parliamentary committees. For example, Sir Robert Francis called on the House of Commons Health Select Committee to monitor implementation of the Mid Staffordshire NHS Foundation Trust Public Inquiry's recommendations through its regular accountability hearings, and the committee agreed.⁴⁹ Sir John Saunders, the chair of the Manchester Arena Inquiry, suggested the Intelligence and Security Committee of Parliament (ISC) monitor implementation of the Inquiry's closed recommendations. However, the ISC declined, citing transparency constraints, but supported the chair's alternative proposal that the Investigatory Powers Commissioner monitor the recommendations, or the Inquiry team be reconvened to do so.⁵⁰

The 2014 HLSC concluded that Commons departmental select committees are best placed to provide formal oversight.⁵¹ However, inquiry recommendations often span multiple departments and may not align neatly within the remit of a single parliamentary committee. Capacity, resources, and turnover amongst committee memberships can also affect continuity and effectiveness.⁵²

⁴⁶ Brian Langstaff, *Letter from Sir Brian Langstaff to the Cabinet Office Minister* (20 May 2024) <<https://www.infectedbloodinquiry.org.uk/sites/default/files/Letter%20from%20Sir%20Brian%20Langstaff%20to%20the%20Cabinet%20Office%20Minister%2020%20May%202024.pdf>> accessed 4 August 2025.

⁴⁷ Infected Blood Inquiry, *Transcript of the Publication of the Final Report* (20 May 2024) <<https://www.infectedbloodinquiry.org.uk/sites/default/files/2024-10/2024-05-20%20Infected%20Blood%20Inquiry%20transcript.pdf>> accessed 31 July 2025, 29-30.

⁴⁸ *Ibid.*

⁴⁹ Health Committee, *After Francis: Making a Difference* (HC 2013–14, 657, 10 September 2013) para 14.

⁵⁰ Intelligence and Security Committee of Parliament, 'Press Notice' (10 July 2023) <<https://isc.independent.gov.uk/news/>> accessed 9 August 2025.

⁵¹ (n29).

⁵² (n12).

The 2024 HLSC went further, proposing the creation of a dedicated parliamentary committee, the Public Inquiries Committee, either as a joint select committee or a House of Lords sessional committee. Its remit would include, *inter alia*:

- Publishing inquiry reports and government responses in a single place online;
- Monitoring implementation of accepted recommendations through policy research, correspondence with government departments, and evidence sessions with ministers and officials;⁵³
- Maintaining a public online tracker showing the status of individual recommendations and publishing implementation reports; and
- Conducting thematic analyses across inquiries to identify systemic policy failures and help prevent future disasters.⁵⁴

While such a committee would offer formal top-down oversight, it would rely on self-reported evidence, with the limitations that brings. Its work, however, could be combined with other mechanisms, such as implementation monitors, to strengthen scrutiny.

Monitoring multiple technical inquiries would require substantial staff, research capacity, time, and access to specialist expertise, which are resources current parliamentary structures may struggle to sustain. This might force it to prioritise some inquiries at the expense of others. Turnover among parliamentary staff and ministers may also undermine continuity and institutional memory.⁵⁵ To date, there has been no announcement to indicate if, or when, a dedicated Public Inquiry Committee might be established.

4.9. National Oversight Mechanism (NOM)

The NOM is a proposed independent body developed by INQUEST, for establishment by the Government, to address the current lack of transparency and accountability in implementing recommendations from inquests, public inquiries, official reviews, and investigations into state-related deaths. Its aim is to prevent repeated failings and avoidable deaths by ensuring that recommendations lead to meaningful change.⁵⁶

The NOM would:

- Collate recommendations, track responses and implementation status, and maintain a public database;
- Analyse recommendations to identify recurring issues and systemic failings; and
- Follow up on progress, escalating concerns and sharing thematic findings.⁵⁷

It is intended to serve as a central resource for parliamentarians, coroners, inquiry chairs, legal professionals, researchers, and others involved in oversight and accountability in relation to avoidable state-related deaths. It would have the power to call in experts, require reporting, and would itself report annually to Parliament. It would be accountable to

⁵³ Recommendations of both public inquiries and major inquests.

⁵⁴ (n10) para 116.

⁵⁵ (n12) Q 81.

⁵⁶ (n25).

⁵⁷ INQUEST, 'No More Deaths Campaign' (INQUEST, 17 March 2024) <<https://www.inquest.org.uk/no-more-deaths-campaign>> accessed 7 August 2025 and (n25).

bereaved families and victims, potentially through an advisory board. Its work would complement that of select committees.⁵⁸

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.

4.10. The media

The media plays a significant role in sustaining public visibility of inquiry findings and exposing failures to implement recommendations once a public inquiry has formally concluded. Media coverage can help maintain public pressure on government departments, public bodies, and other organisations to act on accepted recommendations.

It also provides a platform for victims, survivors, and advocacy groups to challenge inaction, demand transparency, and mobilise public support for reform. By amplifying voices, highlighting gaps, and holding institutions to account, the media has a valuable role to play in post-inquiry scrutiny.

5. Conclusion

Recommendations should not be treated as a drafting exercise confined to the final stage of an inquiry. Their development should be embedded throughout the inquiry process, with implementation in mind from the outset. To be effective, recommendations must be grounded in evidence, realistic in scope, and clearly directed to those responsible for implementation. Early consultation with policy makers, subject-matter experts, and other stakeholders, combined with rigorous internal scrutiny processes, helps ensure that recommendations are credible, proportionate, and capable of being implemented in practice.

Experience from previous inquiries shows that a smaller number of well-targeted recommendations is more likely to be accepted and acted upon. Recommendations should be designed to work together as a coherent and complementary framework, avoiding fragmentation or overreach. Where urgent risks are identified, interim recommendations can play a valuable role in prompting early action. However, they must be supported by a sufficiently developed evidence base and framed in a way that avoids premature conclusions or undermining the coherence of the final recommendations.

Clarity of responsibility is essential. Recommendations should specify who is expected to act. Where delivery requires coordination, a lead body should be identified to help maintain focus and accountability. Formal responses, clear timelines, and structured follow-up should be required. Inquiries should also consider recommending mechanisms for monitoring progress. Where possible, monitoring should combine top-down oversight with bottom-up scrutiny to ensure that action is not only taken but is effective.

⁵⁸ A Private Members' Bill and was presented to Parliament in October 2024 proposing establishment of the NOM and is currently at the second reading stage in the House of Commons; State-related Deaths (National Oversight Mechanism) Bill (2024–26).

Ultimately, the effectiveness of any recommendation depends not only on what is proposed, but on how it is received, acted upon, and followed through. A well-designed recommendation anticipates the realities of delivery, assigns responsibility clearly, and is supported by mechanisms that ensure progress can be tracked and sustained over time.

The overarching aim is to support meaningful and lasting change. That requires recommendations that are not only well-framed but are also supported by a clear pathway to implementation and a system of accountability that continues beyond the life of the inquiry.