An Elementary Primer for Politicians and Potential Chairs on Public Inquiries

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Abstract
There is relatively little central government guidance available on how to set up and run a public inquiry. This short piece seeks to set out the very basic questions that politicians considering creating one—and potential chairs—will need to address. Including, crucially, whether a public inquiry is even the right answer. In the context of the National Health Service, on which this analysis focuses, it also argues that money may be far better spent on applying what is already known from the many previous inquiries—that is, spend it on prevention—rather than waiting to spend it on future similar inquiries that will, more than likely, produce similar findings and recommendations.

Keywords: National Health Service, public inquiry, parliamentary committees, prevention

As this collection of papers makes clear, 2019 is the fiftieth anniversary of the Ely inquiry—widely seen as the first public inquiry into a scandal in the National Health Service (NHS), even if, strictly speaking, it was not a public inquiry. It was held in private. Crucially, however, its findings were published in full.

Since then, NHS inquiries have proliferated (see Powell, in this issue). Indeed, while there have been peaks and troughs in the number of inquiries running concurrently, they have tended to become more common in other parts of the public realm as well, as a recent study by the Institute for Government has shown. Not counting ongoing inquiries, there have been around seventy across government since 1990 at a cost of around £650 million on issues as wide-ranging as the Iraq war, the Leveson inquiry into phone hacking and press ethics, Bloody Sunday and, in the case of the NHS, the ill-treatment of patients at the Mid Staffordshire NHS Trust (hereafter often referred to as the Francis inquiry).

Despite repeated recommendations from parliamentary committees, from the Institute for Government and from others, that there should be a central government unit providing support for inquiries and ensuring that lessons on effective procedure and follow up are learnt, retained and applied, that has not happened—even if the Home Office has taken some steps in that direction in relation to inquiries that it sponsors.

Outside government, there is in fact an excellent, if little known, guide by the Centre for Effective Dispute Resolution on the setting up and running of public inquiries which raises all the key issues. It is one that ministers considering setting up an inquiry, and anyone invited to chair one, would do well to consult—ministers before they decide to set one up, and potential chairs before they accept the task—not least, because the experience of a number of the chairs of previous public inquiries is that they are given remarkably little time, sometimes just an hour or two, to decide whether to do the job, given the urgency with which ministers wish to announce an inquiry once they have decided so to do. That is just one of the flaws with the current process.

So, the purpose of this short piece is to provide a very elementary primer for ministers and potential inquiry chairs on the questions they absolutely should consider before setting up or agreeing to run a public inquiry, including, at the end, the absolutely crucial question of whether a formal public inquiry is even the right approach. It is based in part on a symposium that the
Health Foundation held in November 2018 on the fiftieth anniversary of the Ely inquiry. The participants included some current and former chairs of inquiries, academics and past advisers to inquiries. It is based also on a reading of past reports on public inquiries, from the National Audit Office, the House of Lords select committees, the Institute for Government, and various accounts, in various formats, of the experience of inquiry chairs, including those from Sir Ian Kennedy, Dame Janet Smith and Lord Bichard, all of which are absolutely worth reading should you ever be approached to chair an inquiry. Its main focus is inquiries into the NHS, although much the same is likely to apply in other areas. It outlines the questions that need addressing. It does not provide the answers, as these will vary according to the nature of the subject matter.

Be clear about the primary purpose of the inquiry

This might sound simple, but it is not. Leave aside a cynical interpretation of inquiries—that they are a means of kicking a difficult can down the road in the face of public pressure (with the minister who commissions the inquiry being highly unlikely to be the one who receives its report). Or, even more cynically, that they might be used to show a previous government in a bad light. On a non-cynical view, they are usually seen as being there to establish the facts, work out what went wrong, potentially attribute blame (although inquiries cannot determine civil or criminal liability), and make recommendations aimed at preventing a recurrence. But they are more complex than that.

Sir Ian Kennedy has neatly encapsulated their potential purposes as three-fold. The forensic, the social, and the remedial. The forensic includes discovering ‘the truth’ and learning what went wrong. The social includes the holding to account of organisations and/or individuals, but it also includes catharsis and healing—most notably for those affected by the events being inquired into, but also, on occasion, for a much wider public. The remedial includes prescribing recommendations to prevent a recurrence.

Most inquiries involve—not always successfully—elements of all three purposes. But it was notable that in the symposium that the Health Foundation held, the emphasis by the end of the day was heavily on the catharsis and healing when it came to NHS inquiries into service failures. Providing a sense amongst those affected that they had finally been listened to—a key reason why pressure for an inquiry had built in the first place as patients and their relatives felt that their concerns had not been heard when they had raised them, and that the failure so to do had led to the scandal in question running on and on.

Furthermore, given the fact that NHS inquiries repeatedly find the same causes of failure—weak management, poor communication, bullying, a refusal or a failure to listen to staff and patient concerns and, often, geographic and/or professional isolation—catharsis and healing is at least as important a purpose as another set of recommendations aimed at preventing the failure in the first place. It should be noted, however, that the creation of an inquiry can prolong, or indeed revive and compound, feelings of grief and the demand for accountability among those who have been affected, without either catharsis or healing being achieved (see Sara Ryan, in this issue). There is a notable absence of research on the views of relatives and of patients on the outcome of inquiries. It is also unlikely that the final outcome will provide either catharsis of healing for everyone—particularly in a world where social media appears to have given extra oxygen to conspiracy theories. Even so, being clear about purpose, or primary purposes, is likely to help. Being clear about purpose leads to the next issue.

Who best to chair an inquiry?

Judge-led inquiries have undoubtedly in the past been seen by those affected and by the public, as the ‘gold standard’—even if more recently, in the case of the Grenfell Tower inquiry or the government’s repeated initial efforts to find a chair for the wide ranging inquiry into child sex abuse, judges have come under fire from those affected by the events in question for being too remote, or...
too out of touch, or too much part of ‘the Establishment’.

There are understandable reasons why judge-led inquiries are, nonetheless, often seen as ‘the gold standard’. Judges are seen as politically impartial. They have experience of running hearings, and of analysing information and uncovering facts. But they operate in a world where the court is expected to come to a single verdict—guilty or not guilty, case made or not—when the very nature of the findings of a public inquiry will almost always be more nuanced than that. A point repeatedly made at the symposium, and indeed in some inquiry reports, was that there can be more than one, sincerely and reasonably held, version of the truth. Attempts to produce a single black or white resolution of them—which is the nature of the adversarial court system—will often not work.

To make this point is not to suggest that judges are incapable of nuance. But the appointment of a judge can easily—although it does not have to—lead to an adversarial, lawyer led approach which may well not be the best way to establish what happened. Many lawyers also equals much cost. There are ways to mitigate such an approach. For example, at the Bristol inquiry into child deaths after heart surgery, for example, all questioning was handled by counsel to the inquiry, not by multiple lawyers, through each was able to put forward lines of questioning through counsel to the inquiry.

Furthermore, judges are not necessarily the best people to frame recommendations. They are rarely experienced policy makers. At the Health Foundation’s symposium, some frustration was voiced by former civil servants about how practicable the recommendations from some inquiries have been, and how far the potential unintended consequences of recommendations have been thought through. For example, many saw a conflict between the Francis inquiry’s recommendation of a ‘duty of candour’ on NHS staff (implemented) and its recommendations for new criminal sanctions on board members (unimplemented). The latter was unlikely to encourage the former.

There is a case, therefore, for casting the net wider and seeking a chair with practical and policy expertise around the area in question. For example, the Soham inquiry, completed in 2004, into the murder of two schoolgirls by their school caretaker who had a record of being investigated for sexual offences, but no convictions. Soham was not an NHS inquiry, but it came to have a significant impact on the service. It was chaired by Sir Michael (now Lord) Bichard whose experience as a former local government chief executive and permanent secretary may well have contributed to the practicality of a set of recommendations that have indeed been implemented: those that led to what is now the Disclosure and Barring Service.

Along with the decision on who is best to chair an inquiry comes the question of whether the chair should sit alone, with a panel, or with technical assessors. There are arguments both ways. There has to be an element of ‘horses for courses’. A single chair provides clarity, but carries the obvious risks that go with a single voice: the findings risk being criticised as one person’s view. On the other hand, for some inquiries or elements of inquiry, a sole chair can be an advantage. Dame Janet Smith, for example, has argued that for the first part of her inquiry into Harold Shipman—establishing with the help of medical expertise, just how many patients the GP was likely to have killed—sitting alone was a real advantage. That task involved investigating, initially, 1,000 deaths over a period of twenty-four years. It took eighteen months. ‘It would have been immensely time consuming to have to discuss each individual case with a panel’, is Dame Janet’s verdict.

Nonetheless, the trend has been for chairs to sit with a panel, or at the very least with other assessors. And that looks sensible. As does, the approach adopted by a number of inquiries of testing the practicability of recommendations with practitioners and policy makers, ahead of them being made.

Terms of reference

Although third in this list—because they are a matter for consultation with the chair—the terms of reference are of course of first importance. Too wide and the inquiry will sprawl, running the risk that it will satisfy nobody: a clear risk with the current inquiry into child sexual abuse. Too narrow, or too
narrow an interpretation, and the issue will not be resolved: for example the original Hillsborough inquiry into the death of ninety-six Liverpool supporters at a football match in 1989.

In some more recent and current cases—including Grenfell Tower and the infected blood inquiry—there have been consultations on the terms of reference. That may indeed help, but it is unlikely to satisfy everybody. The Grenfell inquiry, for example, decided against investigating the issue of social housing more broadly. In other words, it will not go beyond examining the causes of the fire and the response to it; the history of the building and its management; and relations between residents, the management company and the local authority. The decision not to extend the inquiry into social housing more broadly, and the impact of that history on what happened at Grenfell Tower, has brought criticism, although some at least would see that as a subject best dealt with through a different mechanism to a judge-led public inquiry.

There can be no detailed guidance here on terms of reference, other than that, case by case, they require considerable thought.

How should the inquiry be run?

This covers a multitude of issues that there is not room to explore here. They include some already touched on—how to ensure the inquiry is inquisitorial rather than adversarial—which includes not just the approach adopted, but the layout of the room and the nature of questioning. Others include how to handle the media and social media. How to manage expert testimony (an issue that came up at the symposium), where having expert testimony taken as a group or panel, rather than by individual, can help both the inquiry and its audience understand the nuances—for example that there may be issues on which expert opinion can legitimately differ. And indeed, how to take an approach that avoids the need for, and the delay involved, in issuing ‘Salmon’ letters (letters issued towards the end to those likely to be criticised, giving them the chance to reply). On these and other issues there is much that is helpful in the Centre for Effective Dispute Resolution’s guidance on inquiries.

Think, even at the beginning, about follow-up

This may sound odd, given that recommendations—if any are in fact made—will be months, perhaps years away. But there is no formal mechanism for follow-up to establish whether the government has, or has not, acted on an inquiry’s recommendations and, if not, why not? The Institute for Government calculated in 2018 that of the sixty-eight public inquiries since 1990, just six had received a full follow-up by a select committee, including Mid Staffordshire, the Chilcott inquiry into the Iraq war, and a ten year follow-up by the Home Affairs select committee on the Macpherson inquiry into the death of Stephen Lawrence.

It is not axiomatic that governments should accept an inquiry’s report in full. There may be many good reasons for recommendations not to be accepted—for example, poor drafting, unintended consequences, excess cost for the perceived benefit, a better way of achieving the same or similar ends. But with large sums—often many millions of pounds—having been spent on a public inquiry, it should be clear what, in the long run, the government has done with the results, with the failure to act on a recommendation, or a rejection of it, explained.

Sir Michael Bichard took the unusual step in his report on Soham of announcing that the inquiry would reconvene in six months to monitor the government’s response. The Institute for Government has proposed that follow-ups to public inquiries should become a routine part of the relevant select committee’s business. That has yet to be adopted—although an inquiry could make it a recommendation in itself. The point is that potential chairs should give thought to how their reports will be followed up at the time the inquiry is created—and get that established—because the moment of their appointment is the time when they have maximum leverage.

One longer term consideration...

There is a widespread perception, correct or not, that inquiries tend to make too many recommendations. The main Bristol report...
had some 198 although to be fair it was asked to make recommendations that would stretch across the NHS. Most of the Bristol recommendations were accepted (in part because they went with the grain of reforms that the government of the day was already making), although a few key ones were not. For example, scrapping the system of clinical negligence and replacing it with some form of no-fault scheme for clinical injury, an approach some still believe would encourage the transparency and open reporting of errors that inquiry after inquiry has recommended. The Francis report contained 290 recommendations, some of which seemed to pull in contrary directions.

It must be the case that tightly focussed recommendations, tested ahead of the report for their practicability, must stand a greater chance of implementation—even though, as is the case with the decision to institute an inquiry in the first place, they will be subject to the politics of the day. Merely as an observation, it is worth noting that the recommendations in Geoffrey Howe’s original Ely report were heavily focussed on what needed to be tackled at Ely—staffing levels, overcrowding, rostering, incident reporting, drug management and the like. Just one went broader: ‘a clear need for some system of inspection of a hospital like Ely’, which led to the Health Advisory Service, the very first NHS inspectorate. It was restricted to long-stay hospitals, and the sensitivities of the day of subjecting doctors to ‘inspection’ led to the ‘advisory’ in its title. As a string of other inquiries followed into scandals at the long-stay hospitals, both geriatric hospitals and those for the mentally ill and handicapped (to use the language of the day), it is clear that the creation of the Health Advisory Service was not transformational. It would, however, be fair to judge that it did make a difference.

Equally, and again merely by way of observation, the Soham report contained just thirty-one recommendations, almost all tightly focussed on the systems needed to exchange information between the police, social services, schools, the health care system and others where adults have responsibility for children. With clear recommendations about which part of government or the inspectorates were responsible for which actions. In other words the systems needed to create what is now the Disclosure and Barring Service.

The most important question for the minister: should there be a public inquiry in the first place?

Full-blown public inquiries—those established under previous legislation and under the Inquiries Act 2005, but also some non-statutory inquiries such as Iraq—are costly and take time. The cost often runs into the many millions of pounds. Bristol cost £14 million.9 Shipman £21 million. Francis almost £14 million. And those are the direct costs. The figure for Francis—the formal public inquiry into Mid Staffordshire—does not, for example, include the costs of the Department of Health and other NHS organisations in preparing and giving evidence to that inquiry—another £6 million according to a parliamentary answer, of which £5.2 million were legal costs. Nor does it include the costs of the first non-statutory Francis inquiry into the same events, for which there appear to be no published costs. But that first report itself ran to two volumes and more than 800 pages of evidence and analysis. And it, in turn, followed an earlier report from the inspectorate, the Healthcare Commission.

The time inquiries take can be substantial—two-and-a-half years for the second Francis report. But, as already noted, many NHS inquiries—as with many child abuse inquiries—make essentially the same diagnosis. Sir Ian Kennedy has quipped that one could almost substitute ‘Ely’ for ‘Bristol’ throughout his report. Sir Robert Francis has noted that ‘a significant number of things that I have said was said so many years ago by Sir Ian Kennedy and no doubt by other people in other reports’, which does raise the question about when a public inquiry is necessary. There are other ways of establishing what happened and why—providing the answers that patients and relatives need—without necessarily requiring the full panoply of a public inquiry.

The investigation into maternal and neonatal services at Morecambe Bay was a non-statutory inquiry covering, like Bristol and like Mid Staffordshire, events that took place
over several—in the case of Bristol many—years. The Morecambe Bay inquiry, led by Dr Bill Kirkup, took seventeen months and its direct costs were just £1.1 million rather than £20 million, just 1 per cent of its cost being lawyers. With the Hillsborough panel as its model, a similar panel approach has been used for an investigation into deaths at the Gosport War Memorial Hospital, while the Liverpool Community Health Services review, also led by Dr Kirkup, was an investigation on the Morecambe Bay model.10,11 These are not without their problems. They cannot compel witnesses—something that a public inquiry can do but rarely needs to: the mere existence of the power leads to compliance. Indeed, some of the board members in the Liverpool Community inquiry refused to cooperate. That did not, however, prevent the inquiry reaching clear-cut conclusions.

There is no easy objective way to measure whether these rather different approaches have been more or less ‘successful’—however success is defined—than full blown public inquiries. There is anecdotal evidence that, in so far as any inquiry can, they have for at least some patients and relatives fulfilled the catharsis and healing elements of an inquiry, that is, exposing what happened and why, with the follow-up to the Liverpool review producing a second investigation. These approaches have also proved able to make recommendations with national implications. For example, the original Liverpool review led to a further review of the currently ineffective ‘fit and proper person test’, aimed at recasting it—both to ensure that executive directors whose actions are beyond the pale can be barred from further NHS appointments while also reinforcing the case, repeatedly made, and again made in the Sir Ron Kerr’s recent report for better training and clearer competencies for managers, including, crucially, clinical managers.12,13

Indeed, investment in the training, development and talent management at all levels is likely to prove a better investment than waiting for the next multi-million public inquiry into the maltreatment of patients to come along and deliver, yet again, the same or very similar, findings. In large measure, we know by now what happens that leads to these cases. Applying what is known would be good prevention, and fifteen or twenty million pounds would buy quite a lot of initial training and development. Included in that should be a point made at the symposium: that a chief executive’s first appointment is often in one of the smaller, more isolated hospitals, often with significant recruitment difficulties. These can be among the most challenging units to manage, and they make up a significant proportion of hospitals that have been the subject of public inquiries.

Finally, just as the repeated recommendation for a central unit to hold the lessons learnt from previous public inquiries—and to provide support for new ones—should be adopted, such a unit should also embrace non-statutory inquiries on the Hillsborough and Morecambe Bay approach. That latter investigation recommended to the Department of Health and Social Care the establishment of a proper framework for such inquiries—pointing out that it was ‘hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence’. It said it managed to overcome those obstacles. But the need, in large measure, to re-invent the wheel each time makes no sort of sense, and the department has not adopted that recommendation.

And for potential chairs...

Recognise that, in the absence of a central government unit to help, it looks a matter of serendipity whether you get support staff who have been involved in an inquiry before. Try seeking some out. There is now a little more central guidance on how to approach the task than before, but not enough. So, talk to those who have undertaken inquiries. Their views are not all aligned, but they will help you define the questions that you will have to address and answer. And given the very limited time you are likely to have before deciding whether or not to undertake the task, read: there is a literature on inquiries. At or near the top of any reading list, I’d put Sir Ian Kennedy’s reflections on Bristol, the transcript of Dame Janet Smith’s Gresham...
College seminar on the Shipman inquiry—which has differing views on some of the issues—the Institute for Government’s report How Public Inquiries Can Lead to Change, and the Centre for Effective Dispute Resolution’s guide to Setting up and Running a Public Inquiry.14

Notes


8 Bristol in fact led to two reports as it was asked, part way through, to conduct a separate but linked inquiry into an issue that the main inquiry had uncovered, namely the removal and retention of human material. That involved an additional sixty-nine recommendations which led to changes to practice and the law.

9 Although, as already noted, Bristol was two inquiries in one.

10 An entirely different approach to establishing what happened after the original Hillsborough inquiry was widely seen as a failure.


