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LEARNING THE RIGHT LESSONS FOR THE NEXT PANDEMIC

*How to design public inquiries into the
UK government's handling of COVID-19*



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Executive summary and recommendations

1. It is imperative that the UK, along with the international community, learns lessons to better prepare for the significant likelihood of future pandemics. Public inquiries in the area of public health can be highly effective tools for fact and cause-finding, lesson-learning, building support for institutional change, and helping the public to make sense of a crisis.
 2. The objectives of lesson-learning and holding individuals and organisations to account are often in tension. Our key recommendation is to prioritise lesson-learning over political accountability for a public health-focused inquiry. We argue for two separate inquiries:
 - a. First and foremost, we call for an inquiry focused primarily on lesson-learning for the UK. Ideally this inquiry should be initiated, coordinated and funded by reputable organisations in the field of public health who could act as credible knowledge-brokers, such as the Wellcome Trust, Nuffield Foundation, or Scientific Academies.
 - b. Secondly, if there are sufficiently serious and well-evidenced allegations of government negligence, a fact-finding, accountability-focused, and public-trust-restoring inquiry should be instituted under the 2005 Inquiries Act.
 3. The terms of reference for a lesson-learning inquiry should be sufficiently comprehensive and flexible to enable the discovery of new root causes and identify important lessons, including those identified through comparisons with other countries. Any accountability-focused inquiry could adopt a narrower focus on actors, allegations and disputed facts.
 4. Completing inquiries in a timely fashion increases the likelihood of recommendations being fully implemented and public trust being restored. A lesson-learning inquiry should aim to deliver interim findings after a year, and a full report after 18 months. A statutory inquiry should deliver findings not later than a year before the government's electoral term ends.
 5. The lesson-learning inquiry requires detailed and early planning and professional project-management to avoid unnecessary delays across the different stages of the inquiry process. The inquiry needs to be sufficiently well-resourced in terms of research and support staff.
 6. The inquiry commission or panel should be sufficiently diverse in their expertise. Members should include at least some experts from countries and international agencies which have the greatest potential to offer positive lessons to the UK. Attempts to balance expert or political views should be avoided. The chair needs to be impartial and open-minded.
 7. The systematic involvement of members of the community would ensure public acceptance of the inquiry's outcomes and improve the context for public engagement in any future pandemic preparedness efforts. Engagement could take the form of a series of citizen-juries, facilitated workshops or focus groups to be run in advance or parallel to the inquiry.
 8. Full use should be made of cross-country comparisons for the purpose of lesson-learning, particularly from those countries that demonstrated lesson learning from previous pandemics and outperformed the UK in preparedness. Evidence gathering and analysis needs to be free of hindsight bias and consider key factors that can impede expert advice, receptivity, and decision-making.
 9. Experts and front-line workers, and representative members of the public need to be involved in advancing realistic recommendations that address the most important causes of problems. Technical and systemic lessons should be separated with a detailed implementation plan.
 10. For the follow-up phase new permanent oversight mechanisms should be created to keep the inquiry alive in some form. Regular reviews, simulations and exercises for remembering can ensure that lessons learnt are not forgotten, and then updated as required.
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Introduction

The COVID-19 disease caused by a new type of coronavirus (SARS-CoV2) has challenged governments, health systems and regulatory agencies across the globe. As of 1 June, deaths attributed to the virus were 38,571 in the UK and 372,377 worldwide.¹ The public health measures taken by many governments in Europe and elsewhere have led to a large decline in economic activity, increased unemployment, caused unprecedented costs to the public purse, and have put an enormous strain on individuals, communities and societies. These consequences demand a serious reckoning about how governments and international organisations can better prevent or at least mitigate harms, particularly as we prepare for new waves of COVID-19 and future pandemics of yet unknown origin.

Given the potential for infectious agents to spread across borders, any attempt to learn lessons from the COVID-19 pandemic will also need to consider international policies, capacities and structures. The World Health Assembly recently adopted a resolution that called for the WHO to conduct an ‘impartial, comprehensive, and independent evaluation’ of the ‘experience gained and lessons learned from the WHO-co-ordinated international health response to COVID-19’ and to do so at the ‘the earliest appropriate moment’.² It will need to ask what more can be done so that WHO member states take all necessary precautionary actions and fully comply with their responsibilities, especially the timely sharing of reliable data about new infections.

Beyond investigations at the international level into the origins of the outbreak, pressure is mounting for an assessment into the public health and political decisions made by individual countries. In particular, it has now become clear that some countries, particularly in East Asia, were better prepared than countries in Europe, and the United States, to tackle the COVID-19 pandemic and took earlier and more effective action to control the spread of the new virus within their borders.³ Despite fears of a second wave in the region, several East Asian countries have managed to keep hospitalisations as well as death tolls relatively low, avoiding most of the lockdown measures implemented in Europe and the United States. Yet, there are also significant differences among Western states in terms of ‘performance indicators’ related to the direct and indirect harm caused by the disease.

In the UK, calls for independent public inquiries have become more frequent and assertive.⁴ Publicly expressed criticism has focused on an alleged lack of preparedness despite presumably well-laid (flu) pandemic plans, under-reaction to warnings from the WHO and other scientific bodies, and a disorganised approach to crisis management. Some have also criticised some of the UK public health measures as not evidence-based and an overreaction that has caused more lasting damage than the disease itself.⁵ Experts advising the government have not escaped criticism either for allegedly not sounding the alarm

1 See Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU), ‘Covid-19 Dashboard,’ coronavirus.jhu.edu/map.html. It is important to note differences among countries in the measurements of Covid-deaths (tested or just suspected cause) and that a full and reliable picture of excess deaths caused directly or indirectly by the virus is likely take much longer to emerge.

2 For the text of the adopted resolution see World Health Organization, ‘Covid-19 Response,’ apps.who.int/ebwha/pdf_files/WHA73/A73_CONF1Rev1-en.pdf. and some first commentary by Patrick Wintour; Julian Borger, ‘Who to Agree Deal over Future Coronavirus Inquiry,’ [The Guardian](https://www.theguardian.com/world/2020/may/18/who-to-agree-deal-over-future-coronavirus-inquiry), [theguardian.com/world/2020/may/18/who-to-agree-deal-over-future-coronavirus-inquiry](https://www.theguardian.com/world/2020/may/18/who-to-agree-deal-over-future-coronavirus-inquiry).

3 Ramon Pacheco Pardo; Mauricio Avendano Pabon; Xuechen Chen; Bo-jiun Jing; Jeong-ho Lee; Joshua Ting; Takuya Matsuda; Kaho Yu, ‘Preventing the Next Pandemic: Lessons from East Asia,’ (King’s College London, 2020).

4 Anthony Costello, ‘A Public Inquiry into the UK’s Coronavirus Response Would Find a Litany of Failures,’ [theguardian.com/commentisfree/2020/apr/01/public-inquiry-coronavirus-mass-testing-pandemic](https://www.theguardian.com/commentisfree/2020/apr/01/public-inquiry-coronavirus-mass-testing-pandemic); Kate Proctor, ‘Public Inquiry into No 10’s Covid-19 Response Inevitable, Peer Say,’ [theguardian.com/politics/2020/apr/03/public-inquiry-into-no-10-covid-19-response-inevitable-kerslake-says?CMP=share_btn_link](https://www.theguardian.com/politics/2020/apr/03/public-inquiry-into-no-10-covid-19-response-inevitable-kerslake-says?CMP=share_btn_link).

5 Jonathan Sumption, ‘Coronavirus Lockdown: We Are So Afraid of Death, No One Even Asks Whether This ‘Cure’ Is Actually Worse,’ [thetimes.co.uk/article/coronavirus-lockdown-we-are-so-afraid-of-death-no-one-even-asks-whether-this-cure-is-actually-worse-3t97k66vj](https://www.thetimes.co.uk/article/coronavirus-lockdown-we-are-so-afraid-of-death-no-one-even-asks-whether-this-cure-is-actually-worse-3t97k66vj); Proctor, ‘Public Inquiry into No 10’s Covid-19 Response Inevitable, Peer Say’; Costello, ‘A Public Inquiry into the UK’s Coronavirus Response Would Find a Litany of Failures’.

earlier and more forcefully, falling prey to ‘group-think’, and senior scientific committees lacking expertise in specific areas of public health, emergency planning and logistics.⁶ The House of Commons and House of Lords science and technology committees have already launched inquiries into various scientific and technological aspects of the national and international response to the COVID-19 pandemic.⁷

Separate from the work of these select committees, however, the UK government has not yet committed itself explicitly to a public inquiry. In early May⁸, Prime Minister Boris Johnson said: ‘Of course there will be a time to look at decisions we took and if we could have taken different decisions’. However, the argument so far has been that holding an inquiry now would be an unhelpful distraction for officials and ministers during crisis management and, in any case, it may only be possible to fairly judge the performance of the UK government vis-à-vis others after months, if not years.⁹

It is against this background that this report seeks to assess whether and why an inquiry into the UK response to COVID-19 would seem sensible, and examine the type of inquiry that would bring the most benefits to inform the UK response to future pandemics and health risks. This report will outline its argument to **hold two, separate inquiries**: First and foremost it is important to prioritise an inquiry **focused on lesson-learning** for the UK. This should be, ideally, initiated, coordinated and funded by reputable organisations in the field of public health who could act as credible knowledge-brokers, such as the Wellcome Trust, Nuffield Foundation, the Royal Academy or the British Academy. Second, and only if there are sufficiently serious and at least initially well-evidenced allegations of government negligence or wrong-doing, a **fact-finding, accountability-focused, and public-trust-restoring inquiry** should be instituted under the 2005 Inquiries Act.

It will be argued that such a two-pronged approach, which would start off with a knowledge-broker-led inquiry into the Government response to COVID-19 that emphasises lesson-learning as its primary objective, would bring the greatest public good and have the greatest likelihood of generating future policy change at the required speed. It would ask: What can the Government learn from the response from COVID-19 that would help us preventing and dealing with future pandemics and their consequences for individuals, society, the Government and health systems?

Setting out its argument for such a sequenced inquiry process, this report seeks to answer four questions:

- 1 *What is the case for launching an inquiry?* By examining the arguments for and against a statutory public inquiry from the literature, we will offer evidence of the positive change that an initial knowledge-broker-led inquiry focused on lesson learning might bring about.
- 2 *What kind of inquiry or combination of inquiries is best suited to advance lesson learning in the UK related to pandemics?* We will argue how two, sequenced inquiries complement each other and will discuss the key design choices that need to be made before and

6 eg Andrew MacAskill Stephen Grey, ‘Johnson Listened to His Scientists About Coronavirus – but They Were Slow to Sound the Alarm,’ [reuters.com/article/health-coronavirus-britain-path/rpt-special-report-johnson-listened-to-his-scientists-about-coronavirus-but-they-were-slow-to-sound-the-alarm-idUSL4N2BV54X](https://www.reuters.com/article/health-coronavirus-britain-path/rpt-special-report-johnson-listened-to-his-scientists-about-coronavirus-but-they-were-slow-to-sound-the-alarm-idUSL4N2BV54X); eg Anthony Costello, ‘The Government’s Secret Science Group Has a Shocking Lack of Expertise,’ [theguardian.com/commentisfree/2020/apr/27/gaps-sage-scientific-body-scientists-medical](https://www.theguardian.com/commentisfree/2020/apr/27/gaps-sage-scientific-body-scientists-medical); for a nuanced early assessment, see Lawrence Freedman, ‘Strategy for a Pandemic: The UK and Covid-19,’ *Survival* 62, no. 3 (2020).

7 UK Parliament Science and Technology Committee, ‘UK Science, Research and Technology Capability and Influence in Global Disease Outbreaks,’ committees.parliament.uk/work/91/uk-science-research-and-technology-capability-and-influence-in-global-disease-outbreaks; Lords Select Committee, ‘The Science of Covid-19 – Lords Committee Launches a New Inquiry,’ parliament.uk/business/committees/committees-a-z/lords-select/science-and-technology-committee/news-parliament-2019/covid-19-inquiry-launch.

8 Prime Minister Boris Johnson at PMQs on 6 May 2020, see Kate Proctor Rowena Mason, ‘Boris Johnson Suggests Coronavirus Lockdown Will Be Loosened on Monday,’ *The Guardian*, 6 May 2020 2020.

9 Reuters, ‘UK Government Will Not Commit to a Public Inquiry on Coronavirus Response,’ [uk.reuters.com/article/uk-health-coronavirus-britain-inquiry/uk-government-will-not-commit-to-a-public-inquiry-on-coronavirus-response-idUKKCN2241QRv](https://www.uk.reuters.com/article/uk-health-coronavirus-britain-inquiry/uk-government-will-not-commit-to-a-public-inquiry-on-coronavirus-response-idUKKCN2241QRv).

during the inception phase of both a knowledge-broker-led and a (statutory) inquiry, to ensure that the first emphasises the lessons than can be derived for future policy.

- 3 *What are the key problems inquiries run into?* We assess how inquiries should fairly judge performance without 20/20 hindsight and distinguish clearly different causes of problems and perceived failures. We distinguish problems in the evidence collection, public engagement and analysis phases.
- 4 *How can we ensure that findings and recommendations made by inquiries lead to significant and long-lasting change in state capacity and performance in future pandemics?* We discuss the ways in which lessons identified by inquiries can be learnt and internalised so that they create institutional memory and increase institutional capacity.

This report, therefore, is an attempt to identify the most effective ways an investigation into COVID-19 can be carried out so that it maximises the chance of achieving what some consider the primary purpose of an inquiry: preventing recurrence. This report does not seek to answer in substance which, if any, accusations against ministers are justified or what specific lessons should be learnt from the experience of responding to this particular pandemic. Nor does it aim to judge the Government's performance thus far in tackling the crisis. Instead, we put forward **a two-pronged approach to investigating COVID-19** by suggesting two, sequenced inquiries in which the first is conducted by experts and focuses on lesson-learning, while a second, judge-led statutory inquiry may focus on accountability. We seek to identify the key features and choices involved in the setting-up, running and follow-up of such inquiries into the COVID-19 crisis that are likely to lead to lesson learning and preventing recurrence.

Given the stakes involved and the significant probability of future pandemics, it is essential to reflect carefully about what we should expect from such inquiries and to avoid making costly design mistakes during the inception phase under mounting public and political pressures. The report is based on the authors' expertise and research in these areas and a synthesis of some of the key literature in public policy, public health, health governance, risk, disaster and emergencies, foreign policy-making and strategic surprise.

1 Purpose, pitfalls and potential: Arguments for and against inquiries

The case for lesson-learning from the current crisis is overwhelming given the scale and nature of the harmful effects experienced in many countries, including the UK. But are public inquiries effective for lesson-learning and promoting institutional memory?

Public inquiries, sometimes also called commissions of inquiry, are typically instituted in the aftermath of disasters, crises and major scandals. Although they can take various forms and address a diversity of issue areas and sectors, some general characteristics apply: they are set-up by the Government or parliament for a specific purpose and duration; they are formally independent in their running and reporting from the executive; they lack the authority to implement their own recommendations; and they are expected to publicly disclose their main conclusions, if not the full report.

Public inquiries also typically serve five different, often closely inter-related goals, with the first two being present in the terms of reference for most inquiries:

- 1 *Fact-finding and cause-finding*: To establish what happened and why, especially when either facts or causes are unclear, hidden or deeply contested.
- 2 *Lesson-identifying and learning*: To improve performance when faced with future similar threats or challenges.
- 3 *To build support*: Among policy communities and the public for more wide-ranging changes to the way problems are defined and how they are to be tackled.
- 4 *Accountability*: To hold key actors to account at political or working-level, possibly leading to resignations or criminal processes.
- 5 *Restoring public trust and support in governments and key institutions*: Through a process of truth and reconciliation after periods of great dissatisfaction, distrust and anger.

It is sometimes argued that inquiries may struggle to deliver equally well on all five objectives and that some of the goals, particularly fact-finding and holding to account, are inherently in tension with each other.¹⁰ One counter-argument to public inquiries is that their core purposes of fact-finding and lesson-learning can be achieved just as well and quicker through other means, channels and structures: parliamentary questions, debates and hearings, expert commentary and research, or media reporting and investigations. Lesson-learning also happens within existing structures of government, administration and service as an integral part of organisational learning, reviews and planning. Under these circumstances, the learning process would not be public, assuring the kind of confidentiality that can lead to more willing involvement and openness of key witnesses, lower running costs, and speed in reporting. It is sometimes argued that public inquiries tend to distract officials and ministers from core business, absorb too much resource and take too long. Because of the publicity surrounding proceedings, the experts, officials and politicians are reluctant to fully engage to avoid damage to their careers or make themselves vulnerable to prosecution. Some criticise inquiry recommendations as politically, fiscally or technically unfeasible and too far removed from everyday policy practice. Even if they are implemented, they may fail to address the root-causes of the problem, create displacement problems and unintended consequences.

The politicisation of inquiries is another cause for concern. Despite their potential positive impacts, they can be prone to manipulation by governments and senior decision-makers within organisations. That inherent bias stems from the way they are chaired and staffed: compromised by political links, inquiry panels or commissions end up being unwilling to cast clear and tough judgements on wrongdoing by politicians or officials,

¹⁰ Arjen Boin, Allan McConnell, and Paul 't Hart, *Governing after Crisis: The Politics of Investigation, Accountability and Learning* (Cambridge: Cambridge University Press, 2008).

are unable to escape narrow terms of reference that are inadequate to tackle the root-causes of a problem, unwilling to formulate inconvenient but necessary recommendations, or if they do, that those recommendations end-up being ignored, watered-down, or shelved in deliberate ways. Too often, the sceptical argument goes, the main purpose of inquiries is not to learn lessons, but to shield governments from immediate public pressure, delay reporting until after elections and control outcomes to avoid embarrassment and unwanted policy prescriptions.¹¹ By changing the volatile audience from the general public and the media to the predictable and slower-moving audience of public inquiries, governments may find it easier to cope with the crisis. Successful public inquiries are described as rare in some of the literature: according to Parker and Dekker: ‘when it comes to enacting meaningful reform, the dustbin appears to be the norm’.¹² Table 1 summarizes the key arguments for and against public inquiries.

Table 1: Common arguments for and against public inquiries

Arguments for inquiries	Arguments against inquiries
Inquiries bring together necessary outside expertise that is not present within the organisation needed for fact and cause-finding	Inquiry members are primarily picked not for their superior expertise, but on other criteria to satisfy some balance of views or to control outcomes in particular ways
They mobilise dedicated research resources not present in organisation/system to gather and analyse evidence	Inquiries duplicate existing resources and could be done more efficiently in-house without distraction costs to officials
They offer a fresh, well-informed perspective to understand problems and advance new solutions	Inquiry members often lack sufficient organisational or street-level expertise to come up-with realistic recommendations
Inquiries are sufficiently independent to pursue questions without fear or favour	Inquiry members are often chosen from within existing elite networks which rely on silent understandings, personal connections and expectations of reciprocity.
They are necessary to obtain classified documents and compel the attendance of witnesses (applicable to statutory inquiries)	Many inquiries are not given those powers and if they do, are often faced with silent obstruction, from bureaucracies or reluctant witnesses fearing blame and prosecution
They are crucial to re-establish trust after alleged scandals through public hearings, transparency of evidence and credibility of the panellists. Through their visibility, they contribute to public sense-making of a traumatic or divisive event.	During the crisis, the public often forms a judgement of who is to blame through selective media reading. It is not open-minded and established perceptions are difficult to shift
They provide additional authority to recommendations and thus increase chances of implementation, particularly if more sweeping changes are needed	Recommendations come too late or governments, officials or street-level operators find ways to ignore or dilute them, whilst the urgency of the crisis has subsided to the media and public

11 Michael Eburn and Stephen Dovers, ‘Learning Lessons from Disasters: Alternatives to Royal Commissions and Other Quasi-Judicial Inquiries,’ *Australian Journal of Public Administration* 74, no. 4 (2015); Mike Lauder, *It Should Never Happen Again: The Failure of Inquiries and Commissions to Enhance Risk Governance* (London: Routledge, 2013); Charles F. Parker and Sander Dekker, ‘September 11 and Postcrisis Investigation: Exploring the Role and Impact of the 9/11 Commission,’ in *Governing after Crisis*, ed. Arjen Boin, Allan McConnell, and Paul t Hart (2008); Andrew D. Brown, ‘Authoritative Sensemaking in a Public Inquiry Report,’ *Organization Studies* 25, no. 1 (2004).

12 Parker and Dekker, ‘September 11 and Postcrisis Investigation: Exploring the Role and Impact of the 9/11 Commission,’ 255.

Arguments for inquiries	Arguments against inquiries
Public health inquiries tend to be focused on more specific issues which can have positive implications for their duration and cost.	Limited attention is often given to the selection of committee members, method and processes to be used for the inquiry, and can sometimes be hurried and based on informal processes
Public health inquiries raise public awareness of public health issues, and help the case for support of future policy agendas to tackle critical public health threats and improve health care standards, providing an authoritative account of the crisis ¹³	Inquiries can entangle public health issues into a political process and thus risk popular resistance to future life-saving interventions
Responding to a crisis of international reach, inquiries entail diplomatic dividends and catalyse political will to future collaborative strategies of mitigation	Inquiries can become entrenched in geopolitical disputes that might stifle an honest process and exacerbate strained international relations
Inquiries can focus attention on critical issues and recommending change to government (or inter-governmental) authorities and institutions	A narrowly set terms of reference circumscribed can foreclose more comprehensive reforms—eg poverty, racial disparities, social equity etc

It is not difficult to find cases of inquiries that are vulnerable to such criticisms. Yet, based on substantive research, we argue that **the sceptical argument is significantly overstated** and often stems not from the nature of public inquiries themselves, but from common errors made at inception and during public inquiries that prevent them from achieving their primary purpose. There is, in fact, a wide range of literature on single cases as well as some comparative work that suggests inquiries that have not fallen prey to these errors have been successful in providing concrete recommendations that have been followed by policy implementation.¹⁴ Many inquiries, whether at national, regional or international level, have indeed led to sweeping and positive changes in organisations, systems, and whole sectors, which substantially reduced or even prevented future similar problems.¹⁵

Some examples include accident investigation boards after airplane crashes which have massively improved air-safety controls and engineering; inquiries of genocide and ethnic cleansing that created new structures and policy around conflict and mass atrocity prevention; investigations into political scandals that led to resignations, prosecutions and lasting changes in the law for whistle-blowers; investigations into intelligence failure that led to the creation of better processes and structures; and public inquiries into recent pandemics which contributed to international reporting agreements and greater transparency and co-ordination.¹⁶ Moreover, in some cases, post-mortem investigations can play a significant, if not decisive, role in bringing about broader changes in problem definition, approaches

¹³ Brown, 'Authoritative Sensemaking in a Public Inquiry Report.'

¹⁴ Emma Norris and Marcus Shephard, *How Public Inquiries Can Lead to Change* (Institute for Government, 2017); Sandra L. Resodiardjo, 'Wielding a Double-Edged Sword: The Use of Inquiries at Times of Crisis,' *Journal of Contingencies and Crisis Management* 14, no. 4 (2006); Hilary Pickles, 'Using Lessons from the Past to Plan for Pandemic Flu,' *Bmj* 332, no. 7544 (2006).

¹⁵ Max H. Bazerman and Michael D. Watkins, *Predictable Surprises: The Disasters You Should Have Seen Coming, and How to Prevent Them* (Boston, MA: Harvard Business School Publishing, 2008). Alastair Stark, *Public Inquiries, Policy Learning, and the Threat of Future Crises*, First edition.. ed. (Oxford: Oxford University Press, 2018).

¹⁶ For instance, the Canadian SARS commission led to the establishment of the Public Health Agency of Canada dedicated to coordinating federal disease control, prevention and response and a large blocks of federal funding dedicated disease surveillance by the provinces; following the Health Committee of the Council of Europe investigation into the World Health Organization's response to 2009 H1N1 outbreak, which issued a report leading to more transparent processes in declaring Public Health Emergencies of International Concern.

and organisational set-ups.¹⁷ Even if many inquiries have not reached all their objectives, one needs to compare their performance and impact to alternative ways of achieving one or more of the five purposes listed above. Individual expert commentary, media investigations, parliamentary select committees and debates often involve a high level of politicisation and partisanship. They are, therefore, no substitute for an independent, authoritative and fact-based inquiry that aim to instigate learning and major policy change grounded on a careful analysis of what happened, why it happened and what can be done to prevent it from happening again.

Although most of the studies hitherto have focused on government-funded inquiries, such as those falling under the 2005 Inquiries Act or parliamentary select committees, **inquiries can also be undertaken or co-ordinated by non-governmental actors**, such as the Carnegie Commission on the Prevention of Deadly Conflict or the Harvard/LSHTM panel into Ebola to prevent future pandemics.¹⁸ Such knowledge-broker-led inquiries, eg convened by trusts such as Wellcome, potentially together with academies, universities and reputable think-tanks, could play a major role in fact-finding and lesson-learning. Perhaps crucially, knowledge-broker-led inquiries have several advantages. First, they can start their investigations sooner; while a report by the National Audit Office concluded (based on a sample of 10 recent inquiries) the average time between the onset of an incident and the creation of a statutory inquiry is 6.4 years.¹⁹ We suggest this period would be much shorter for a non-statutory, knowledge-based inquiry. Since many of the relevant documents that can produce lesson learning for the (near) future are not classified, such knowledge-broker-led inquiries would not run into insurmountable access issues. Moreover, an inquiry of this type necessitates not only extensive public health expertise but also insights from management science and public policy planning in order to understand whether and what precisely went wrong in preparing for the outbreak and what policies and institutions could be established in order to address these failings. A combination of trusts, think-tanks and universities would produce a valuable stock of expertise that could complement and support government-created inquiries.

Public inquiries as public health tools

Public inquiries have played a key role in the past as a platform to establish scientific consensus and advance preventative practice in the area of international and, latterly, global health. The International Sanitary Conferences (ISCs) running from the mid 19th to early 20th centuries, brought together European nations to create a new international forum for epidemic governance. Prompted by a series of devastating cholera outbreaks, the ISC was tasked with determining the role of quarantine as a prophylactic measure and establishing common codes of sanitary practice. That dual purpose required a novel format: each state sent two delegates, a doctor and a diplomat. While highly contentious and often concluding in deadlock, the series of 14 ISC formed the institutional template for the League of Nations and the World Health Organization and, ultimately, the legal precedent for the International Health Regulations. It is within this regulatory framework that more recent pandemics – SARS, H1N1, and Ebola – have been brought under public scrutiny and interrogated as crises for which both international and national actors could bear some responsibility. The role of the WHO has formed the crux of post-pandemic investigations, which may see it alternatively as government criticism (SARS 2001), engaged in ‘disease mongering’

17 Sandra L. Resodihardjo, *Crises, Inquiries and the Politics of Blame* (London: Palgrave Macmillan, 2019); S. Dekker, ‘Learning under Pressure: The Effects of Politicization on Organizational Learning in Public Bureaucracies,’ *Journal of Public Administration Research and Theory* 14, no. 2 (2004); Stark, *Public Inquiries, Policy Learning, and the Threat of Future Crises*; Bruce Stone, ‘Success in Public Inquiries: An Analysis and a Case Study,’ in *Royal Commissions and the Making of Public Policy*, ed. Patrick Weller (South Melbourne: Macmillan, 1994); Jeffrey R. Stutz, ‘What Gets Done and Why: Implementing the Recommendations of Public Inquiries,’ *Canadian Public Administration* 51, no. 3 (2008); Resodihardjo, ‘Wielding a Double-Edged Sword: The Use of Inquiries at Times of Crisis.’

18 Carnegie Corporation of New York, ‘Preventing Deadly Conflict: Final Report,’ (1997); London School of Hygiene & Tropical Medicine, ‘Independent Panel of Global Experts Calls for Critical Reforms to Prevent Future Pandemics,’ lshtm.ac.uk/newsevents/news/2015/ebola_report.html.

19 National Audit Office, ‘Investigation into Government-Funded Inquiries,’ (2018), 17.

(H1N1 2009) or guilty of gross negligence (Ebola, 2014-16).²⁰ The reports of these inquiries have catalysed significant change within the organisation whether in terms of increased transparency in declaring a pandemic emergency, or in the form, source and verification of epidemic reporting to avoid delay and pre-empt obfuscation and biased interests.²¹ As it is rarely the case that outbreaks can be prevented entirely or their blame laid squarely on one set of actions or actors, the significance of investigations is perhaps in catalysing intergovernmental action and the necessary solidarity for pandemics going forward.

Moreover, public inquiries have been particularly important in **revealing the underlying institutions, structures and activities that prevent the implementation of effective action to protect public health**, particularly at the national level. Described as ‘truth machines’,²² public inquiries are critical for the public release of important documents and testimonies that over the years have revealed the actions of industry and government, becoming a major public health tool to generate policy change. Inquiries have been particularly effective in cases where public health objectives clash with powerful economic and political interests by private and government actors that attempt to undermine the activities carried out by national and international public health agencies. Example of these abound in the public health literature, but most recently have involved public inquiries into the actions of governments and private actors to tackle non-communicable disease epidemics. These include public inquiries into the extent of tobacco companies’ interference to undermine the tobacco epidemic control strategies and their implementation; government and private sector negligence in the management and disposal of harmful chemicals and substances that place a threat to public health; and the role of the global food industry in undermining efforts to address the obesity epidemic. The tobacco epidemic is different from COVID-19 in the sense that it is caused by an intentionally manufactured product in contrast to an infectious diseases that has its origin in wild animals. However, human behaviour and government policies may still contribute to making disease outbreaks less likely or harmful. It is this context that public inquiries have been powerful instruments to exert pressure on governments to change policies. What is more, an important lesson is that public inquiries related to public health do not need to involve intensive public hearings or parliamentary proceedings. Instead, impact comes from **the possibility that inquiries offer to gather and analyse evidence** of documents and records, as well as their dissemination of report and recommendations. A successful public inquiry can thus take the form of scientific analysis of documentary and other evidence.²³

Infectious disease epidemics present a distinct set of challenges and, arguably, opportunities to any process of public investigation and adjudication. Because communicable diseases are generally understood as ‘natural’ in origin, assigning responsibility is irreducible to uncovering the interests and motives of specific actors. While the speed of response or degree of system readiness can amplify and exacerbate transmission, these failings are often obliquely related to an outbreak’s cause. The 2014 outbreak of gastroenteritis in Havelock North, New Zealand, provides a paradigmatic example: despite uncovering key omissions in the regional council’s risk assessment and response, poor standards of care was only one in a series of contingent structural and climatological factors that led to the contamination of the water supply.²⁴

Attribution is particularly ambiguous for ‘emerging’ disease outbreaks; when knowledge of the clinical or public health risks is incomplete, preparedness can only

20 See for example; Fidler, D. 2004. SARS, governance and the globalization of disease, London: Palgrave Macmillan; Gostin, Lawrence O. ‘World health organization reform: lessons learned from the Ebola epidemic.’ Hastings Center Report 45.2 (2015): 6-7; Vance, Michael A. ‘Disease mongering and the fear of pandemic influenza.’ *International journal of health services* 41.1 (2011): 95-115.; Kamradt-Scott, Adam. ‘WHO’s to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa.’ *Third World Quarterly* 37.3 (2016): 401-418

21 Social Health and Family Affairs Committee Parliamentary Assembly Council of Europe, ‘The Handling of the H1N1 Pandemic: More Transparency Needed.’

22 Clive Bates, ‘UK Parliamentary Inquiry; Smuggling and BAT,’ presentation at the Amman Consultation

23 Regional Office for the Eastern Mediterranean & Blanke World Health Organization, D. Douglas, *Towards Health with Justice: Litigation and Public Inquiries as Tools for Tobacco Control* (World Health Organization: Regional Office for the Eastern Mediterranean, 2002).

24 ‘Government Inquiry into Havelock North Drinking Water,’ (Auckland, New Zealand 2017).

ever be a speculative exercise.²⁵ To a large extent, the evolution of public health has been driven by disease commissions or investigative committees – from the Cholera Inquiry Committee, upon which John Snow served, to the British Colonial Indian Plague Commission – which have served to generate critical insights into disease aetiology and further, exposing negligence and assigning blame onward transmission.²⁶ In many cases, these ‘public inquiries’ *avant la lettre*, served as decisive turning points in epidemiology as a science, crucial not only in providing an authoritative account of an outbreak as a particular *event* but also in consolidating public health as a field of knowledge and practice. A key example for this report was the Harvard-LSHTM Independent Panel on the Global Response to Ebola. Drawing together a wide range of expertise from academia, civil society and the third sector, the panel took a ‘global, system-wide view’ to ensure the necessary policy changes to prevent outbreaks in the future. In addition to leading to a restructuring of the WHO to increase scientific capacity, the panel served to create political will and engagement, catalysing new partnerships and regulatory mechanisms to advance emergency research and development.

Key recommendations

We argue that independent public inquiries have a huge potential to make a positive difference to the prevention of future pandemics, especially through **lesson-learning, building support for policy and systemic change** as well as helping the public make sense of a traumatic event. Existing mechanisms of internal lesson-learning and external scrutiny through news media and opposition are not sufficient in terms of expertise needed to rigorously analyse the multi-faceted impact of COVID-19 and the substantial probability of future pandemics. There is a substantial risk that without an inquiry, lesson-learning could be crowded out by politicisation dynamics, leading to personalisation, blame-shifting and a lack of consensus on the way forward. Alternatively, there is a risk of the ‘wrong’ lessons being learnt, ie those lessons easily captured in tweet threads or media reports that obscure the bigger picture and deeper root causes.

It is true that inquiries have not always delivered against expectations, especially in the UK context.²⁷ However, one can learn lessons about how to avoid the common pitfalls and realise their potential. Many of the reasons given for why inquiries fail to deliver on expectations can be addressed or at least mitigated, particularly during the inception phase,²⁸ but also during the inquiry. There is much that inquiry panels can do within their room for manoeuvre to maximise the chances of success.

There is a significant risk of politicisation and blame-shifting strategies within a broad culture of seeking to address performance problems by replacing individual leaders rather than tackling underlying problems in collective beliefs, structures, organisations, and policies. Against this background, **we argue in favour of two, sequenced inquiries**. The first public inquiry should prioritise the purpose of lesson-learning, even at the expense of investigating the performance of individuals and holding them to account. Such inquiry is more likely to lead to the **urgent changes in policy and institutions** that are required to deal with future pandemics. An inquiry focused on the performance of individuals, we argue, should be the object of a separate, perhaps parliamentary or judiciary inquiry. The latter is likely to involve a much longer timeframe and involve a more complex set of political actors and obstacles that render their success more uncertain than a public inquiry that emphasises lesson-learning and the strengthening of public health institutions, both critical to future threats posed by pandemics. Even if a judiciary or parliamentary inquiry into the performance of actors and

25 Carlo Caduff, ‘On the Verge of Death: Visions of Biological Vulnerability,’ *Annual Review of Anthropology* 4 (2014).

26 Nicholas H. A. Evans, ‘Blaming the Rat? Accounting for Plague in Colonial Indian Medicine,’ *Medicine Anthropology Theory* 5, no. 3 (2018).

27 For an overview of landmark inquiries in the field of UK intelligence see Mark Phythian, ‘The Politics of Commissions of Inquiry into Security and Intelligence Controversies in Britain,’ in *Commissions of Inquiry and National Security: Comparative Approaches*, ed. Stuart Farson and Mark Phythian (Santa Barbara, CA: Praeger, 2011).

28 Alastair Stark, ‘Left on the Shelf: Explaining the Failure of Public Inquiry Recommendations,’ *Public Administration* (2019); *Public Inquiries, Policy Learning, and the Threat of Future Crises*.

government is ultimately justified and conducted, key insights from a knowledge-based inquiry will offer the 'scientific' basis for allegations that may be made against particular individuals, government agencies or advisory groups.

2 Inception and design phase of inquiries

The inception phase matters greatly to the success of an inquiry as it sets the conditions, legal frameworks and resources required for a successful inquiry. These are very difficult to change once the inquiry has started and runs into problems. Mistakes made during the inception phase are difficult to fix. For instance, if the terms of reference are too broad to ensure timely reporting and actionable recommendations, or too narrow so that key questions are deliberately excluded and root causes of a given problem cannot be addressed. When inquiries are set up, there is a public interest that they have the best possible chance of success.

The first challenge in this phase is to ensure that a government does not abuse its powers to decide whether a public inquiry is needed, control the outcomes in its favour, either through the terms of reference, the legal basis and powers, resources, and, of course, the appointment of chairs and panel members. The sooner in a crisis a government calls an inquiry, the more control it usually has on the outcome. In later stages of the crisis or when issue salience is high, opposition, media and public scrutiny tend to lead to less government control and a more independent and forceful inquiry.²⁹

We propose to focus on **five main considerations in the inception and design phase** of both a knowledge-broker led inquiry and a statutory inquiry: Their legal basis and investigatory power, the terms of reference, the chairing and panel composition, the timing for interim and main reporting, and their resources.

1. Choosing the right type(s) of inquiry

Aside from parliamentary select committees or civil service reviews, there are several types of inquiries the government has at its disposal, and they can take statutory or non-statutory form. Under the Inquiries Act 2005, inquiries may be established by ministers from the central government or any of the devolved administrations. In most cases, it is the relevant minister who decides when to set up (and when to dismantle) the inquiry, as well as who chairs the inquiry. They equally establish the terms of reference of the inquiry, which may be expressly amended during the inquiry.

Arguably, if there are sufficiently serious and well-evidenced allegations of government negligence or wrong-doing, a statutory inquiry established under the Inquiries Act 2005 may seem the most appropriate type of inquiry. This because public concern for the events extends significantly beyond a specific case of death to wider public health issues, especially since so many frontline workers have died after contracting the virus, most likely during their work.³⁰ Yet, we argue that there are significant limitations to such statutory inquiries, such as their very long timeframes, which need to be borne in mind, so as to take the appropriate measures to alleviate them. They can create unfortunate dynamics of blame-shifting amongst scientific experts, officials and decision-making that are not conducive to soliciting testimony and may affect current crisis management.

Therefore, we suggest that **such a statutory public inquiry should be preceded by a private inquiry into the facts and lessons that can be learned** from the current pandemic. It should be established and funded independently from government, drawing on the expertise of the wider scientific and professional community. It should be focused on establishing the facts and contrasting them to a well-established standard of what an appropriate public health response might have been, as a statutory inquiry can run into the danger of blame shifting without sufficient scientific basis to judge the actions of individuals or government agencies. This private inquiry should explicitly avoid focusing on questions of personal accountability

29 Stuart Farson and Mark Phythian, 'Toward the Comparative Study of National Security Commissions of Inquiry,' in *Commissions of Inquiry and National Security*, ed. Stuart Farson and Mark Phythian (Santa Barbara, CA: Praeger, 2011).

30 House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: Post-Legislative Scrutiny. Report of Session 2013-14,' (2014).

(and would thus not meet some of the five purposes mentioned in the previous section) to avoid politicisation and ensure full participation of relevant witnesses. It should contribute to fact-and-cause-finding as well as lesson-learning in the short-to-medium-term. There is a scientific consensus that new pathogens with similar or even greater potential than SARS-CoV-2 to trigger pandemics will emerge. Moreover, should no vaccine be found, it is likely that this current COVID-19 pandemic will last several years.³¹ Lessons must be learnt and learnt quickly. As a result, there should be two distinct inquiries that would have a separate structure and nature.

First, one inquiry led by private organisations that are formally separate from government, but the subject expertise and networks to act as knowledge-brokers. Potential candidates are trusts such as Wellcome, foundations such as Nuffield, scientific academies or groups of leading universities. This inquiry would be focused on how to be better prepared for future pandemics, both in terms of health systems, but also in terms of dealing with the balance of harms and benefits of public health measures.

Second, a statutory inquiry with a narrow mandate to investigate the most serious allegations supported by at least some level of preliminary evidence. This could be, for instance, whether patients and care-workers were recklessly exposed to risk, whether high-quality warnings and advice about the dangers to people in care-homes were ignored without any mitigating factors, and whether the government was untruthful or deliberately misled in its public communications.

2. Terms of reference

On average, five per cent of the inquiry running time consists of setting the terms of reference and appointing the chair and the inquiry team.³² The actors setting the terms of reference can steer the inquiry into a certain direction, obfuscate certain aspects by leaving them outside the scope of the inquiry and/or establish procedures the inquiry can use.³³ Setting the right terms of reference is, thus, a crucial endeavour. The terms of reference should not be so broad that the inquiry becomes overloaded and unable to report sufficiently swiftly. This is what happened with the Iraq inquiry. On the other hand, it can be problematic if the terms of reference are set so narrowly that issues at the heart of the problem cannot be investigated properly. We suggest the following terms of reference for both inquiries recommended here:

Table 2. Suggested terms of reference for the two inquiries

	KNOWLEDGE PRODUCTION AND LESSON-LEARNING (KNOWLEDGE BROKER-LED)	ACCOUNTABILITY AND PUBLIC TRUST (STATUTORY INQUIRY)
GUIDING PURPOSE	To determine which lessons the UK government and other relevant UK-based actors should learn to improve preparedness and crisis management for the next pandemic with unknown characteristics.	To investigate whether the UK government, through negligent or reckless actions or failures to act, before and during the crisis, caused the death of patients and key workers.
SPECIFIC QUESTIONS	To what extent and why were some countries better prepared than the UK to deal with new pandemics in terms of stockpiles, legislative frameworks, and healthcare systems?	To what extent were previous recommendations from pandemic planning exercises ignored? For what reason?

31 Sharon Begley, 'Three Potential Futures for Covid-19: Recurring Small Outbreaks, a Monster Wave, or a Persistent Crisis,' Statnews, [statnews.com/2020/05/01/three-potential-futures-for-covid-19](https://www.statnews.com/2020/05/01/three-potential-futures-for-covid-19).

32 National Audit Office, 'Investigation into Government-Funded Inquiries,' 9.

33 Resodiardjo, *Crises, Inquiries and the Politics of Blame*, 40.

	KNOWLEDGE PRODUCTION AND LESSON-LEARNING (KNOWLEDGE BROKER-LED)	ACCOUNTABILITY AND PUBLIC TRUST (STATUTORY INQUIRY)
	To what extent and why did some countries activate their containment measures much earlier than the UK? What can be learnt from this?	Did the government's understanding of the evolving threat of SARS-CoV2 align with the best scientific advice? Or was this motivated by other more problematic concerns?
	What could have been done to generate testing capability more quickly?	To what extent did the UK government ignore WHO and scientific advice on specific issues such as testing? For what reason?
	What kind of stockpile and production capability does the UK need to deal with the next infectious disease outbreak/ pandemic, which may differ from SARS-CoV-2?	To what extent did the UK ignore high quality warnings about shortages of PPE and the situation in care homes?
	What forms of regional (EU) and international co-operation are critical for the UK to participate in and contribute to in the future?	Were the UK government suppression measures rooted in evidence or rather caused by mimicking others in response to political pressure?
	Which measures of social-distancing should a government adopt in the future that are most effective, yet have the fewest economic and social side-effects?	Where scientific deliberations influenced or manipulated for political reasons and by inappropriate influence by political advisors?
	Was official expert advice provided to the government deficient when compared to the international state of the art? What can be done to improve the quality and timeliness of expert advice provided to the UK government?	Should experts have warned earlier and more forcefully given what they knew? For what reasons did they not do so?

3. Chairing the inquiry and panel composition

The composition of the inquiry panel or commission, and especially the chairing, matters greatly to the outcomes it generates. **Panel members need to be widely recognised as authoritative experts** in fields relevant to the inquiry. Moreover, they must be seen as reasonably open-minded, without an obvious axe to grind or party-political affiliation. The importance of a prerequisite equanimity applies to both statutory and knowledge-broker-led inquiry teams; however, it can be difficult to achieve, particularly on topics upon which a majority of experts may have previously published and offered commentary. The chairs, in contrast, need to have sufficient understanding of different disciplines, but do not necessarily need to be highly specialised subject experts themselves. What is needed are fox-like cognitive styles, ie people who have at least some insight from a range of different fields and who can balance conflicting views and evidence rather than those who know a lot about one specific area and have strong world views. It would be helpful for chairs, or co-chairs, to combine expertise in leading a multi-disciplinary team of researchers, dealing with different strongly-expressed views and being cognisant of the reception of inquiries in public. While a bipartisan approach is helpful, there is a risk of just balancing out political views by sending representatives from opposing camps, leading to internal panel polarisation and minority

opinions. As a safeguard against governments seeking to control outcomes in statutory inquiries through the appointment of specific panel members, it would be helpful **to delegate the appointment of panel members to an independent person or chairing judge, perhaps advised by an autonomous scientific body.** It is important to have sufficient expertise of policy-making and front-line implementation on board to ensure that policy recommendations are written in a way that makes them implementable.

Public Inquiries held under the Inquiries Act 2005 are usually chaired by a judge. 44 out of 68 inquiries between 1990-2017 have indeed been chaired by a Judge. There are many reasons why judges are regarded well suited to the role of chair, Judges have experience running hearings and thus understand legal and procedural complexity, they are trained investigators and, perhaps most important, are regarded as politically independent. However, there are certain advantages to conducting public inquiries in a format that is not circumscribed by the protocols of a court-case. If the chair is not a judge, his or her involvement with the process would not conclude with the 'verdict' of the report; appointees could also be made on the basis of their specialist knowledge as well as policy making skills which could prove critical to the implementation of recommendations.³⁴ Judges are also used to aim for a high burden of proof for criminal convictions and cognisant that charges against hearing all evidences and tight procedural rules can lead to judgement being squashed. As a result, Judge-led inquiries can be more cumbersome and drawn-out.

Panellists are optional, and they are appointed by the minister, who does not need consent from the chair. The chair of the inquiry has a huge impact on how the inquiry is conducted, both for a statutory inquiry and a knowledge-broker-led inquiry. They interpret the terms of reference, decide the focus of the inquiry, may choose more or less innovative procedures, decide which part of the inquiry will be public, how they interact with witnesses and what their distance is from crisis managers. This last trade-off is tricky since, on the one hand, a greater distance from decision-makers may increase legitimacy. On the other hand, a closer distance to crisis managers may mean the inquiry remains closer to the policy reality of the issue at hand, which may increase the likelihood that inquiry suggestions are adopted.³⁵ Chairs may promote inquiry tactics that enable a contribution to the public debate by properly engaging with the media. Such behaviour may make 'a line of thinking publicly acceptable and officially thinkable'³⁶ and increase the chances of inquiry success.³⁷

The appointment of the chair and an appropriate panel is equally crucial in knowledge-broker-led inquiries focused primarily on lesson-learning. Given the range of policy areas and communities affected by the pandemic, the commission should include a **sufficiently broad range of expertise.** It would be insufficient to have only virologists and epidemiologists involved given the front-line challenges in hospitals and care-homes, in logistics and planning.³⁸ Moreover, this crisis has revealed unexpected challenges of balancing harms and risks in different areas against each other. While most attention has been focused on the direct death toll of COVID-19, the government's response also created multifaceted, indirect and unintended harms to mental health, safeguarding of children and other vulnerable groups, educational attainment gaps, job losses and huge rise in public debt. Some of the early accounts of the decision-making raise the possibility that the kind of lockdown measures imposed in late March 2020 were examined too late, precisely because they were not considered a feasible option given the expected harm created by them.³⁹ We know from other disaster events, such as the Icelandic volcano eruption in 2010, that displacement risks are insufficiently considered up-front and thus create risks of both under

34 Norris and Shepherd, *How Public Inquiries Can Lead to Change*, 17-18.

35 Resodihardjo, *Crises, Inquiries and the Politics of Blame*, 40.

36 Stone, 'Success in Public Inquiries: An Analysis and a Case Study,' 248.

37 Resodihardjo, 'Wielding a Double-Edged Sword: The Use of Inquiries at Times of Crisis,' 204.

38 J. Chambers, K. Barker, and A. Rouse, 'Reflections on the UK's Approach to the 2009 Swine Flu Pandemic: Conflicts between National Government and the Local Management of the Public Health Response,' *Health & Place* 18, no. 4 (2012)

39 George Arbuthnott Jonathan Calvert, Jonathan Leake, Dipesh Gadhur, '22 Days of Dither and Delay on Coronavirus That Cost Thousands of British Lives,' *The Sunday Times*, 23 May 2020.

and over reaction.⁴⁰ Therefore, the commission will need to involve experts from different public areas who can engage in a dialogue over balancing judgments.

Similarly, the commission should include **expert members from other countries** which are currently perceived to be performing well in terms of the initial phase of the pandemic. On current data, countries such as Germany and Sweden have been able to suppress infection curves better than the UK, have a lower death toll and have been able to leave lock-down sooner than the UK or have never introduced blanket lockdown measures in the first place. It has been widely pointed out that countries in East Asia, such as South Korea, have been better prepared to deal with such viruses and acted earlier and more effectively through a combination of measures.⁴¹ It would therefore be important to involve international experts from these countries in the panel to help with drawing on or commissioning research that compares countries' performance and to advise on which capacities and strategies were most important as candidates for UK lesson-learning. We also recommend including **representatives of international health agencies** to widen the horizon further, integrate emerging international expert consensus, and examine particular challenges in how the UK relates to, acts within, and communicates with such agencies in the future.

To ensure that the policy recommendations of the inquiry are actually considered helpful by frontline workers, the inquiry should **include practitioners**, scientific communities, frontline workers (in this case, doctors, nurses, those working in acquisition, administrators and managers of public health services) and non-partisan policy implementation actors during the knowledge production process, which could contribute to implementation success. **Members of the public** – including the family of victims, participants in research, but also people selected at random from the population should also be considered. This diverse and broad-base inclusion will enhance the understanding of the inquiry of the concerns, capacities and restrictions for those implementing the recommendations. This could be done through the organization of focus groups focused on the policy fit of preliminary recommendations or citizen juries to adjudicate and feedback those policies. The inclusion of expertise from the front-line also ensures that the recommendations are formulated and framed in a way that can be consumed and digested by implementors.⁴²

Deciding on timing

The chair of the Bloody Sunday Inquiry, Lord Saville, was asked whether there were any lessons to be learned for future inquiries. Although he doubted that 'another Bloody Sunday Inquiry' would be less costly, he stated that 'the secret to getting it as cheap and quick as it is possible to do is forward planning: get your team in place, get it organised, organise your IT, where the inquiry is going to be held, who is going to get hold of the witnesses, who is going to interview the witnesses, in what manner, what questions are going to be put, who should be represented by lawyers and so on. Get all that out of the way at the beginning and you are likely to speed things up substantially'.

These lessons go somewhat against the previously held government (and opposition) position that now is not the time for an inquiry, as the focus should be on steering the country through a crisis. The ground needs to be prepared in time and preparations of an inquiry could and should take place in parallel to crisis management. Evidence needs to be preserved, and time is, therefore, of the essence. Moreover, and as mentioned previously, the current crisis may last for a long time and the sooner lessons are identified, the better.

We suggest that **the knowledge-broker-led inquiry should issue its interim findings after a year, followed by full findings within 18 months. The statutory inquiry focused on accountability and public trust issues should issue an interim report within two years and a final report within three years, ie at least a year before the next general election.**

40 Christoph O. Meyer, 'Over- and under-Reaction to Transboundary Threats: Two Sides of a Misprinted Coin?', *Journal of European Public Policy* 23, no. 5 (2016).

41 Pacheco Pardo, R., et al. (2020). *Preventing the Next Pandemic: Lessons from East Asia*, King's College London.

42 Stark, *Public Inquiries, Policy Learning, and the Threat of Future Crises*, 10; Dominic Elliott, 'The Failure of Organizational Learning from Crisis – a Matter of Life and Death?', *Journal of Contingencies and Crisis Management* 17, no. 3 (2009).

Resources

Two ways in which inquiries can be hampered is if they are given insufficient resources to get to the bottom of issues or if they lack the necessary expertise. The Denning inquiry in the UK was led by a single person with some secretarial assistance.⁴³ Being starved of necessary resources, especially research staff, is a way for government to limit the potential political damage, but can also be caused inadvertently by under-estimating the task at hand. Whether or not resources are sufficient depends of course on how wide the terms of references are, how quickly results need to be produced, but also the type of inquiry. Judged inquiries and fully public inquiry tend to take longer and cost more.

'If you are going to have a thorough, proper, fair inquiry [...] it is going to cost, necessarily, a large sum of money and take a very long time, simply because, if you are going to do it properly and fairly, you have to look in the greatest possible detail at the evidence and other materials that are available on which you are going to form a view. That is the starting point. If you try to do an inquiry on the cheap or you try to do it quickly, you come seriously unstuck. Lord Widgery was asked to do an inquiry quickly and, if I may say so, boy did he come unstuck.' (Lord Saville, chair of the Bloody Sunday Inquiry)

Public inquiries need to strike a difficult balance between being thorough on the one hand in order to make sure the right lessons are learned, and being able to provide relatively rapid results on the other. Not least because public inquiries tend to be both time-consuming and expensive. In the UK, the frequency of public inquiries has increased and spending on them was £638.9 million between 1990 and 2017.⁴⁴ For the Bloody Sunday Inquiry, which took 12 years to complete, expenditure was £191.5 million⁴⁵, for a large part due to costs of legal representation. It has been criticized for both its length and cost. The Leveson Inquiry took a little over a year, with 97 hearing days, and cost about £5.4 million. The Chilcot Inquiry on Iraq cost £13 million and took more than seven years to report.⁴⁶ It finished on 6 July 2016 after it was constituted in 2009 and open sessions with hearings of witnesses concluded in February 2011. The inquiry had to reconstruct eight years of material and do so meticulously, striking a difficult balance between meeting the need for public accountability by being thorough on the one hand, and speedy results for the families of the bereaved in the other. Families of soldiers killed in the Iraq War threatened to take legal action over the report delays, which, according to Sir John Chilcot, were due to the 'Maxwellisation process' where individuals criticised in the proceedings are given the opportunity to respond, but which were similarly due to the broad terms of reference.⁴⁷ Based on nine inquiries held between 2002 and 2012⁴⁸, the average cost per year is £4.73 million.

Completing inquiries in a timely fashion substantially increases the likelihood of recommendations being fully implemented and public trust restored. We argue that public inquiries should take no longer than two years from the moment they are agreed and should issue interim reports before final reports. There should be at least a year left in the electoral term of the government to allow for changes to be made and government to be held accountable. To ensure a smooth and effective process, avoiding unnecessary costs and timely completion, the lesson-learning inquiry we propose requires professional project-management to avoid unnecessary delays across the different stages of the inquiry process. The inquiry needs to be sufficiently well-resourced in terms of research and support staff.

43 Phythian, 'The Politics of Commissions of Inquiry into Security and Intelligence Controversies in Britain,' 57-58.

44 Norris and Shephard, *How Public Inquiries Can Lead to Change*, 3.

45 House of Commons, 'Daily Hansard – Written Answers, Public Inquiries,' publications.parliament.uk/pa/cm201213/cmhansrd/cm121102/text/121102w0002.htm#121102w0002.htm_spnew17.

46 The Iraq Inquiry, 'Inquiry Costs,' webarchive.nationalarchives.gov.uk/20171123124056/iraqinquiry.org.uk/the-inquiry/inquiry-costs; The Leveson Inquiry, 'Inquiry Costs,' webarchive.nationalarchives.gov.uk/20140122144920/levesoninquiry.org.uk/about/inquiry-costs.

47 BBC News, 'Sir John Chilcot Facing Legal Action over Report Delays,' bbc.com/news/uk-politics-34072126.

48 Bloody Sunday, Shipman Inquiry, Dr David Kelly Inquiry, Soham Murders, Mubarek Inquiry, Billy Wright Inquiry, Rosemary Nelson Inquiry, ICL Inquiry, Baha Mousa Inquiry.

3 Running the inquiry: evidence gathering, public engagement and analysis

Once the key decisions are taken as discussed above, the next phase is about making the inquiry fully operational and launching it. Although the advice in the following applies to both the inquiries we suggest, our focus is on the running of the initial, knowledge-brokered inquiry focused on lesson-learning. **Good planning at the outset is crucial** to the effective running of the inquiry, making sure that existing resources are sufficient to the tasks and that discussion papers, interim reports and main reports can be communicated in a timely manner. Avoiding delays and sticking to the timetable is vital to minimise the risk of losing public support and interest and ensuring that recommendations are implemented, ideally by those who were in power at the time of the crisis and established the inquiry. Since the COVID-19 crisis is multi-faceted and wide-ranging and international in nature, it will be important to break up over-arching questions into manageable work-streams, leading to distinctive activities and outputs. One option would be to separate questions of preparedness from questions of crisis recognition and management, or to focus on discrete and specific questions. Appointing one or more experienced project managers will be important to keep this work on track. Beyond developing realistic project planning and putting the capacities in place to monitor and implement it, one can distinguish three partly-overlapping phases: evidence gathering, public engagement and analysis, including the writing of discussion papers and reports.

In the evidence-gathering phase, desk research on open sources, including media investigation, is the first step towards building a reliable and sufficient evidence base. This also helps to build up a list of witnesses to be interviewed. However, one must avoid biases creeping in at the evidence collection phase as that can strongly affect the resulting analysis and recommendations. It is important to ascertain a broad and accurate sense of expert and grassroot-practitioners opinion as it evolved before and during the pandemic and its consequences. Those most frequently cited sources in the media may not be representative of the state of the art within a given field. In fact, there is research to suggest that the most media-visible experts are more likely to be wrong in their judgements.⁴⁹

Conversely, one needs to resist searching only for those whose assessment, warnings and opinions turned out to be right in retrospect because they may be innately sceptical rather than being better analysts. This applies not just to individual experts, but can also apply to research groups, agencies, civil society actors and international organisations. Without mapping and understanding expert views as well as their credibility, one can easily underplay the diagnostic difficulties to recognise problems accurately and early. The inquiry would need to look at not just who sat on key scientific committees advising the government, but also whether and to what extent important experts or areas of expertise were not represented. To avoid hindsight biases and the misleading judgements flowing from them, the evidence gathering process should consciously look for countervailing views, spotlight significant debates among experts about the quality of evidence and its interpretation, and highlight key uncertainties as they evolved over time. Counterfactual reasoning can help to explore whether acting earlier or more decisively would have been politically feasible and to explore the consequences.

In contrast to inquiries into major foreign policy failures or indeed for highly politicised issues such as Brexit, it should not be too difficult to access relevant scientific advice on the pandemic usually classified as 'official'.⁵⁰ Many of the papers produced by the government's scientific advisory committee have already been published. However, some sections of these documents were initially redacted and only made public again after criticism. The

49 Philip E. Tetlock, *Expert Political Judgement: How Good Is It? How Can We Know?* (Princeton, NJ: Princeton University Press, 2005).

50 A good indication of what is possible on already published material is Freedman, 'Strategy for a Pandemic: The UK and Covid-19.'

Government has published minutes from the Scientific Advisory Group for Emergencies (SAGE) meetings 1 to 34, up until 7 May. Additionally, a number of additional pieces of evidence have been published on 29 May 2020 which detail how SAGE decision-making takes place. In total, this amounts to over 100 papers.⁵¹ The membership of key committees such as SAGE has equally been published as a result of media pressure and following advocacy from experts on the committee. A representative cross-section of these experts could then be invited to testify through either public or, when requested, closed hearings. So even for a non-statutory, privately-run inquiry it should be possible to get a fair picture of how international and national expert opinion across disciplinary areas evolved before and during the pandemic.

For questions about political accountability, which is mainly applicable for the statutory inquiry rather than for the suggested knowledge-broker-led inquiry, it can be difficult to obtain evidence from within the government machinery such as minutes from the meetings of the cabinet or the emergency committee COBRA. Furthermore, there may be useful evidence relating to messages sent via mobile phones and those received from outside the UK, including transcripts of phone calls of government ministers with senior officials or politicians from other countries or relevant international organisations such as the WHO. While statutory powers under the Inquiries Act 2005 can help for commissions to get access to such material, we argue that public pressure is a better means to get the release of documents that the government or the civil service feels is controversial, sensitive or might undermine its position. In times of high sensitivity or political disagreement, there is a tendency to obfuscate and leave vague issues in written communication and the difficult conversations happen face-to-face and are not recorded or only in a rather abbreviated form. For this reason **witness testimony is absolutely crucial for inquiries focused on questions of performance and accountability.**

Witness testimony could also be an important part of a knowledge-led inquiry provided the line of questioning is probing, but not designed to catch someone out for individual failings or score party-political points. Public hearings of experts, practitioners, officials and ministers are not just crucial for evidence gathering, but also for keeping media and public interest in the problem, the inquiry and its outcome alive. Public hearings can help to build public and political support for solving problems even before the inquiry reports. The downside risk is that media reporting of such hearings may be highly selective and itself subject to politicisation pressures and spinning, so that conclusions are drawn that fit pre-existing views and inclinations about who is to be blamed. This is arguably what has happened in the case of the Chilcot Inquiry on Iraq and, to a lesser extent, with the Leveson-Inquiry into phone hacking. This strengthens our case for two separate inquiries – one more devoted to lesson-learning and with witnesses being primarily national and international experts, practitioners from outside of government and citizens being affected in various ways by the crisis. Trying to keep the lesson-learning inquiry as depoliticised and removed from the performance of individuals as possible could help to ensure broader and bipartisan support for the emerging recommendations on what to change.

Earlier, we raised the potential dangers of politicising a public inquiry focused on lesson-learning by involving the media and the public throughout the entire process. On the other hand, and somewhat counterintuitively, an approach to depoliticizing the proceedings may be to directly engage certain members of the public with the sole objective of achieving lesson-learning and enabling recommendations of the inquiry to generate policy change. Such engagement can take the form of providing testimony—the Pennington inquiries, for instance, into E.Coli outbreaks in Scotland (1996) and South Wales (2005), highlighted the critical role of the participation of victims in creating public awareness for food safety. Building lay experience and account of the crisis proceedings to some extent helped to orient the media narrative, mitigate speculative fears and enable collective closure.⁵²

51 Government Office for Science and Scientific Advisory Group for Emergencies, 'Government Publishes Sage Minutes,' gov.uk/government/news/government-publishes-sage-minutes.

52 Pennington TH. The role of the media in public health crises: perspectives from the UK and Europe. In: Bennett P, Calman K, Curtis S, Fischbacher-Smith D, editors. Risk Communication and Public Health. 2nd ed. Oxford: Oxford University Press; 2010. pp. 81–96.

Beyond its cathartic effects, the transparent involvement of members of the public in the proceedings is arguably crucial when there is significant degree of uncertainty around the evidence being brought to bear. The strategy of participatory justice, for example, can serve to restore public confidence in a governmental system by which they have either felt excluded or underserved. While we would not suggest an extensive form of community mediation, **the premise of involving community members in the judicial process could be key both to ensure acceptance of the inquiry's outcomes and creating the contexts for public engagement any future preparedness efforts and pandemic responses.** One could imagine, for instance, a series of citizen-juries, facilitated workshops or deliberative focus groups run in advance or in parallel of the proceedings focusing on the key set of consequences of the response or the relative value of mitigating effects going forward. These participatory approaches have been critically important to adjudicate the value of introducing new technologies such as genetically modified organisms or forecast the potential concerns, social and ethical implications novel climate change measures may entail. What is key about these measures is that representatives of the public are not merely informed about an issue but rather creating a dialogue between citizens and policy makers, to collaboratively consider the facts and debate the value of particular outcomes.⁵³

Any inquiry into COVID-19 would be well-served not just by looking at past document and hearing witnesses, but also by drawing on and commissioning research into the specific questions. There is currently an unprecedented amount of research happening world-wide in relation to the virus, treatments and vaccines, but also into questions of public health and government responses. UKRI, the EU, and many private funders have launched rapid response funding schemes or allowed existing grant-holders to repurpose and shift research into COVID-19 and its consequences. **The inquiry should consider commissioning research particularly around issues of identifying lessons the UK could learn** and developing suitable benchmarks and strategies for comparing the performance of countries across the world. This will be essential for the analysis phase of the inquiry. We know that countries in the developed world have adopted different strategies at different points of time for dealing with the virus, which can give clues as to which one has worked best and might be replicated. **There is, for instance, good reason to look at countries more closely, particularly in East Asia, that were able to keep infection and death rates low** and did so through strategies that mitigated collateral damage to mental health, social cohesion and economic activity. Were the differences in outcomes the results of better preparedness, better early recognition or better choices in the crisis management? **Comparisons with well-performing countries are important for identifying lessons that the UK could learn from these countries.** At the same time, the inquiry will need to resist naïve lesson-picking as some lessons could not be easily transferred or would not work because of more structural differences between countries, for instance, the degree of international travel connections and mobility, population density, household size and composition, climate and culture, or overall funding levels of health and social care systems.

Comparisons with other countries can also help to address questions about performance of experts, political actors and institutions for the knowledge-led inquiry. How can we explain that some countries in East Asia responded more effectively in the early stages of the pandemic, at times being sceptical of reports on the outbreak in China and the WHO response? Why did some countries act before the WHO called it a pandemic? Did the UK adopt its lock-down measures at a similar point to other countries in relation to respective infection curves and death-rates or significantly later? Was the expert advice given to UK decision-makers in any way inferior or superior to comparable advice provided to government elsewhere in Europe or indeed world-wide? Or were decision-makers less receptive to it or acted late? If so, what might be causes for these observed differences since errors can be made on the basis of the best available yet still uncertain evidence at the time, or for problematic reasons. To what extent are any shortcoming the result of systemic or

53 Tavella, Elena. 'How to make Participatory Technology Assessment in agriculture more 'participatory': The case of genetically modified plants.' *Technological Forecasting and Social Change* 103 (2016): 119-126.; Lezaun, Javier, and Linda Soneryd. 'Consulting citizens: technologies of elicitation and the mobility of publics.' *Public understanding of science* 16.3 (2007): 279-297; Degeling, Chris, Stacy M. Carter, and Lucie Rychetnik. 'Which public and why deliberate? A scoping review of public deliberation in public health and health policy research.' *Social Science & Medicine* 131 (2015): 114-121.

organisational problems, rather than due to a senior leaders' temperament, cognitive and leadership styles, political ideology and beliefs or other overriding political agendas and distractions at the time? Are countries headed by certain type of leaders more likely to do well?⁵⁴

When disaster strikes and people suffer, there is a widely recognised tendency to find not just a cause, but also a reason or motivation for why this has happened. A key question is whether and to what extent a disaster seemed preventable. Even in the case of viruses that naturally evolve and mutate, there is a tendency to look for human agency at least as a contributing factor to explain why the spread of the virus was not contained early or slowed down more. A more internationally-focused inquiry would look at the role of the destruction of wildlife habits played, the role of wet markets and hygiene standards, and of course, the role Chinese officials at local and national level played in December 2019/January 2020 in suppressing virus-related information. When approaching these questions, any kind of inquiry should be aware of and guard against strong pressures and biases towards blame. We know from other disasters about the existence of a strong psychological and social impetus to attribute personal and political blame for undesirable events. A common misconception in the aftermath of disaster is that the magnitude of the harm is directly proportional to the degree of culpability. However, we know from research that big disasters are not necessarily caused by big mistakes, but are more often the result of more diffused chains of errors build into systems, procedures and cultures.⁵⁵ Indeed, where discrete errors in judgement occur, these faults tend to be down to a lack of sufficient training, time or resources to do their jobs properly. This is why we propose to separate a statutory inquiry that focuses on (personal) accountability and wrong-doing from an inquiry focused on lesson-identifying and learning.

If a second, statutory public inquiry focused on questions of accountability set out to establish whether and to what degree individual officials could be criticised, it matters greatly why experts or decision-makers acted the way they did. Were any errors made, honest mistakes made by officials working to the best of their ability and given the training, resources and support at their disposal? Or are individual office holders guilty of negligence or even wrongdoing as they had the knowledge or intent to cause harm through their actions or inaction, which may constitute a crime. For instance, rejecting, suppressing or lying about good-quality evidence and advice in favour of picking lower-quality advice and experts just because they better supported their ministers' personal views or policy preferences; failing to consult with or listen to responsible officials and ministers to avoid hassle and criticism; not being sufficiently hard-working and being distracted from their job by personal concerns; understanding and accepting that people would come to harm due to inaction, but prioritising instead short-term electoral concerns or those of a much smaller group of people or interests; generally failing to live-up to basic requirements or standards of holding high public office, including laws and policies in place.

In the aftermath of a crisis during which there were many casualties, the calls for understanding what happened, whether it was foreseeable and, most importantly, who was responsible, abound. A problem is that sometimes, such calls are met by hasty commentary in the media, which usually displays a high degree of hindsight bias. Such analyses tend to be, to paraphrase the German philosopher Schlegel, prophecies looking backwards. For both a knowledge-broker-led inquiry and a statutory inquiry, **it is important to contextualize the performance of analysts and decision-makers, since there may be important mitigating factors that impacted their ability to anticipate and manage the crisis.**

54 An argument has been made that many of the better performing countries were headed by female heads of government, eg Anne-Marie Croteau Louise Champoux-Paillé, 'Why Women Leaders Are Excelling During the Coronavirus Pandemic,' *The Conversation*, theconversation.com/why-women-leaders-are-excelling-during-the-coronavirus-pandemic-138098; Amanda Taub, 'Why Are Women-Led Nations Doing Better with Covid-19?' *The New York Times*, [nytimes.com/2020/05/15/world/coronavirus-women-leaders.html](https://www.nytimes.com/2020/05/15/world/coronavirus-women-leaders.html).

55 Charles Perrow, *The Next Catastrophe: Reducing Our Vulnerabilities to Natural, Industrial, and Terrorist Disasters* (Princeton, NJ: Princeton University Press, 2007); *Normal Accidents: Living with High-Risk Technologies* (Princeton, NY: Princeton University Press, 1999); Bazerman and Watkins, *Predictable Surprises: The Disasters You Should Have Seen Coming, and How to Prevent Them*.

The three most important mitigating factors are the diagnostic difficulty each crisis poses, the state's capacity to anticipate based on expert consensus and the influence of the political environment prevailing at the time.⁵⁶ With regard to the first, diagnostic difficulty, the inquiry needs to examine where the COVID-19 crisis sits on the scale of events to reasonably expect on one side, and the bolts from the blue on the other. For example, while the emergence of a zoonotic disease could reasonably have been expected, to what extent could a zoonotic infectious disease of this kind, which is highly transmissible, not in the least due the high number of asymptomatic patients, have been expected? There have been media articles lamenting the 'wet markets' in China where the virus would have originated.⁵⁷ But accurately forecasting which zoonotic diseases would emerge and with what potential impact could be very resource-intensive and affected by a high degree of uncertainty as the PREDICT project, which aims to identify emerging pandemic threats, shows.⁵⁸ Moreover, the inquiry needs to consider the speed of the spread of the disease, as well as with the great difficulties governments worldwide had (and still have) when it comes to obtaining important information about this very novel disease. Especially in the beginning, there was only limited information coming from China with regards to the spread and lethality of the disease. And very important questions with regards to how easily the virus spread among children or on whether it was airborne remained unanswered. Mark Rutte, the Dutch Prime Minister, said in early March: 'we need to make 100 per cent of the decisions, with only 50 per cent knowledge, and carry the consequences'.

The problem is not just that there is insufficient knowledge, but equally that **there is much conflicting advice from experts**. On the issue of whether children may transmit the disease, for example, experts are very divided.⁵⁹ The inquiry should therefore equally examine the extent to which there was a workable consensus among experts, and what the information-base was for decision-makers. Again, considering the high likelihood of experts disagreeing on the interpretation of evidence, the engagement of public will serve to anchor debates around the appropriateness of policy-choices in the set of lived experiences of those who were subject to them. It can take the form of accounts of personal experience or through more formal deliberative processes, such as citizen juries or focus-group. This form of active engagement can ensure that future learning is more closely aligned with public values and help to restore faith in the authority of scientific and government actors.⁶⁰

A final mitigating factor to be considered in any inquiry evaluating the performance of decision makers should be the extent to which the prevailing political environment was helping or hindering.⁶¹ There has been speculation about the impact of Brexit on the UK's coronavirus response.⁶² On the other hand, however, the UK government's intensive involvement in the handling of Brexit would not have been considered conspicuous or potentially dangerous should the current pandemic not have come to pass. One can imagine what would have happened if the government had been focusing its attention on the coronavirus crisis instead of Brexit negotiations, in a scenario in which the virus threat would have waned after having been contained in China. In such a case, there would likely be criticism stating the government was distracted by the coronavirus and insufficiently paid attention to the issues surrounding Brexit. In short, whilst hindsight bias needs to be avoided, the inquiry should investigate whether resources had been ringfenced in the event of an unexpected domestic or international crisis, and whether this was sufficient.

56 Nikki Ikani, Aviva Guttman, and Christoph O. Meyer, 'An Analytical Framework for Postmortems of European Foreign Policy: Should Decision-Makers Have Been Surprised?', *Intelligence and National Security* (2020)

57 Peter Engelke Barry Pavel, 'Irresponsible Wet Market Practices Led to Covid-19. China Hasn't Learned Its Lesson,' Euronews, [euronews.com/2020/04/30/irresponsible-wet-market-practices-led-to-covid-19-china-hasn-t-learned-its-lesson-view](https://www.euronews.com/2020/04/30/irresponsible-wet-market-practices-led-to-covid-19-china-hasn-t-learned-its-lesson-view).

58 'Predict,' UC Davis, ohi.vetmed.ucdavis.edu/programs-projects/predict-project.

59 Smriti Mallapaty, 'How Do Children Spread the Coronavirus? The Science Still Isn't Clear,' *Nature*, 7 May 2020.

60 ESRC, 'Citizen's Jury,' esrc.ukri.org/public-engagement/public-engagement-guidance/guide-to-public-engagement/choosing-your-activities/citizens-jury.

61 Ikani, Guttman, and Meyer, 'An Analytical Framework for Postmortems of European Foreign Policy: Should Decision-Makers Have Been Surprised?'

62 'The Guardian View on Brexit Trade Talks: Folly and Distraction,' *The Guardian*, 20 April 2020.

4 Lesson identifying, learning, and remembering

There is a tendency to conflate the distinct challenges of identifying and learning lessons. Identifying lessons usually comes in the form of explicit recommendations. Ideally, these recommendations are based on a sound analysis of what the main individual, operational, organisational and systemic causes of performance problems were as discussed in the previous section. The key risk is that the lessons identified by the inquiry as important to learn, are actually ‘shelved’, not taken to the implementation stage, or if they are implemented for a while, become easily diluted and forgotten. To prevent this, the inquiry needs to take the challenge of formulating recommendations seriously.

Stark argues that recommendations get shelved when they do not fit the policy reality on the ground, when big picture policy changes need to be further refined to be practically implemented, or when they arrive at the ‘street level’ without local delivery capacity being considered.⁶³ Based on the extant research, **an important success factor for inquiries is that their recommendations be feasible**. Recommendations stand a lower chance of success when they are politically, technically or budgetarily unfeasible.⁶⁴ A key question is whether the concerns, resources, capacities and politics at the street level are adequately taken into account.⁶⁵ Although the inquiry needs to be able to address the root causes of the problems and should not shun proposing systemic and sometimes costly policy revisions, it should also avoid only proposing policy recommendations that are not feasible in terms of the budget. After the 2007 flood in the UK, an important recommendation of the Pitt Inquiry concerned the use of a specific drainage technology to decrease the occurrence of such floods. Since such drainages are not very cost efficient, many local authorities have neglected to install them. According to Stark’s interviewees, this was cited as an important lesson-learning failure in this inquiry that could lead to the repetition of the same mistakes in the future.⁶⁶

Equally important is the practical feasibility: Do front-line workers consider the recommendation actually helpful? To ensure such a policy fit, **the inquiry should include practitioners, scientific communities, frontline workers (in this case, doctors, nurses, those working in acquisition, administrators and managers of public health services) and non-partisan policy implementation actors** during the knowledge- production process, which could contribute to implementation success.

It helps if the produced inquiry **recommendations are specific**, as this would mean recommendations would not need extensive policy refinement and triaging after the inquiry is over, thus speeding up implementation, and it would also enable the testing of policy fitness during the inquiry process. Recent comparative research on inquiries has found that they are most effective at producing instrumental learning – developing specific policy tools – than at enhancing pre-crisis policy systems/producing major policy change.⁶⁷ Furthermore, the recommendations should avoid staying at the abstract level of recommending cultural and organisational change, as such change is very difficult and will not happen just because it is written in a public inquiry report.⁶⁸ This does not mean the recommendations cannot include systemic changes which include major financial expenditures and institutional expansion. Indeed, successful inquiries offer both technical and systemic recommendations.⁶⁹

The challenges of the implementation stage after the final or main report have been in that issues tend to receive even less attention by observers even though poor follow-up might render years of hard work void of impact. Like a screenplay that needs to be brought alive by actors and directors interpreting the words in the script, inquiry reports need

63 Stark, ‘Left on the Shelf: Explaining the Failure of Public Inquiry Recommendations.’

64 Resodihardjo, ‘Wielding a Double-Edged Sword: The Use of Inquiries at Times of Crisis.’; *Crises, Inquiries and the Politics of Blame*.

65 *Public Inquiries, Policy Learning, and the Threat of Future Crises*, 12.

66 Stark, ‘Left on the Shelf: Explaining the Failure of Public Inquiry Recommendations,’ 12.

67 *Public Inquiries, Policy Learning, and the Threat of Future Crises*, 10.

68 K. Walshe, ‘The Use and Impact of Inquiries in the Nhs,’ *BMJ* 325, no. 7369 (2002).

69 Stutz, ‘What Gets Done and Why: Implementing the Recommendations of Public Inquiries.’

policy officials to find the lessons across the report findings, to interpret, implement and internalise them – when they are relevant and within their policy remit – in their own organisation. This is not always easy. The Health Foundation found that only 44 of the 290 recommendations from the Mid Staffordshire Inquiry ‘are solely within the remit of NHS organisations to do something about, and only an additional seven can be addressed by staff at the front line’.⁷⁰

A particularly illustrative case of the implementation challenge is the Iraq Inquiry published in July 2016. In terms of length, it is comparable to Marcel Proust’s magnum opus *A la recherche du temps perdu*. Newspapers had to call in help from the greater public to find answers to basic questions amidst the voluminous material, such as whether the invasion increased the risks of terrorist attacks on UK soil.⁷¹ At the Ministry of Defence, it took 20 people around 10 days to read the 2.6 million words spread over 12 volumes. Their goal was to subsequently decide on its key messages. It had appointed a ‘Chilcot Director’, Roger Hutton, to lead this process. The team conducted interviews, ran workshops, held town hall meetings and went as far as analysing comment threads under Roger Hutton’s blog posts to track views on implementation.⁷² It was all intended to make sure that the lessons identified by the Iraq Inquiry, which due to the unique subject matter at hand were less tangible than some inquiry reports are, would live on in the department. The Foreign Office conducted a similar exercise responding to the report and, in the wake of the Iraq Inquiry, parliament asked the Public Administration and Constitutional Affairs Committee (PACAC) to investigate lessons to be learned from the shortcomings of the Iraq Inquiry process and lessons for the machinery of government.⁷³ The government has, through the National Security Advisor, equally engaged in a ‘lessons learned investigation’ across Whitehall, based on the report. It is perhaps ironic that the output of a report that intended to learn lessons from decisions made by the government, requires such enormous effort to distil those very lessons. The Iraq Inquiry may be a difficult example in this respect, since questions of accountability and closure of the historical record played a very important role in the inquiry process.

The effort put in the identification of lessons does show that, after the painstaking and time-consuming work of setting up and running the inquiry is done, and sometimes years have passed, **the implementation and follow-up stage** is only about to begin. After digesting the inquiry report and identifying its key messages and lessons, officials often need to work out abstract or high-level recommendations during policy refinement stages, moving from meta-level observations to concrete policy actions.⁷⁴ These policy refinement stages may lead to significant problems in the implementation, showed in previous case study research. In Australia, writes Stark, a recommendation regarding the process of post-earthquake building inspections was deemed too impractical by practitioners and therefore were not implemented. More strikingly, he writes that the Canadian SARS inquiry was followed up by a special committee for policy refinement, which in the process ended up going against recommendations. Especially when reforms are politically tricky or involve big expenditure, a ‘subsequent round of policy analysis awaits these lessons, conducted via reviews, taskforces and ‘mini-inquiries’ which will map out blueprints for implementation, take decisions about the viability of policy pathways or even re-evaluate the merit of an inquiry’s recommendation in greater depth’.⁷⁵ A policy refinement period is unavoidable and even desirable, as organisations and specific departments need to make sense of the most relevant lessons for their organisation. As discussed in the previous section, problems like those which occurred in the Canadian SARS inquiry, where refinement led to policies that went

70 John Illingworth, ‘Francis: A Year On,’ The Health Foundation, health.org.uk/blogs/francis-a-year-on.

71 ‘Help Us Report on the 2.6m Word Chilcot Report,’ The Guardian, theguardian.com/uk-news/2016/jul/06/we-need-your-help-reporting-on-chilcot.

72 Tamsin Rutter, ‘Chilcot Rocket Fuel’: How Government Implemented Iraq Inquiry Recommendations,’ *Civil Service World*, 14 September 2018 2018.

73 Public Administration and Constitutional Affairs Committee, ‘Lessons Still to Be Learned from the Chilcot Inquiry. Tenth Report of Session 2016–17,’ (2017), 5.

74 Stark, ‘Left on the Shelf: Explaining the Failure of Public Inquiry Recommendations.’

75 *Ibid.*, 6.

against original recommendations, could be mitigated when the inquiry recommendations are specific and not too abstract.

To improve the accountability of those responsible for interpreting and subsequently implementing inquiry recommendations, the suggestions made by the House of Lords in 2014 are reiterated here. They argued, thus far fruitlessly, for public bodies to have a statutory duty to stay within a specified time whether they accept the inquiry's recommendations and, if so, what plans they have for implementing them; and to publish their policy refinement plans or response within three months after the publication of the inquiry report.⁷⁶

There currently is no central repository for inquiry recommendations, nor is there a central governmental responsibility to track whether they have been implemented or have had an impact.⁷⁷ There equally is no formal procedure holding the UK government to account regarding the implementation of the recommendations made in inquiries. Of the 68 inquiries that have taken place between 1990-2017, only six have received a full follow-up by a select committee to ensure that government has acted. 'Given the seriousness of the subjects being addressed by inquiries and the huge sums of public money invested in them, the inadequacy of monitoring and accountability mechanisms in the aftermath of inquiries is striking and a cause for concern', it has been argued.⁷⁸ The National Audit Office (NAO) has repeated this call for greater oversight of the recommendations of public inquiries, as based on its research of 2018, it lamented the fact that there was no oversight across government for monitoring or tracking whether inquiries achieved their intended impact, or whether recommendations have been implemented. The NAO examined 10 inquiries, of which eight provided a total of 620 recommendations, among them the Mid Staffordshire Inquiry into NHS care failings. It found that such information of progress was only available in half of those cases. In the other four inquiries, parliament had received update from ministers, but without specific details as to actions taken or recommendations implemented.⁷⁹ Moreover, the NAO estimates that of the 620 recommendations, 45 per cent were accepted by government, a further 33 per cent were 'accepted in principle', 'partially accepted' and 'subject to wider reform', seven per cent were explicitly rejected, and no clear response was given to the remaining 15 per cent.⁸⁰

It is important that the inquiry report becomes part of organisational planning, and that regular reviews of the recommendations take place. These reviews should involve the original inquiry panel. It has, therefore, been recommended that the Cabinet Office tasks a **new unit with developing legislation and policies recommended by inquiries**. This unit should act as a 'lesson repository' for inquiries, to ensure or co-ordinate oversight and implementation, but equally to 'champion the cause' of the inquiry recommendations within government. The House of Lords made some practical recommendations in this respect, suggesting this unit would be responsible for all of the practical details of setting up an inquiry including, but not limited to, assistance with premises, infrastructure, IT procurement and staffing. They equally stated this unit should ensure that on the conclusion of an inquiry, the secretary delivers a lessons-learned paper from which best practice can be distilled and continuously updated.⁸¹ The government has hitherto stated it does not deem such a standing unit to be necessary given the infrequency and duration of the inquiries.⁸² Therefore, thus far, such efforts have taken place in an ad hoc fashion.⁸³ It is, however, reiterated here that such implementation reviews should be executed by a lasting and well-resourced permanent unit, whose reporting is publicly accessible and can be scrutinised by parliament. Others

76 House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: Post-Legislative Scrutiny. Report of Session 2013-14,' 85.

77 National Audit Office, 'Investigation into Government-Funded Inquiries,' 31.

78 Norris and Shephard, *How Public Inquiries Can Lead to Change*, 4, 26.

79 BBC News, 'Call for Greater Oversight of Recommendations of Public Inquiries,' bbc.com/news/uk-politics-44215981.

80 National Audit Office, 'Investigation into Government-Funded Inquiries,' 10.

81 House of Lords Select Committee on the Inquiries Act 2005, 'The Inquiries Act 2005: Post-Legislative Scrutiny. Report of Session 2013-14,' 56.

82 National Audit Office, 'Investigation into Government-Funded Inquiries,' 26.

83 'Government Response to Lessons Still to Be Learned from the Chilcot Inquiry. Tenth Report of Session 2016-17,' (2018).

have argued that such a proposed unit should be scrutinised by PACAC or a standing parliamentary select committee.⁸⁴ This select committee should hear from the inquiry chair about how successful the government has been at the implementation stage.⁸⁵ Equally important is to hold regular reviews with those responsible for policy refinement.

Relatedly, there should be **regular reviews of the implementation of the inquiry** recommendations involving the original panel at regular intervals. **The initial review should take place six months after the report is published** and would predominantly concern the progress made in the policy refinement stage. Subsequently, **the inquiry panel should be heard at 12-month intervals to discuss the implementation of the suggested recommendations.** It has been argued that the inquiry chair or co-chair should be called before the PACAC or alternative select committee to give evidence on their personal view as to whether the government has been successful at implementing the inquiry recommendations. Not just because ‘potential for embarrassment may, at the very least, spur the government into explaining why it dissents from the view of an inquiry’, but preferably because it would be another incentive for the government to implement the inquiry recommendations.⁸⁶ Moreover, the inquiry chair – who has already tied their name to the inquiry – could play an important role in championing the report after the inquiry is over.

In the NAO investigation into public inquiries, a successful implementation trajectory can be found which took place after the Mid Staffordshire Inquiry. The Department of Health and Social Care managed the response to the 290 recommendations the inquiry made. The inquiry chair had maintained a dialogue with the ministers after the inquiry had ended. Ministerial meetings, which were held weekly, were used to systematically go through the report in order to identify the key message and develop a response. Subsequently, the NAO writes, the Department of Health and Social Care set up sub-groups involving arm’s length bodies and other health partners to go through and reflect on these recommendations and actions. Throughout this process, parliament was regularly updated on actions taken to implement the recommendations.⁸⁷ The example shows how the post-inquiry phase can be structured and transparent in a way that optimises the chances of lessons being learnt.

Finally, it is important to **keep the inquiry report lessons** alive not just in the medium-term by keeping the inquiry panel engaged in the implementation phase, but equally in the long term. Amidst organisational churn and limited absorptive capacity, how can it be ensured that lessons are embedded in organisations and not forgotten? This type of ‘institutional amnesia’ is still poorly understood, and specific remedies are not yet available.⁸⁸ However, several actions can contribute to sustaining organisational memory, including: the establishment of formal procedures and structures; the development of manuals and standard operating procedures; the running of mandatory regular exercises such as simulations and workshops; scenario work in fixed intervals in the years following the report; and tapping into the current potential of information technology.⁸⁹ When lessons become routine, the specific lessons may be forgotten, but the procedures will live on.⁹⁰

84 Norris and Shephard, *How Public Inquiries Can Lead to Change*, 4-5.

85 James Murphy, *The Discursive Construction of Blame* (2019), 273.

86 Ibid.

87 National Audit Office, ‘Investigation into Government-Funded Inquiries,’ 31.

88 Alastair Stark, ‘Explaining Institutional Amnesia in Government,’ *Governance* 32, no. 1 (2019).

89 Dekker, ‘Learning under Pressure: The Effects of Politicization on Organizational Learning in Public Bureaucracies.’

90 Barbara Levitt and James G. March, ‘Organizational Learning,’ *Annual Review of Sociology* 14, no. 1 (1988).

5 Conclusion

This report highlights the huge potential of public inquiries to ensure that lessons are learned from COVID-19 to help the UK prepare for a future pandemic. Yet, we need to be aware of the considerable risk that inquiries, particularly in the UK context, to disappoint against high public expectations. For this reason it is critically important to avoid rushed decisions about how to set-up an inquiry and to carefully scrutinise any attempts by political actors to control outcomes.

Our key recommendation is to prioritise lesson-learning over political accountability for a public health-focused inquiry. We argue that such an inquiry should not be led by government but led by suitably qualified ‘knowledge-brokers’, namely organisations with the relevant expertise and networks connecting them to policy without being part of the executive. We suggest that organisations such as Wellcome, the Nuffield Foundation, scholarly societies, Academies or networks of universities could be well placed to fund and establish an inquiry led primarily by experts. The sufficient participation of grass-roots professionals and policy managers could also increase the chances of full implementation. We also believe that this inquiry should be transparent, involving some public hearings and **engaging individual citizens** through testimonies and deliberative discussions. However, public engagement should be achieved in a way that it does not lead to overly politicised discussions focused on the performance of individual actors, but on the institutional and policy lessons to be learned. Instead, such public involvement should be considered only if it serves the primary purpose of lesson learning for ‘preventing recurrence’. This inquiry should be structured to issue an interim report after a year and a final report 18 months after the start.

While we have argued for the primary importance of an inquiry aimed at lesson-learning, we also acknowledge calls for a second statutory inquiry that examines a narrow set of the most well-evidenced and serious allegations made against some of the actors and organisations before and during the first wave of the COVID-19 crisis. If there is sufficiently strong public support, we argue that such an inquiry should be led by a judge with some experience in public health matters and established under the Inquiries Act 2005. It should be properly resourced with a precise, focused mandate and expected to report no later than spring 2023 to ensure sufficient time for drawing personal, political, legal and policy consequences from any report within the present government’s mandate. This inquiry could positively contribute to public sense-making and strengthening of trust in government, experts and public health institutions. Yet, we cannot overstate the argument that a statutory inquiry should not cast a shadow over what we believe is a more pressing inquiry that prioritises lessons-learning that would help the UK to be better prepared for the next pandemic in the years and decades to come.

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