

Public Inquiries and the Management of Public Risk

Introduction: Inquiring into Inquiries

‘Admittedly, their faith in magic has been misplaced, but that has not prevented them from demanding commissions of inquiry into every accident and post-mortems for every death.’

Douglas and Wildavsky (1982: 33) in their seminal reflection on the growth of a culture of risk in America during the 1970s

The demand for public inquiries has become commonplace in contemporary Britain in politics and, perhaps more significantly, in society more widely. It is both a recognised campaigning tactic for those seeking redress or reform, and part of a ‘cultural script’ insisting that ‘something must be done’ following negative events and experiences. Calling for a ‘full public inquiry’ now indicates that an especially uncompromising ‘something’ is necessary. Inquiries are often charged with no less than ensuring that events must be certain to ‘never happen again’. In short, inquiries are a primary form of response to public risk or the perception of public risk as captured by exceptional events.

According to leading American scholar, Sheila Jasanoff (2006: 218), the public inquiry has become, ‘Britain’s favoured mechanism for ascertaining the facts after any major breakdown or controversy’. They have also acquired significance beyond their function as a ‘favoured mechanism’. Some of those reflecting on their practical involvement attest to the wider importance of inquiries. They are described as a: ‘pivotal part of public life in Britain’ by the Commons’ Public Administration Select Committee (2005: 7). For Lord Laming, ‘...they occupy an important place in our society’. Arguably, public inquiries are symbolic of what we now define ourselves, and pride ourselves on being: an open, transparent society where, when something goes badly wrong, the powerful are held to account and the powerless cannot simply be ignored. It is in this respect we can understand their glowing description as ‘the guardian of the public interest’ by the Judicial Committee of the Privy Council in 2003 (cited in Blom-Cooper 2003). By contrast, a country like Russia can remain closed and undemocratic in our perceptions irrespective of formal democracy, at least partially because it does not allow independent investigation that might challenge and implicate those in authority. Irrespective of public anger and disbelief following the sinking of the Kursk submarine in 2000, for example, the political elite did not feel obliged to publicly review what went wrong and punish those responsible. Whatever the many problems that have arisen with British ‘government by inquiry’ there are no voices arguing for a return to the more closed government that does not allow public scrutiny of what goes wrong.

A useful starting point for any investigation is the character and extent of work already carried out. From this perspective, to judge by the volume of research and reflection on public inquiries, they hardly seem the most promising or important of subjects. Comparisons are difficult, but in this author’s experience - where even the most obscure phenomenon attract considerable intellectual attention, at least

somewhere - the comparative lack of work on inquiries seems astonishing. For it is important to establish that public inquiries in the UK are not an obscure or arcane instrument of governance. On the contrary, particularly as they are so self-consciously public in character, they are an instrument of unusually wider significance and consequence. So what has been written about public inquiries, and what has shaped these studies? Unsurprisingly given the continually debated legal basis for inquiries and specific arguments over the character they should take, there are some reflections by senior judicial figures who have led major inquiries (e.g. Howe 1999; Winetrobe 1997; Blom-Cooper 2003). There have recently been two substantial political reports on inquiries stimulated by debate leading up to the introduction of the new Inquiries Act in 2005. The Commons' Public Administration Select Committee produced a comprehensive report in 2005 on 'Government by Inquiry' (PASC 2005), and the Department for Constitutional Affairs deliberated on 'Effective Inquiries' a year earlier (DCA 2004). Both reports formed part of a review of the conduct of inquiries stimulated, above all, by their significant financial cost. What is especially useful about these reports is that they drew up lists of 'inquiries into matters of public concern' from 1900 to 2004 (PASC 2005), and 'notable inquiries' since 1990 (DCA 2004). Given the difficulties involved in defining the territory of public inquiries, these lists provide a firm foundation for reviewing the evolution of the inquiry instrument, even though the reports themselves are of limited direct relevance to thinking about inquiries in the context of managing public risk.

Other professionals who have had cause to reflect upon inquiries have been those in areas most affected by their consequences. Some professions have experienced wholesale reorganization, and subsequently live in anticipation of further inquiry scrutiny. It is in health, social care and social work that inquiries have had the most tangible and clear impact, and it is unsurprising that it is from academics working in these fields that the most substantial contributions on inquiries have emerged – albeit concerning inquiries in their own field rather than more broadly (e.g. Butler and Drakeford 2003; Stanley and Manthorpe 2004). Within this, particular incidents and inquiries, most notably the inquiry into how social services failed to prevent the horrific murder of Victoria Climbié have stimulated the most research and debate (e.g. Parton 2004; Reader and Duncan 2004; Munro 2004).

Most of the material on inquiries is concerned with particular events or at least groups of events; there is little reflecting on inquiries more broadly. There are only a small number of little-known academic articles that reflect on the meaning and implications of public inquiries (Ashforth 1990; Elliott and McGuinness 2002; Brown 2003). In these kinds of contributions inquiries are seen as part of a 'post-disaster ritual', for example (Post et al 2004). More recently a useful political science doctorate and subsequent articles have examined inquiries in terms of their political efficacy (Sulitzeanu-Kenan 2006a; 2006b). Beyond these relatively limited fragments on inquiries there is a need for far more research in this area, and hopefully this scoping report will help contribute towards stimulating more 'inquiry into inquiries'. But the question remains, why they have attracted so little attention when the case for their objective significance can be made so easily?

Common sense suggests that an inquiry is merely an after-the-event review of a major negative incident, in order to reduce the chances of recurrence. Fundamentally it is because of this perception of them as entirely responsive instruments that inquiries

have attracted so little intellectual attention. Yet, think again, and it is quite obvious that inquiries play an active role in contemporary political culture, professional conduct and life more generally. These impacts have not only been felt through their specific recommendations but, more generally, the language and assumptions they have generalised. Our answers to questions such as ‘what is racism?’ and ‘who should be allowed to work near children?’ have been partly cast by inquiries. Now routine assumptions such as that, left to their own devices, corporations are likely to readily compromise our safety for their profits can be seen to have consolidated themselves through inquiries into major incidents such as train crashes. Once we understand society’s sense of public risk as an active process it begins to become clear why examining public inquiries is potentially useful. A focus on inquiries begins a discussion and focus which understands that what are ostensibly social and political *reactions* to risk can be at least as important as the risk itself; in fact they are far more than mere reactions. If we can speak of ‘risk actors’ we might also speak of ‘risk instruments’ and the public inquiry should be considered a prime example.

So what does a focus on public inquiries allow us to do? There are several ways in which examining public inquiries can be seen as a particularly useful focus through which to better understand the dynamics, forms and contradictions of public risk. As the quote from Douglas and Wildavsky with which we began indicates, inquiries cut to the heart of our very different sense of the accidental and how far we should go to guard against it. Through inquiries we can keenly focus on society’s changing attitude towards misfortune, responsibility, blame, and even our basic sense of how to view what has occurred in the past.

In more specific terms looking at inquiries can help better decide on whether, and the extent to which the UK is indeed a ‘risk society’. In the RRAC report on public risk it was explained how difficult it is to provide evidence, one way or the other. Public inquiries are an established instrument that allows comparison of our reaction to significant events over a long period of time. As will be elaborated in the next section, contemporary inquiries have been increasingly concerned directly with matters of public risk. As instruments they encapsulate some of the key issues involved in the socio-political response to public risk, notably hindsight, blame attribution and our view of the accidental. Indeed, a useful way of understanding a risk culture is one where we organise society and conduct our behaviour on the basis of exceptional experiences that are actually unlikely to become normalised. Thus, for example, children’s freedom has been severely curtailed in recent years because of anxieties about paedophiles. In this respect how society responds to exceptional events and whether it is able to maintain a sense of proportion in the face of them is a measure of its standing as a risk society.

In the UK it is through inquiries more than any other means that we decide upon our response to significant events, and the character of inquiries should hold important clues about society’s orientation to risk. In fact, major recent inquiries have very direct association with important areas of public risk aversion, from the central role played by the Bichard inquiry (into the Soham murders) in extending regulation of adults working near children, to the consolidation of clinical governance in the NHS following the major medical inquiries of recent years. Roles played by different actors in these processes may be more precisely delineated through examining their role in particular inquiries. There are occasions where inquiry reports can become iconic

documents themselves, most notably with the inquiry report into 9/11 which was the number one seller on Amazon.com, selling more than 1.2 million copies (Warren 2007). More commonly, inquiry chairs subsequently acquire a media profile and become spokespersons for issues and concerns. William Stewart, chair of the mobile phone inquiry, and Sir Michael Bichard both became regular commentators on issues of child protection, for example. The fact that the first inquiry is generally known as the Stewart Inquiry and the latter as the Bichard Inquiry attests to the significantly personalised character of recent inquiries.

This report will help to provide a foundation for thinking about the state of public risk in the UK through tracing and characterising the changing nature of events deemed worthy of inquiry. Most ambitiously this scoping report will try and address direct questions regarding the impact of inquiries on public risk, such as:

- Do they provide a breathing/thinking space?
- Do public inquiries result in the amplification or diminution of risk?
- Does the setting up of a public inquiry predispose government to taking action, and possibly more action than if there had been a reflex knee jerk reaction in the immediate aftermath of the problem?
- The shift of authority from parliament to the judiciary and associated compromising of the very independence that invites resort to their authority
- How they can end up *accusing* individuals rather than only *inquiring* into causes
- Hindsight bias
- Inquiries focus attention on exceptional events. Does this focus on the exceptional cause problems, in particular in terms of how society views the balance of evidence for certain risks?
- Do public inquiries change the nature or types of risk that society faces, reducing certain risks but encourage others - perhaps through making (inappropriate) recommendations that have implications outside the immediate area covered by the inquiry?
- Are the recommendations of inquiries generally implemented? Are there any characteristics of inquiries (or recommendations) that lead to recommendations being accepted / not accepted?
- Could the rise of the availability of visual images of disasters be a relevant factor in increasing outrage, and thus the demand for inquiries?

It is difficult to address such questions directly. An important methodological problem is not only the absence of any kind of 'control'; a comparative event not subject to an inquiry-type treatment against which comparisons could be made. Further, by their nature events demanding an inquiry are considered relatively unique. Through drawing comparisons and contrasts the report attempts to find some ways around this fundamental problem of the unique character of the subject of inquiries some broad conclusions can be drawn.

This report considers public inquiries from a similar perspective on public risk to that established by the BRC and RRAC. The BRC's 'Whose Risk Anyway' report (2007) mapped a cycle of how public expectations of zero risk are fuelled by political adaptation to short term pressures to respond. It may be that a similar process can be

identified regarding inquiries, whereby public expectations that any accident, misfortune or tragedy must be met by institutionalised blame attribution furthers the consolidation of a culture of public risk. Inquiries also squarely raise the problem of political leadership identified by the BRC report, 'Whose Risk Anyway' (2007). Highlighting the centrality of political leadership in confronting public risk was a key, and unique feature of this report. The resort to public inquiries raises important questions about political leadership in the face of public risk, and whether, and when it is right that it should instead resort to the apparently independent authority of the public inquiry. Politicians have turned to public inquiries in the modern era because it has seemed that independent, non-political expertise might be more trusted to manage the response to major events. It may not only be useful to ask why particular issues have been deemed worthy of national inquiry, but why so many of the major public risks of recent years have been passed away from political to 'expert' judgement.

Section 2: An Age of Inquiry?

‘a tiresome cliché has been invented, namely a ‘full public inquiry’, as if there was some sort of half baked inquiry which might suffice on occasion...’
(Clothier 1996 cited in Prins 2004:21)

‘...the pressure for [public inquiries] is increasing all the time, and there is a risk that we overdo it and go over lots of events which are very similar where there are not a lot of new lessons to be learned, but I accept that as an inevitable development over several years’
Sir John Gieve, Home Office Permanent Secretary (cited in PASC 2005: 8)

‘no government wants inquiries; they are usually in circumstances where the government is in trouble...They are not popular things for governments’
Lord Heseltine (cited in Sulitzeanu-Kenan 2006: 44)

More Inquiries or Just More Incidents?

Particularly since the 1980s the number of inquiries has increased making ours, arguably, an ‘age of the inquiry’ (Stanley and Manthorpe 2004). Most recently, in May 2008, the Ministry of Defence bowed to legal pressure and agreed to an independent public inquiry into the death of Baha Mousa in Iraq in 2003. This is not to suggest that the call for an inquiry is not still resisted; such is the case with the continued rejection of an inquiry for over a decade into the deaths at Deepcut Barracks, for example (BBC 2002). Such an example illustrates that even if they have become more readily resorted to, they remain instruments that are not resorted to lightly. Public inquiries involve the giving up direct political control over the response to major events and in a way that is self consciously open to close public scrutiny. Particularly when they concern events that occur under the incumbent administration – and are therefore likely to criticise their conduct – they remain an instrument of last resort.

A fundamental difficulty poses itself when attempting to assess patterns in the number of inquiries over time. The straightforward assumption would be that inquiries are held following an incident of sufficient scale or importance to merit one, and therefore any pattern in their frequency tells us nothing more than that there have been more or less of such incidents. This report suggests a very different way of looking at inquiries, however, where inquiries are seen as active and influential in their own right; where they have taken on a ‘life of their own’ apart from the incident with which they are concerned.

There are different types of inquiry - as the next section will indicate - but an increase in their number and range is evident in the different forms and scales of these reviews. Of the fifty-nine inquiries held in the health sector between 1974 and 2002, there were two in the 1970s, five in the 1980s, and fifty-two between 1990 and 2001 (Walshe and Higgins 2002). Between 1994 and 2005 inquiries into homicides by people with a history of mental illness became mandatory, resulting in between sixty and one hundred inquiries taking place over this time period. The distinctively routinized process of inquiry in the health sector is part of a new regime of clinical governance

intended to win back public trust through demonstrating transparency and accountability, a goal to be partly achieved through holding up individual clinical inadequacies as a focus for blame and punishment. Although these sector-specific inquiries are distinct from the high-profile public inquiries at the heart of the 'age of inquiry', they are also connected, with health and mental health being a prominent focus of several of the iconic inquiries of recent years. Alder Hey and Bristol Royal Infirmary remain synonymous with malpractice, for example, following high profile inquiries in 1998 and 1999 (Alaszewski 2002).

The House of Commons Public Administration Select Committee (2005) has usefully compiled a list of 'Inquiries into Matters of Public Concern' from 1900-2004. They identify a total of 89 since 1900. Until recently they are relatively evenly spread over time, with around 4 in most decades and, typically, only 1 in any given year (apart from 1916). From the 1980s they increase significantly in number however, rising to a peak between 1997 and 2001 of 4 each year. There are a total of 30 'notable inquiries' since 1990 in a separate list compiled by the Department for Constitutional Affairs (2004). Whilst they include no means of comparison with other decades, it might reasonably be suggested that 30 major public investigations in 14 years is significant, and double the annual number of inquiries into 'matters of public concern' that took place over most of the Twentieth Century.

Common sense might suggest it has been not so much an 'age of inquiry' as, at least partly, an age of strangely coincidental accidents. It is particularly the series of large-scale tragedies that struck the latter Thatcher years that appear to confirm there has not been so much a social and cultural shift as simply a series of 'acts of god'. As the commentator Simon Jenkins (2006: 137) put it:

'Luck had long been Thatcher's closest ally but now it began to run out. Britain in the late 1980s was afflicted by a strange run of accidents swamping the public's attention'.

Disasters of that period he mentions include the sinking of the Herald of Free Enterprise ferry, the Piper Alpha oil rig explosion, Kings Cross fire and Clapham train crash, the Marchioness collision on the Thames and the Hillsborough football stadium tragedy. These were very public, large scale events, some of which – like Hillsborough – were broadcast before our eyes on television. There has not subsequently been a collection of comparable experiences, and in this sense it was perhaps not an age, but a passing moment of inquiry. From another popular perspective it was no coincidence that there was such a glut of disaster during these times, as these were 'accidents waiting to happen' (Cook 1989) to quote the title of a popular book of the period. Above all, a narrow focus on profit displacing concern with health and safety is identified as the force increasing the likelihood of accidents, and it is therefore the privatisation of the Thatcher years and beyond that is singled out. Perhaps the most consistent focus of this perspective remains the newly privatised rail network and the series of major train accidents after the breakup of British Rail remains widely understood as its direct consequence.

But the relationship between events and the reactions to them is far from straightforward, as indeed is understanding patterns of comparative political development more generally in recent years. Thinking about the apparently unique set of disasters faced by Britain in the late 1980s/1990s we should recall that other countries such as Japan and France also experienced their own, quite different events that led society in a similar direction of evoking widespread retrospective reflection and affirming a heightened sense of public risk. In France it was the issues of the blood transfusion scandal and mounting concern over asbestos, in particular, that led to 'new moralities of risk and political responsibility', as internal French politics came to be organised around anticipating and avoiding responsibility for the 'next' focus of public outcry (Roussel 2003). In Japan, it was the gas attack on the underground system and the Hanshin earthquake of 1995 that played an equivalent role to experiences such as BSE in the UK and the scandals in France. What was deemed an inadequate political response to these events created a sense of a Japanese political class as adrift as back in John Major's Britain, and a country beset by a 'vague anxiety' (Leheny 2006).

Historically Changing Reactions

Any review of the role of inquiries and public risk must not only consider the inquiries themselves, but consider why it is regarded as necessary that an issue be the subject of an inquiry. The act of deciding to hold an inquiry over an issue marks it out as a significant public risk. Thus it was found that activists against mobile phone masts, for example, were affirmed in their belief that they are a public risk by the very fact that the government decided to hold a public inquiry into them (Burgess 2004). Because we become accustomed to the changing political culture of which we are a part, the historical distinctiveness of issues to which society chooses to respond can escape our attention. It is scarcely questioned that it was right to hold an inquiry into the Soham murders, for example, yet it is surely only in the context of the intense and very recent preoccupation with paedophiles and child safety in general that an inquiry could be considered an appropriate response to such an incident.

Whether and how society responds to 'disaster' or what may otherwise be deemed a major event is by no means self evident, but historically, politically and culturally conditioned. Consider the reaction to two maritime collisions on the Thames, separated by over 100 years. The Princess Alice sunk on the Thames in 1878 with the loss of over 600 lives. There was certainly no public inquiry, and the perfunctory inquest couldn't decide which ship was to blame (Neal and Hines 1992). But, by modern standards, it was the public reaction that was more curious. Hundreds of relatives and other onlookers went out the next day on the Alice's sister ship to see the crash site for themselves! The contrast couldn't be starker with the reaction to the sinking of the Marchioness in 1989, with the loss of 51 lives. This time there was a full inquiry after a decade long campaign by relatives which still goes on today, raising wider issues not only about navigation on the Thames but the treatment of corpses following tragedies.

But surely there are some incidents that are simply objectively so important that they must demand society's full concern and attention? What about a munitions factory explosion with large scale loss of life which destroys a significant part of the capital city? Actually, even in this case response is dependent upon the era and circumstances in which it took place; in this case the Silvertown munitions explosion of 1917 which killed 73 and devastated a large part of the East end was marked only by a plaque. It was deemed that investigation would have been bad for the war effort, despite the fact that the lessons to be learnt regarding citing munitions factories near major population centres might have been usefully and painlessly drawn out by an inquiry. Thinking historically about what has been deemed worthy of inquiry suggests a dramatic swing from a deferential to a rights-based and redress-centred culture where it is simply expected that no misfortune can be allowed to happen; that there is 'no such thing as an accident', as some would now have it.

A related historical trend was for a failure of implementation with the early inquiries that did take place, affirming a criticism that is still made of even contemporary inquiries (see section 5). One, unusual, domain where inquiries did take place into public disaster was in relation to football, the 'nation's game' (Elliott and McGuinness 2002: 24). There was a crowd surge inside the then new Wembley stadium in 1923 that injured more than 1000 spectators. An inquiry was pursued by a Departmental Committee on Crowds under the direction of the Secretary of State for the Home Department. It recommended a system of licensing football grounds – to be performed by local authorities - but was not subsequently implemented. A public inquiry was established under the same direction into the deaths of 33 people at Bolton football stadium in 1946 in similar circumstances. There was a reiteration of the need for further legislation, and active enforcement mooted, but the system of 'self regulation' continued. Real change was evident only after the 1960s with the next significant stadium disaster - at Ibrox stadium in 1971 when 60 people were crushed to death. This time the inquiry laid the foundations for the Safety at Sports Ground Act of 1975. Subsequent disasters at Bradford Stadium in 1985 (56 dead), Heysel also in 1985 (39 dead) and Hillsborough in 1989 (96 dead) eventually led to reorganisation of the whole industry and transformation of the 'nation's game'.

'Accidents Will Happen'

Historically changing reactions and the coincidence of major public risk issues and associated political crises in different countries ask questions of the common sense assumption that events 'just happen' and an increase in inquiries is only a natural response. All manner of events internationally appear to have led to similar conclusions, suggesting that what is most important is not the events themselves but what we choose to take from them. More light can be shed on the much more indirect relationship between events and reactions by focusing on a more contemporary issue – our response to rail crashes. The example of train crashes is quite central to contemporary inquiries and captures a popular perception that life indeed may be more risky and therefore 'something must be done'. Rail crashes are also a useful measure of changing responses as they take place relatively consistently over time. The country's foremost expert on rail accidents is Imperial College's Andrew Evans, and the material that follows draws upon the rigorous analysis available at his website.

It is relatively widely recognised that there is a basic transport ‘risk paradox’ involved in comparing our heightened perception of danger from, relatively very safe, rail travel with car driving which, whilst much more dangerous, does not evoke the same level of concern. This contrast is illustrated by calculations showing that the introduction of further safety measures for rail with the automatic train protection in the early 1990s meant the death/cost ratio was around £14 m per life – whereas on the roads it’s about £700,000. The larger and less recognised risk paradox is that, as the railways have become safer, so the reaction to increasingly rare fatal accidents has become greater. Statistically, there are now around only two train crash fatalities per year, the culmination of a secular decline which has steadily continued through the Twentieth and into the Twenty First centuries.¹ The extent of improvement can also be indicated through the rarity of track worker deaths, hundreds of whom died even in the earlier post war years. Nonetheless, despite the increasing rarity of rail-related deaths,

‘...never before in railway history has there been such an outpouring of inquiry reports into accidents and train protection systems, containing in total well over a thousand pages, several hundred recommendations and much food for thought’ (Hall 2003: 5).

The relentless decline in fatal rail incidents has continued irrespective of privatisation, no matter how strong the perception that the era was blighted by a succession of profit-driven disasters. As an aside it seems likely that the popular association between privatised railways and accidents is based on widespread experience of a disorganised system with unclear lines of command; if they can’t run an efficient system the, not unreasonable, assumption is that this inability might also be responsible for the accidents about which so much is heard. In reality there is evidently no direct relationship between the organization of railways and the likelihood of fatal accidents. Consider, for example, that aspects such as the rolling stock used (from ‘slam-door’ to automatic entry carriages, for example) change slowly over time largely irrespective of whether they are in private or state hands. On a wider level we can also readily appreciate that other forms of privatised transport such as airlines are obsessively safety conscious despite the need for profits, not least because of the calamitous prospect of an accident on the credibility and therefore financial viability of any carrier.

Considering the nature of accidents such as those on the railways it is unsurprising that we can find no clear relationship between them and a system of ownership. All accidents are multi-causal; it is through an unfortunate combination of events likely to be innocuous in themselves. This is not to say that a key factor such as the visibility of particular stopping sign cannot be singled out, but it must not be forgotten that it was only in a very particular context that any individual failing becomes important. Such are the enormous problems facing inquiries that attempt to reconstruct the haphazard nature of past events. Some improvements from inquiry recommendations may make a slight change in the balance of probabilities, but it cannot be meaningfully said that: ‘if we don’t have this then that would happen...’ Nor is this to suggest that train

¹ Additionally there are about 15 level crossing incidents; 10-15 ‘others’ such as personal accidents like falling downstairs; and around 150 (unproven) suicides

accidents should not be investigated. Unlike road crashes, train incidents are part of a system (unlike probable individual error in car accidents) and there is always good reason to thoroughly investigate with the possibility that operational lessons can be drawn by specialists. What is at issue is the scale and profile of any investigation, the messages it sends out and how balanced its conclusions and recommendations. More immediately, we can be confident considering the rail example that the increased propensity to hold major inquiries bears no clear relationship to the general scale of the problem. It seems we are concerned by events of a smaller scale than in the past; indeed it seems we are concerned by quite different matters altogether.

A Shift of Concerns from State and Political Authority to Social and Public Risk

There has not only been an increase in the number of inquiries, but a shift in their focus of concern towards public risk; public risk being understood as negative events with a public impact - most of which suggest the possibility of further, relatively indiscriminate impact. This is clearly demonstrated if we break down the PASC (2004) list of 'inquiries into matters of public concern since 1900'. The phrase used by the Committee is a useful one, as what is deemed to be 'of public concern' has clearly changed. Or rather, it is only relatively recently that what is deemed to be of 'public concern' has become central to deciding upon what should be inquired into. In the first half of the Twentieth Century as they first evolved, inquiries classically concerned matters relatively internal to the state and political class, and their authority. This is unsurprising given the original function of inquiries (to be elaborated in section 4) of restoring political authority and trust under circumstances where it is seen to be only possible through resort to independent adjudication. Such was the case with the defining 'early modern' inquiry, into allegations of political corruption concerning the construction of Marconi's wireless telegraph stations just before the First World War.

Prior to the 1980s, inquiries were mostly concerned with traditional matters of state and political authority. Besides questions about the propriety of leading politicians, as was the case in the Marconi affair, they classically concerned:

- the conduct of war
 - eg inquiry into South African war (1902)
 - eg inquiry into the rebellion in Ireland (1916)

- state security
 - eg official secrets act (1937)

- policing
 - eg inquiry into conduct of the metropolitan police (1925)

Whilst inquiries that might be bracketed in the category of 'traditional state' continue to this day (Bloody Sunday, David Kelly), they are eclipsed from the later 1980s by those into public risk in its various forms. From 1985 up until 2004 only 13 out of the 41 inquiries can be classified as more 'traditional'. Whilst definitions and the respective cases for including particular examples remain debatable, there is a case to suggest that 28 of the 41 inquiries concern public risk.

These 28 can be further broken down into sub-themes :

Child Murder and Abuse

- Soham Child Murders 2004
- Victoria Climbié child abuse murder 2001
- North Wales Child Abuse 1996
- Dunblane Killings 1996
- Cleveland Child Abuse 1987

Financial Collapse

- Collapse of Equitable Life Insurance 2001
- Collapse of BCCI 1991

Food Production

- Foot and Mouth Disease 2001
- BSE/vCjd 1997

Medical Malpractice...and Murder

- The 3 Inquiries into health service complaints 2002
- Rodney Leward, Kent hospital malpractice 2000
- Mass Killing by Dr Harold Shipman 2000
- Alder Hey Hospital Child Organ Use 1999
- Bristol Royal Infirmary 1998
- Killings by Nurse Beverley Allitt 1993
- Deaths of elderly patients from food poisoning in Wakefield 1986

Transport and Other Disasters

- Identification of Victims Following Major Transport Accidents 2000
- Sinking of the Marchioness on the Thames 2000
- Thames River Safety Inquiry 1999
- Ladbroke Grove Rail Crash 1999
- Joint inquiry into train protection systems 1999
- Southall Rail Crash Enquiry 1997
- Hillsborough Football Stadium Disaster 1989
- Clapham Rail Crash 1988
- Piper Alpha Oil Rig Disaster 1988
- Kings Cross Station Fire 1987
- Crowd safety at football grounds 1985

Those highlighted by the PACS correspond closely to the list of '*Notable Inquiries Set Up Since 1990*' identified by the DCA (2004). Listing them simply in chronological order, and indenting those concerning public risk underlines the preponderance of public risk inquiries in recent years:

Weapons of Mass Destruction 2004

- Soham 2004

David Kelly 2003

- Ayling, Neale and Kerr/Haslam (doctors)2002

FV Trident 2002

- Equitable Life 2001
- Victoria Climbié 2001
- Foot and Mouth 2001
- Shipman 2000
- Marchioness 2000
- Identifying Victims after Transport Accidents 2000
- Train Protection systems 1999
- Ladbroke Grove 1999

FV-Gaul 1999 (ship)

- Alder Hey 1999
- Thames River Safety 1999

MV Derbyshire 1998 (ship)

- Bristol Royal Infirmary 1998

Bloody Sunday 1998

Sierra Leone Arms 1998

- BSE 1997
- Ashworth Hospital 1997
- Stephen Lawrence 1997
- Southall 1997
- Dunblane 1996
- North Wales Child Abuse 1996
- Beverley Allitt 1993

Arms to Iraq 1992

Flotation of Mirror Newspapers 1992

- Collapse of BCCI 1991

Changing Political Culture

This long term shift in the focus of inquiries can be seen to parallel a transformation in British political culture, and it would be reasonable to suggest that inquiries reflect these changes and have even played a role in bringing them about. In the simplest terms it suggests the increasing intrusion of matters of public concerns, rather than those more internal to the state and political elite. More broadly it involves a cultural shift concerning deference and authority, and fundamentally different conceptions of responsibility, blame and even the value of life itself and its meaning. These combined socio-cultural changes are more significant than the scale and character of the events themselves in understanding the increasing number and different character of contemporary inquiries. Whilst these enormous changes cannot be outlined in any detail here, a brief sketch of some of them is necessary to establish that there is indeed a close relationship between these changes and the changing character of inquiries.

In the previous section it was described how the reaction to the sinking of the Princess Alice in 1878 was virtually the opposite of what would be expected given today's sensibilities. Not only was it clearly viewed as an accident, but it's possible recurrence little occurred to anyone. It had little 'meaning', and the prurient interest of those who went out on the sister ship the following day was to see where it had happened. Clearly, under such circumstances, there was unlikely to be an inquiry into

a 'matter of public concern' as the issue was simply not configured in such a fashion. Or consider other examples that illustrate both a very different social psychology indifferent to far more real and imminent risk than is generally experienced today. In the same Victorian era, especially prior to the Railways Act of 1889 there were regular train accidents, mainly caused by the fundamental lack of basic safety apparatus. Transport owners, nonetheless, typically refused to accept responsibility for accidents, and in a sense were the real embodiment of capitalism's early social indifference. But for the Victorians the problem was a wider one of reconciling any concern about accidents with any regulatory consequences. The 'principle of self government in the conduct of our affairs' was central, and regulation seen as antithetical to the entrepreneurial spirit at the heart of Britain's success. These assumptions were a considerable barrier to any wider consideration of 'accidents'. It was thus unusual for any investigation to go beyond the immediate circumstances of an incident, as is now the norm. In so far as responsibility was assigned, it was not unknown for employees – notably the train driver - to be identified to the authorities by their employers.

It was only with the accumulation of significant accidents in particular domains that the call for change emerged and regulations and better standards introduced. For example, false fire alarms in public theatres leading to panic and crushing were a regular occurrence on both sides of the Atlantic and eventually led to the questioning of theatre management and their disregard for safety issues. Pioneering figures dedicated themselves to shaming the authorities into making improvements and imposing changes on theatre owners. The fundamental problem was that most accidents involving significant casualties were of the poor, who, whilst in the majority, scarcely figured in the attentions of Victorian society. It is thus unsurprising that greater interest in accidents and the extent of inquiry that went with it was often catalyzed by incidents involving 'respectable' victims. The mass drowning in Regents Park during the Great Freeze of 1866-7 caused uproar as the majority of victims were middle class. Whilst there was no public inquiry in the modern sense, this was scarcely necessary as demands for remedial action were swiftly met. Interestingly, the incident also betrayed a quite different attitude towards individual responsibility as there was no question that the skaters themselves might have been at fault in published commentary on the incident (Neal and Hines 1992). There were also occasions where, even though the victims themselves might be from the 'lower orders', the context was seen as significant and reflection and action demanded. Such was the case at the launching of the first class cruiser, Albion, in 1898 which was in the presence of royalty and intended to be a public celebration of patriotism. Whilst the 38 onlookers killed were unremarkable, it is not difficult to imagine how even at this time the incident became a focus of national attention and demand that 'something be done'. Gradually, accidents were beginning to be seen in a more systemic fashion, beginning the journey towards today where we can scarcely conceive of an accident pure and simple.

The transformation in inquiries is also the result of quite different issues becoming the preoccupation of society. The beginnings of a 'risk society' were discernible with the contrast between interest in potential nuclear accidents and relative disinterest in a 'traditional' mining tragedy. In 1957 17 miners were killed in a mining disaster at Kames Colliery, in Ayrshire. A month earlier, on the nearby Cumbrian coast, there had been a fire in a nuclear reactor. Fortunately there were no deaths and no known

injuries in the Windscale nuclear accident. Most people soon forgot the Kames tragedy but the Windscale accident captured the headlines, preoccupied ministers and engaged senior officials, scientists and engineers for months and has entered the folklore of 'near miss' nuclear disasters (Arnold 1992). Even before greater contemporary sensitivity to indeterminate risks to health, the development and use of nuclear weapons was a particular focus for concern. By contrast, deaths from mining accidents were relatively common and excited little enduring attention.

Like in so many other ways, what sociologists call 'late modern' society can be dated to the social transformations of the 1960s. It was during this time that the first health inquiry was held. The Ely inquiry of 1967 into hospital maltreatment was the first that although conducted in private, was fundamentally open to public, certainly to media scrutiny. This inquiry suggested a changing attitude to health and the once revered National Health Service. A year earlier came the Aberfan landslide in Wales that buried the village, including its school with the loss of 144 lives. The famous Tribunal that followed can be regarded as the first contemporary inquiry, especially in the sense that the inquiry resolutely set itself against any dismissal of the tragedy as a mere accident without cause or blame. The Aberfan inquiry was pushing against a still entrenched, unyielding and relatively anti-democratic authority personified by the Coal Board who refused to initially even contemplate, let alone accept their responsibility for the landslide. Rather than accommodate this response, however, the Inquiry was prepared to condemn the Coal Board in the strongest possible terms, something deeply shocking at this time:

'The Aberfan disaster is a terrifying tale of bungling ineptitude by many men charged with tasks for which they were totally unfitted, of failure to heed clear warnings, and of total lack of direction from above'.

In one of its most memorable phrases, the Report described the colliery engineers as 'like moles being asked about the habits of birds'. The Tribunal endorsed the comment of the counsel for the Aberfan Parents' and Residents' Association, that Coal Board witnesses had tried to give the impression that 'the Board had no more blameworthy connection with this disaster than, say, the Gas Board' (Austin 1967; McClean and Johnes 2000). Although a sign, or rather an anticipation of changing times, it was also clear that responses to Aberfan still betrayed a quite different political culture. The bereaved parents of Aberfan decided that they did not want to pursue prosecutions despite the damning verdict of the inquiry because that would be to 'bow to vengeance' (Wells 1995: 25). To grossly simplify, it was a culture of deference on the one hand and arrogance on the other. Since that time it appears that public deference has not simply become weaker but completely evaporated, displaced by a culture of rights and entitlement. It is more difficult to imagine such a response in contemporary Britain, where what previously might have been regarded as a 'bow to vengeance' has been recast as a 'search for answers' or couched in the language of 'making sure it doesn't happen to someone else'.

If we are living in an 'age of inquiry' it is perhaps not best thought of narrowly in terms of an increase in their number or even their scope. What may be most significant is the routine call for them to take place; the demand that an inquiry takes place denotes that an event is worthy of our attention and would not be complete without it. This refrain is not solely or even principally concerned with a need or

desire to establish the facts of an event, but reflects an impulse to attribute meaning to what might historically have been considered accidental or unforeseeable events. The widespread call for a full public inquiry after the official reports into the London bombings in May 2006 was not narrowly, even principally addressed to the course of events already meticulously detailed, for example. The demand was significant and characteristic in the ready assumption of institutional blame. Inquiries *mean* something important, and the nature of the reaction to national incidents that come to be regarded as defining – along with the selective inattention to those that do not - tell us much about contemporary preoccupations and anxieties. We would certainly seem to live in an age of the demand for inquiry, which is not fundamentally concerned with the inquiry procedures and even conclusions – especially if they do not conform to the expectations that fault will be found and institutional blame allocated.

A significant indication that the demand for inquiries has acquired a life of its own is how: ‘...members of the public, almost as a reflex reaction, still seek a public inquiry in the aftermath of fiascos and disasters’ and, perhaps more significantly, irrespective of how the most recent inquiry is likely to have been dismissed as a whitewash should it not come to damning conclusions. Sulitzeanu-Kenan (2006b: 647) notes how in the wake of disappointment with the Hutton Report (55% considered it a whitewash; 26% thought it judicious and balanced), 54% of the public still wanted an inquiry into the Iraq war, with only 32% opposed (YouGov survey, 30-31 January 2004). And in our very public age it appears that political leadership may find such claims irresistible despite the problems that public inquiries are associated with in the political imagination. As one of the quotes with which this section began indicated, inquiries are not intrinsically attractive to politicians; commentators have suggested that Blair held a particular aversion, for example, only bowing to one with the very public death of a civil servant. That they have become so much more routine instruments of contemporary governance despite their political uncertainties is testimony to an instrument that has come of age.

Section 3: Defining Inquiries

Different Forms of Inquiry

There are different means of inquiring into experiences and how we do so – the forms, procedures and conventions - can make a difference. A defining characteristic of public inquiries is their determinedly public character and this shapes how events are reflected upon and this reflection is subsequently disseminated. The 9/11 Commission report has proven very influential in American society, for example. It became a best-seller not only because of the significance of the events considered but also because it ‘reads like a novel’ (Warren 2007). After considering other forms of investigation than the public inquiry, this section will examine their particular characteristics in more detail.

The term ‘public inquiry’ is a loose one (PASC 2005: 7). To complicate matters further, it can refer to a number of different means through which events are reviewed. Wikipedia’s definition of a public inquiry is an: ‘...official review of events or actions ordered by a country's, state's or province's government.’ By this definition all manner of inquiries internationally might be included. There is also a very specific type of inquiry in the UK - with which we are particularly concerned in this report - that is recognized as a distinctive, ‘British contribution to the legal world’ (cited in Sulitzeanu-Kenan 2006: 625). This section will begin by distinguishing the type of inquiry of interest here from its close relatives.

A major type of what is often referred to as a ‘public inquiry’ is the *planning inquiry*, where public deliberation is sought on a major project – a larger scale version of the public consent routinely sought for building works. The Planning Inspectorate, an agency of the Department for Communities and Local Government, routinely holds public inquiries into highways and other transport proposals. Although there is obvious potential for confusion as these have the same name as *inquiries* such as into BSE, they can also be relatively easily set aside and defined as ‘planning’ rather than ‘public inquiries’. Yet their public character is important to planning inquiries also, and they may be better described as *public planning inquiries*.

Some events that could become the subject of public inquiries are simply investigated through *statutory internal investigation*. It is sometimes when the provisions of these do not allow them in particular instances that responsibility passes to a public inquiry. Because no mine workers were killed at Aberfan it could not be investigated through the Mines and Quarries Act and a 1921 Act inquiry was necessary. In the Marchioness case the maritime investigating body, MAIB, had only recently been created and it was decided it lacked sufficient authority and, again, a more public form was necessary. What we can see from such contrasting examples is that the decision whether to hold an inquiry or not is not simply a matter of judgement but also involves quite specific, ‘local’ factors. The conduct of inquiries can also be influenced by such particular factors. Banking law meant that the BCCI inquiry had to be conducted in private, for example, even if, like all inquiries, findings could not be so restricted.

Sulitzeanu-Kenan (2006: 47-51) identifies the *royal commission* as the principal alternative to the public inquiry within government. They are created by the Head of

State on governmental advice to look into important, often controversial matters, and invariably chaired by a senior legal figure - usually a retired judge - and can be granted very significant powers, including summoning witnesses under oath, seizing documents and the holding of proceedings *in camera*. Often taking place over a prolonged time period, they usually result in substantial reports whose subsequent influence varies immensely. Many of these elements are as true of public inquiries as they are of royal commissions. Royal Commissions are really distinguished from public inquiries in two ways; they typically:

- concern themselves with more general issues, as opposed to the specific events that are the substance of public inquiries
- are not conducted publicly, with input restricted to written evidence

The distinction between public inquiries and Royal Commissions is worth dwelling upon, as it suggests some of the reasons why it may be public inquiries in particular that have become such a focus for public risk. In one sense there is some evidence of a comparable trend in the development of Royal Commissions to that identified in the previous section concerning public inquiries. We can isolate 'classical' early commissions directly concerned with the state and the maintenance of its authority, in examples such as the:

- Royal Commission on the Defence of the United Kingdom (1859)
- Royal Commission on the Health of the Army (1856–1857)

As with public inquiries, since the 1960s, commissions have concerned some matters of public risk which we can identify from the following list of inquiries since that time:

- Royal Commission on Environmental Pollution (1970)
- Royal Commission on the Press, United Kingdom (1974–1977)
- Pearson commission (1973-1978), Royal Commission on Civil Liability and Compensation for Personal Injury
- Royal Commission on Criminal Justice (1991)
- Royal Commission on Long Term Care for the Elderly (1998)

Yet it is really only the commissions on environmental pollution, and then personal injury that have concerned the realm of public risk. In any case, it is not really possible to identify trends at all, as there is not a large enough pool of Royal Commissions from which to reflect.

It may be a useful exercise to consider why Royal Commissions do not appear to have made the same social and political impact as public inquiries. There may be no refrain or demand for a 'royal commission' as there is for a public inquiry because:

- A 'public inquiry' may be a specific instrument of government but it also common parlance
- Without a 'public' character Royal Commissions do not invite wider engagement
- Royal Commissions are not focused on single, dramatic events

- Royal Commissions are removed from the fray of immediate political pressure and the pressure of time
- Their responsiveness is limited by their very precise terms of reference
- They do not invite expectations of blame attribution in the same way

Because of their very different character Royal Commissions are not expected to fulfil the same function as public inquiries, most notably the restoration of political and institutional confidence and trust. Royal Commissions gather expert and professional views on particular areas in a much less responsive fashion. What public inquiries and Royal Commissions do share in common, however, is the accusation of both being used to ‘kick issues into the long grass.’ The accusation and effectiveness of any such role for public inquiries will be discussed in the next section. There are grounds for suggesting that Royal Commissions may more effectively ‘kick issues into the long grass’ because, firstly, they tend to take the momentum out of issues rather than concentrate their focus (as public inquiries do), and, secondly, their long time frame further removes issues from immediate pressures. They remain better suited to policy advice and planning rather than investigative tasks.

Select Committees as investigative instruments predate public inquiries which can only really be said to have begun with the Marconi Scandal of 1912. Parliament has endowed them with significant compulsory powers (to subpoena witnesses, force their attendance, and require submission of documents). Whilst witnesses enjoy some legal protection select committees have the power to charge and punish for contempt (Sulitzeanu-Kenan 2006b: 23). But select committees can’t order a government department to provide access to documentation without a motion in the House and are only able to ‘invite’ ministers and MPs. From the perspective of gaining access to all the information they require, Sulitzeanu-Kenan suggests that Select Committees face greater problems. Public inquiries are more flexible, not having to observe the procedure of MPs asking questions in turn and not being restricted to the once-a-week sessions characteristic of select committees.

Prior to the First World War, parliamentary committees broadly dealt with four types of issue:

1. Questions of public policy
2. Questions related to proposed legislation
3. Scrutiny of financial rectitude
4. Alleged abuses and misconduct involving government or official representatives

(Johnson 1979 in Sulitzeanu-Kenan 2006b: 23)

Through the Twentieth Century select committees have increasingly concerned themselves only with the third category of issues. Most significantly from the perspective of public inquiries the fourth category became removed from their responsibility, having had it transferred from the remit of Royal Commissions in the late 1500s. Ad hoc parliamentary committees to investigate charges that implicated government were subject to accusations of being too influenced by political rivalry. Following the Marconi Scandal the public inquiry emerged as an instrument with the capacity to neutralise charges of political bias associated with government and politicians ‘investigating themselves’. Even in their more restricted role, the political

character of Select Committees makes them more subject to pressures that can lead to a blunting of criticism and liable to produce black and white judgements (Sulitzeanu-Kenan 2006b: 50).

As an alternative to public inquiries within the House, the *Parliamentary Commissioner for Administration* (PCA) conducts investigations referred by members and reports to a select committee. It has the same powers awarded under the 1921 Tribunals of Inquiry Act, ‘...but its jurisdiction is limited to inquiring into allegations of maladministration, and cannot look at policy matters, or ministerial actions or decisions’. Such investigations are ‘private reports may be ‘censored’ by ministers in the ‘public interest’ and debates of PCA reports in the House are rare’ (Sulitzeanu-Kenan 2006b: 49). More recently there have been concerted calls from the Public Administration Select Committee to restore and even extend their authority. The PASC (2005) report calls for control over the commissioning of inquiries to shift from the executive and towards the legislature. Another report (PASC 2008) goes further and argues for parliamentary commissions of inquiry as part of a project to restore parliamentary accountability and better control over the Executive. These calls indicate dissatisfaction with the restricted scope of select committee inquiries which are excluded from initiating and controlling inquiries into what are deemed major crises and incident.

Planning inquiries, Royal Commissions and Select Committees can be relatively clearly distinguished from public inquiries. Perhaps more confusing are *tribunals*. Certainly in Eire, but also in Scotland, public inquiries are often known simply as tribunals. What is important to establish is precisely where the expression *tribunals* figures in the world of inquiries, which is as the act which forms its principal legal foundation. Having emerged, ad hoc, in the late 19th Century, public inquiries acquired formal status in the 1921 Tribunals of Inquiry Act, which still provides the legal basis for the most powerful form of inquiry (Sulitzeanu-Kenan 2006: 625). This type of inquiry is classically used in response to a ‘nation-wide crisis of confidence’, however that might be defined.

But inquiries can have other legal bases and other inquiries are also statutory, with the power to compel witnesses to attend and give evidence. Legally, the Tribunal and Inquiry Act did not exclude non-statutory inquiries being set up under Crown prerogative by ministers, such as the Falklands and BSE inquiries, or using legislation such as the Merchant Shipping Act of 1970. In fact only 24 of the major inquiries since 1921 have been formally based on the Tribunals Act. Of the inquiries with which this report is particularly concerned (see list in chapter 2) the only inquiries based directly on the 1921 Act were: Shipman, Dunblane, and the North Wales child abuse (it is also worth noting that Aberfan was a tribunal inquiry). In addition, the Tribunals Act works alongside other specific (statutory) inquiries, such as under the Police Act of 1964, the Railway Act of 1974 and the NHS Act 1977. The legislative basis for some, like Lord Laming’s inquiry into the murder of Victoria Climbié was in more than one parliamentary act: the NHS Act 1977, Children’s Act 1989 and Police Act 1996.

A distinction can be made between:

- a. *Tribunal of inquiry*
- b. *A statutory public inquiry using other existing legislation*
- c. *A non-statutory public inquiry* – governed by the the 1921 Act but allowing more flexibility in the conduct of the inquiry and no formal powers to compel witnesses and documents. Examples would be the BSE and Butler inquiries.
- d. *Ad hoc, independent inquiry* – this type of inquiry is mostly held in private and is often used by the Department of Health. An example of this would be the (external) Shipman Inquiry which was known as a ‘public independent inquiry’.
(BBC 2004)

This is not to suggest that the categorisation of public inquiries is entirely self evident and does not involve judgement. There will rightly be discussion and disagreement particularly over what constitutes ‘notable’ or ‘inquiries into matters of (major) public concern’ – particularly in areas such as health where inquiries have become relatively routine.

The Public Inquiry and its Characteristics

So exactly what is a public inquiry and what are its characteristics? In general terms an inquiry is: ‘a retrospective examination of events or circumstances surrounding a service failure or problem, specially established to find out what happened, understand why, and learn from the experiences of those involved’ (Walshe and Higgins 2002). What is often understood by the term, however, are the ‘notable’, major, even iconic inquiries that have often had a significant impact within society. For Elliott and McGuinness (2002: 47): ‘Within the UK, the public inquiry is the generic term used to describe mechanisms for investigating high profile disastrous inquiries’. Lord Howe (1999) similarly distinguishes public inquiries, explaining:

‘The kind of inquiry that I wish to discuss here is that triggered not by some broad policy question but by a specific event or activity which would be inappropriate for investigative consideration by with House of Parliament. I have in mind, for example, an inquiry to investigate serious allegations of improper conduct in the public service; or to establish the cause of some major disaster and to learn lessons from it; or to consider some other matter of public concern, which requires thorough and impartial investigation and which may not be dealt with by ordinary civil or criminal processes.’

Another definition is provided by Lord Clyde, who sees them as: ‘concerned primarily with investigation into the facts of some past incident...political scandals, major public calamities and crises of regime legitimacy’. Recent academic research on inquiries distinguishes a systematic set of criteria:

1. An ad hoc institution; that is, one established for a particular task; once its primary task is concluded, the tribunal is dissolved
2. formally external to the executive
3. established by the government or a minister

4. as a result of the appointer's discretion: that is, not the result of a requirement prescribed by any statute or other rule
5. for the main task of investigation: a criterion used to distinguish between investigative and advisory functions
6. of past events
7. in a public way; that is, it is not only directed inward (to the appointing body) but also outward, to the public, typically during a crisis of confidence between the government and the public in a way which allows public exposure of relevant facts to public scrutiny
(Sulitzeanu-Kenan 2006a: 624)

Sulitzeanu-Kenan (2006b: 61) also provides the most succinct definition – as it is meant by the likes of Howe and in this report - as an: ‘ad hoc institution established to investigate past event(s) in a public way...’ We might add the qualification held by the Home Office that those defined as public inquiries are restricted to those headed by a member of the judiciary (Elliott and McGuinness 2002: 15).

So what are the *essential* characteristics of a public inquiry? It is an ad hoc body charged with thoroughly investigating the background to events and experiences deemed of sufficient gravity to warrant such a response. Inquiries do this in a deliberately public fashion, both regarding proceedings and the publication of proceedings. Alongside its public character it is the perceived independence of both executive and legislative functions that is most crucial. This independence creates the potential to do what (partisan) political institutions cannot - restore confidence, even trust under circumstances where it is perceived that political institutions are too compromised. In other words government ‘borrows’ the authority of (neutral) expertise (Drewry 1996).

At least formally, their other common and very important characteristic remains that none have been initiated by proceedings on the part of one party against another. Inquiries should not be adversarial; all, almost by definition, are inquisitorial in substance and in form. For example, there is currently an inquiry into an explosion in 2004 at a plastics factory that killed 9 people in Scotland, and this, the ICL inquiry makes very plain from the beginning, in briefly explaining its nature, that:

The Inquiry is inquisitorial in order to enable the matters giving rise to concern to be examined independently for specific purposes prescribed by its terms of reference, within a reasonable timescale, and without the burden adversarial examination imposes on both time taken and the public purse. Adversarial examination in the United Kingdom is reserved to the proper courts for the determination of the rights and the liabilities of individuals and persons and any award of damages or compensation.
(ICL Inquiry)

From this perspective inquiries should concern themselves with responsibility in the causal (factual) sense rather than also in the culpability (legal) sense. In practice, accompanying the proliferation of inquiries, some, contested, procedural differences have emerged. Most significantly in recent years, there was heated public debate between Sir Richard Scott and Lord Howe of Aberavon over an ‘inquisitorial’ or

‘adversarial’ approach to inquiry procedure, following Scott’s inquiry into the ‘arms for Iraq’ affair (Howe: 1999).

Public inquiries are public in that not only are written submissions encouraged – as is the case with most forms of inquiry – but that lay members can listen to oral evidence. The Chairman of the ICL inquiry has made it clear publicly that he is prepared to consider questions from ‘any interested person’. Their public character is defining; it is central to the description of inquiry proceedings in the new 2005 Inquiry Act, for example. Following the act’s section on ‘evidence and procedure’, the second section concerns ‘public access to inquiry proceedings and information’. Here it is specified that:

- ‘Subject to any restrictions imposed by a notice or order under section 19, the chairman must take such steps as he considers reasonable to secure that members of the public (including reporters) are able –
- a. to attend the inquiry or to see and hear a simultaneous transmission of proceedings of the inquiry
 - b. to obtain or to view a record or evidence and documents given, produced or provided by the inquiry
- (Inquiries Act 2005: 8)

There are, however, then extensive ‘restrictions on public access’ in the Act, detailing the circumstances under which they can be imposed. Their defining public character dictates that great care and attention has to be paid to any limit on the expectation of public access.

In the simplest terms, public inquiries are intended to find out why something happened and help prevent it being able to happen again. This is reflected in some of the terms of reference which form the basis for their guidance. As a relatively typical example, these are the terms of reference for the ICL inquiry:

1. To inquire into the circumstances leading up to the incident on 11 May 2004 at the premises occupied by the ICL group of companies, Grovepark Mills, Maryhill, Glasgow.
2. To consider the safety issues arising from such an inquiry, including the regulation of the activities at Grovepark Mills.
3. To make recommendations in the light of the lessons identified from the causation and circumstances leading up to the incident.
4. To report as soon as practicable.

The conclusions of the inquiry are delivered in the form of a written report, given first to the government, and soon after published for public consumption. The report will generally make recommendations to improve the quality of government or management of public organizations in the future. It is through their recommendations that inquiries have most impact. As the current Lord Chancellor explains: ‘Implementation of these has not only helped to prevent or deal with recurrence of the events investigated, but has also often helped to satisfy those affected by the events, and the general public, that the right lessons have been learned’ (Effective Inquiries 2004: 7). This is reflected in how they function, where:

‘...there is a lengthy process whereby evidence is given to a tribunal (often chaired by, or solely comprising, a senior judge) by those involved in the relevant events. The tribunal then writes a report in which it records its findings of fact and makes recommendations as to changes in the law or administrative practice which would reduce the chances of another disaster occurring again’ (Steele 2004: 739).

What is revealing here is that public inquiries are not only unique in their form and character but in their very ambitious character. Public inquiries hold out the expectation we can reduce, perhaps even prevent ‘another disaster occurring again’.

Section 4: The ‘Function’ of Inquiries

‘The families have felt strongly that no full public inquiry too place and that cannot bring their loved ones back, but it can, I hope, bring some peace of mind to know that their case can be told and lessons can be learned for the future.’

Deputy PM John Prescott announcing an inquiry into the Marchioness riverboat accident a decade after the tragedy
(Cited in Elliott and McGuinness 2002: 15)

Considering a ‘Function’ of Inquiries: So it doesn’t happen Again?

Even if there is a demonstrable increase in the number and range of inquiries they are certainly not embarked upon lightly and remain an instrument of last resort. Public inquiries remain unpredictable particularly when their focus is on an issue that has taken place on the ‘watch’ of the incumbent administration. To consider they have a function beyond the direct tasks of identifying what happened and why might seem cynical or to be implying that there is a wholly conscious process at work. This need not be the case. The fact is that the inquiry process is part of the response to exceptional events that invite intense scrutiny, it is necessarily intensely political. Decisions about how best to deal with a particular crisis and calculations that a public inquiry would be most suitable must involve some kind of strategic thinking, and thereby a sense of what an inquiry might achieve. This section will assume that we can intellectually identify ways in which they serve a function or are at least intended to so, and that this may be a useful exercise. It may help us understand why instruments that only rarely have been regarded as an unequivocal success, that are, at least hypothetically dreaded by politicians and routinely dubbed a ‘whitewash’ by the public, nonetheless continue to be resorted to, and even more commonly demanded.

It might seem curious to ask what inquiries are *for* – what function they might fulfil - as it is so self evident as to scarcely be worth asking. Surely they are to find out what went wrong and take steps to make sure it doesn’t happen again – in relation to an incident so serious that only the most open and wide ranging investigation would suffice? This common sense view is reflected in some definitions of the purpose of public inquiries and the stated aims of specific inquiries themselves. Take the example of the current ICL inquiry (2008):

- There is often a strong feeling, particularly following high-profile controversial events, that an independent public inquiry should ascertain what happened and why, and identify what can be done to prevent such an event happening again.
- The aim of the Inquiry is to establish the facts and circumstances that led to the explosion, to establish how it occurred on the day, and to make recommendations seeking to prevent a recurrence of any similar event.

Derived from reflection on disaster investigations, the Rt. Hon. Lord Justice Clarke (2000:7) sees two purposes of a public inquiry, ‘namely ascertaining the facts and learning lessons for the future’. For Elliott and McGuinness (2002: 15), meanwhile, their central aim, ‘is the collection of evidence and fact finding’. Such a process is

likely to involve establishing the focus and extent of blame. Sir Louis Blom-Cooper (1993: 20) spells out the implications more precisely as being: ‘to examine the truth...what happened...how did it happen, and who if anyone was responsible, culpable or otherwise, for it having happened?’ It is through their recommendations that inquiries have most impact and their function fulfilled. As the current Lord Chancellor explains: ‘Implementation of these has not only helped to prevent or deal with recurrence of the events investigated, but has also often helped to satisfy those affected by the events, and the general public, that the right lessons have been learned’ (DCA 2004: 7).

The function of simply finding out what happened is the most straightforward justification for inquiries but does not account for some of their important characteristics. An immediate question is why ‘finding out what happened’ should be done through the expensive, elaborate and very public means of the public inquiry rather than one more internal to the relevant professionals. It is not difficult to appreciate that professionals with shared understandings and language are likely to come to an appreciation of ‘what went wrong’ more quickly and efficiently without external legal, media, political and campaigning pressure. As an illustration consider the UK rail industry. Some form of inquiry is necessary following any incident and there are now competing professional organisations dedicated to aggressively investigating any accident that takes place. This is the result of the intense, politicised and legalised interest in rail incidents which is at least partially the product of the high profile inquiries of recent years. Such scrutiny has led to defensive practice within the rail companies and employees are instructed not to speak with investigators without legal support. With the recent legalising of corporate manslaughter such defensive practice is likely to be consolidated. Reconstructing the circumstances in which an incident occurred is a painstaking task that requires as free an exchange of recollections and opinions among experts as possible. Loading such processes with a range of other pressures and requirements may be unhelpful to the process. Even if it is considered that it was necessary to mount successive rail inquiries in the way that was done it cannot be argued that doing so in such a public manner was determined by the basic needs of fact finding and lesson learning. Such functions have been carried out by internal rail investigations for a century or more and it is partially because of them that such steady improvements in safety have occurred.

As we now routinely expect that ‘lessons will be learnt’ and the guilty identified and held responsible, we lose sight of a number of important assumptions that are being made in this process. In the first place, the inquiry response embodies the assumption that all accidents have been preceded by a predictive pattern of events or conditions. To identify those, it is implied, will make it possible to avoid similar incidents in the future: ‘the job of the inquiry is to understand the past in order to improve the future’ (Feldman 1999: 22). This assumption frames the way we consider the circumstances of the incident, as contributory factors rather than as circumstances that might have other social rationales or roles. This is by no means to suggest a conspiracy; there is certainly no ‘controlling mind’ to borrow a phrase from the related world of corporate liability. The character and function of public inquiries has unfolded and evolved in specific historical and political circumstances, and has been shaped by, and played its own role in shaping them. A particularly important concurrent development has been the attack on the alleged vested interests of professional groups such as medics and lawyers that was instigated during the Thatcher era. The focus of contemporary

inquiries has reflected this development, with far more now concerned with the practice and conduct of the professions than politicians.

'Borrowing Authority'?

Framed in political rather than legal terms fact finding and lesson learning have always been secondary to their political role. Inquiries were resorted to historically where it was felt that it would be better that politicians were distanced from deliberation, and that public trust would be better ensured or retrieved through more independent examination. As indicated earlier, the management of the Marconi scandal where leading politicians were accused of corruption is the seminal public inquiry. Sulitzeanu-Kenan (2006: 625) explains that:

‘The basic argument underlying these inquiries is that crises, disasters and scandals often result in public disquiet and in loss of confidence in the body politic. Confidence can only be effectively restored by thoroughly investigating and establishing the truth and exposing the facts to public scrutiny’

Most immediately, the announcement of an inquiry may improve the image of an appointing minister, and in the slightly longer term suggest an agenda-setting effect, as the issue might be ‘kicked into the long grass.’ Overall, the political *resort to* inquiries has been described as a process of ‘borrowing authority’, defined as: ‘...the deployment by politicians of the judges’ status and credibility to defuse matters which those politicians feel they can neither safely ignore or tackle by normal political and parliamentary methods’ (Drewry 1996: 369). The establishment of an inquiry indicates that it was not felt that the issue could be credibly confronted by political decision-making alone but instead the authority of formally independent expertise must be invoked.

Subjecting themselves to independent scrutiny as the Prime Minister did directly in the Scott Inquiry can be seen as a means of restoring confidence in their integrity. More specifically, appointing an inquiry may lead to a reduction in the responsibility attributed to the appointing government minister, and Sulitzeanu-Kenan (2006a;b) investigates this hypothesis. The focus on this historically given role for inquiries tends to ignore the fact that the focus of inquiries has shifted, however. As indicated in the previous section, public inquiries now tend more to concern matters of public risk than the reputation of the body politic directly.

As a political and institutional imperative, inquiries are intended to engage with a perceived crisis of trust or confidence between the public and institutional authority. Increased *resort to* inquiries reflects a greater perceived need to invoke expert authority, as political institutions are subject to greater mistrust (Cabinet Office Strategy Unit, 2002). Inquiries also engage with more specific areas of perceived mistrust. The inquiry into mobile phone radiation, for example, was at least partially an exercise in overcoming the perceived legacy of mistrust bequeathed by the handling of the BSE crisis, through demonstrating a new willingness of scientific risk management to investigate even hypothetical fears (Burgess 2004). Such an orientation suggests a diminishing requirement of scale or significance in what is

deemed to require investigation and reflection; if inquiries are to fulfil such a trust restoring function it suggests more ready resort to this instrument than in the past, where the scale of events would not seem to justify such a response. The holding of inquiries into family tragedies such as the Soham murders might confirm such an hypothesis, but demand further exploration and comparative reflection.

Catharsis and Restoring Victim and Public Confidence

The function of inquiries extends beyond the deceptively simple ones of fact finding and lesson learning, but also beyond that of restoring political authority. Their public character is clearly central to this form of investigation and the way in which inquiries might engage with the public, or at least sections of it, have become increasingly important. Alongside Lord Howe, Louis Blom-Cooper is one of the legal pioneers of the contemporary inquiry and it may be no coincidence that he was credited with the ‘common touch’ and an ability to engage public feeling. Singling out Blom-Cooper’s contribution to public inquiries as his ‘most important outlet for his abundant talents’, Lord Woolf (1999) wrote how: ‘his understanding and ability to relate to the public have again and again been called on by the government of the day and other institutions...when matters of great public concern have arisen’. As there is an historic shift in the focus of inquiries away from the state and towards public risk so too there has been a greater emphasis on their role in helping victims and their families grieve and provide a cathartic function for communities and even the public as a whole. The dramatic increase in the extent to which inquiries are oriented towards the perceived needs of victims – variously defined – is an important development.

Geoffrey Howe concurs with the conclusions of research into homicide inquiries that there are four functions of inquiries: learning, discipline, catharsis and reassurance. He elaborates very little on these notions, such is his concern to highlight the dangers of assigning blame, and creating the impression that ‘the public will be safe from any repetition of disaster’ (Howe 1999: 296). ‘Learning’ and ‘discipline’ essentially concern the functions of fact finding and subsequent implementation; he is insistent that even if conducted privately inquiries must publish their findings with prior notification so that publicity is generated. This makes it possible to: ‘make an effective contribution to fault-finding and consequent reform in the services under review’ (Howe 1999: 303). In this sense he cites the Ely Hospital Inquiry (which he chaired) as the first where, even though conducted in private, a full report was published and thereby ‘the veil of secrecy removed’. Howe’s categories of ‘catharsis’ and ‘reassurance’ concern inquiries’ wider public role. A cathartic function is seen to be fulfilled simply by the right of victims to be heard, as Chairman, Professor Uff explained in his opening remarks to the Southall Inquiry, for example. It is established that victims of tragedy want two things: to know exactly what happened (no matter how painful) and that it should not happen to others in future (Prins 2004: 29). It can be suggested that ‘catharsis’ is the function most pertinent to the victims of inquiry incidents and their families, and ‘reassurance’ to a wider public that such events will not be repeated (and potentially affect them). But there is no intellectual or practical clarity of any such difference and the blurring of these two functions is inevitable.

Howe identifies inquiries into health related crises as particularly important to 'go public', despite the centrality of confidentiality issues to medicine. The Kennedy Inquiry into children's heart surgery in Bristol 'is one case in which the "public confidence" factor understandably tilted the scales in favour of a public inquiry'. The Stephen Lawrence Inquiry and, much further back, the Aberfan Inquiry 'are evident examples of cases where only full public inquiry could have matched the expectations of public opinion' (Howe 1999: 301). It is not clear why Howe's sense of public expectations is so clear-cut, but he sees that an inquiry was necessary for the function of restoring public confidence. The cathartic effect is relatively clear in relation to direct and indirect victims of tragedy in terms of the grieving process. Howe cites the example of an Aberfan villager who had lost his family in the disaster and for whom the famous cross examination of Coal Board chief Lord Robens had been 'balm to my soul' (Howe 1999: 302). The cathartic function becomes less clear the further away one travels from direct experience of tragedy, and prolonged legal argument over claims of trauma whilst watching the Hillsborough football stadium tragedy on television are pertinent in this regard. On the other hand it may be argued that 'the nation' now becomes so emotionally bound up in a case such as the Soham murders or disappearance of Madeline McCann that we are all somehow in need of catharsis; certainly there seems little doubt that these cases have made significant impact, even stimulating more cautious parenting. At the same time an inquiry into an experience such as the Soham murders can be seen as playing a central role in heightening rather than absorbing public anxiety. It should be asked whether in this case the public are being treated as if they were an extension of the victims or their families. This may be the logic of holding an inquiry into the Soham murders, as if they were to reassure parents everywhere that every effort will be made to limit the chances of it happening again – even though 'we all know' no such guarantees can be made.

Howe points out that there is very fine line between providing catharsis and stimulating demands for blame and retribution. Whilst highlighting the cathartic benefits of attacking Coal Board officials he acknowledges that they 'were "pilloried" so publicly that they became "pariahs in the eyes of the Aberfan villagers", often their life-long neighbours' (Howe 1999: 302). 'Blaming and shaming' may be intrinsic to this process, despite it clearly being a step beyond the simple 'right to be heard' (Peay 1996; Wells 1995). At the very least this problem highlights the need for the legal representation for the subjects of inquiry.

Whatever the problems involved even in the Aberfan inquiry it stands as a relatively clear marker against which a subsequent expansion in the domain of catharsis and reassurance has expanded and may be now unclear. Expectations of what an inquiry can achieve have been raised, at least partly by perceived successes such as Aberfan. Some expectations, such as for redress and establishing a broader truth of what happened, may come into conflict with each other. The quote from John Prescott with which this section began announced an inquiry into the sinking of the Marchioness following a decade of campaigning by relatives of the 30 victims. The case is interesting from a number of different perspectives, asking questions of what lessons can really be learnt by going back into the detail of events so long past (against the historically immediate character of inquiries) and the morality of doing so considering the impact on those likely to be reinvestigated. 'Lesson learning' is evidently not simply about making sure another similar accident takes place but a process to help victims' families achieve 'peace of mind'. In this respect the process has a symbolic

character comparable to the political function of inquiries in relation to the demand that ‘something be done’; the real outcome is secondary to the perception that procedures have now been changed and that will necessarily make further incident less likely.

There is evidence that inquiries have become more oriented towards the emotional needs of victims and their families and are therefore attempting to fulfil a greater cathartic function than ever before. In one sense it is unsurprising that inquiries should reflect the wider trend towards the elevation of the victim that is evident in the general cultural environment and in government policy, particularly law and order. On the other hand it may be problematic to elevate personal experience and feelings in proceedings so concerned with establishing precise chains of events and causes. Curiously from a scientific perspective, the views of new variant CJD victims’ families were made prominent in the BSE inquiry. The problem may not giving victims and their families an opportunity to be heard than what status is assigned these feelings. The process of public reassurance appears to have become synonymous with taking their views seriously; a process that suggests they will be regarded as somehow equivalent to evidence-based ones. The elevation in the place of victims and their families has raised expectations, and it is significant in this respect that the families of the victims of Harold Shipman successfully forced an open public inquiry on the issue. But it is not exclusively only the views of victims and their families that are now commonly engaged by inquiries, but other ‘unofficial voices’ that somehow manage to be seen as representative of this perspective more widely. William Stewart, head of the mobile phone radiation inquiry, made a personal and determined effort to flatter not victims (as there were none in an inquiry into the possible threat of mobile phone radiation) but campaigners against mobile phone masts (and, by contrast, marginalise organised scientific views such as those of the official body charged with protection from radiation, the NRPB).

A Blame Function?

There is a further possible function of inquiries that flows from the changing focus and target of contemporary inquiries towards matters of public risk and away from the traditional focus on the state and its political actors. Inquiries have expanded in such a way as to be principally concerned with the conduct of professionals such as social workers, engineers and doctors. As a previous BRC report (2006) noted, politicians and the state are at the centre of a cycle of raised safety expectations, such that following even historically relatively minor incidents there is a media-led chorus demanding that ‘something be done’. Politicians thus feel under intense pressure to make perhaps unrealistic promises. Might inquiries be regarded in this same context, whereby the ‘something’ to be ‘done’ demands a target, and the subjects of inquiries fulfil that role? After all blaming, targeting others is a political ‘function’ as old as providing ‘bread and circuses’. The resort to a process of blaming professionals might be seen as taking pressure away from politicians and may even add to their credibility as they align themselves with a public (safety) interest against the narrow self interest of professional and corporate cultures. Certainly, assigning blame – especially to those not allowed proper means of reply or redress - is recognised as perhaps the principal potential problem with inquiries (e.g. Howe 1999).

There is some evidence in the character of contemporary inquiries to support the idea that professions and their expertise have become the targets of inquiries and that this might be considered a political function. An important tendency of modern inquiries is the increasing singling out of professional 'cultures' for criticism rather than individuals. This is evident in the frequency with which inquiry reports and subsequent media coverage highlight a professional environment which serves their own narrow, self-perpetuating interests but is at odds with the interests of patients and customers. The allegedly racist 'canteen culture' of the police targeted by the Stephen Lawrence inquiry is an example, as has been the working culture of surgeons attacked in high profile medical inquiries. Inquiries related to the private sector such as railways more routinely identify a corporate culture of compromising safety through the drive for profit. The typically wide-ranging recommendations of contemporary inquiries often involve measures to open up professional cultures to external rather than self-regulation.

A shift away from only blaming the individual is particularly clear in the rail industry. Following the 'SPAD' accident at Purley after the Clapham crash of 1989 there was a strong sense of injustice about the jailing of the driver and he was released early. Subsequently an assumption has developed that individual blame is inappropriate, even representing a 'whitewash'; the driver involved in the Southall crash wasn't even prosecuted, for example. In inquiries concerned with the private sector such as these the focus has tended to move up the managerial hierarchy. This is also indicated by the determination with which it has now been established that 'corporate manslaughter' can be legally pursued without the establishment of a 'controlling mind' that previously stood in its way.

It is important to recognise that the trend away from blaming the individual (other than perhaps a rail company CEO!) cannot simply be regarded as recognition that assigning blame is unproductive. In a sense the shift signals a determination to cast the net of blame more widely, to not only the actions of the negligent individual but the very way in which professionals conduct their business and exercise their expertise. Of course, this is not to suggest that negligent professional cultures do not exist or that inquiries have not been effective in rightly exposing them. For example, Munro (2004: 85) describes the 'frighteningly bad' management of the murdered child Victoria Climbié, where 'a set of professionals trying to avoid taking responsibility for Victoria's welfare by minimising their interpretation of their own role as much as possible and relying on someone else doing the necessary work'. Inquiries in this domain also indicate that the targeting of professional cultures does not preclude the specific targeting of individuals. The Beckford report had no hesitation in naming and blaming the two workers in the frontline of social and health services in the London borough of Brent. In the Climbié Inquiry the front line social worker was castigated by the press, sacked by her employer and even placed on the register of people considered unsuitable to work with children in any capacity. Whatever the rights and wrongs of blame in this case, however, its demoralisation of the social work profession can be seen as further undermining the quality of service, as professionals leave the service or become more concerned with only sticking rigidly to bureaucratic procedure – lest they find themselves before an inquiry.

Assisted by the public inquiry into the Soham murders, Ian Huntley can be seen to have become a kind of folk devil fulfilling a social function of focusing public hatred (even though the inquiry's focus was on the alleged failings of police checking procedures). But Soham may be unusual in the way it provided such a relatively clear focus, and even in this case it is difficult to identify any clear political benefit. It may be more useful to view blame as an unconscious end product of a reactive process which serves little clear function. A key characteristic of inquiries are that they are not under political control and there is little evidence of any overall, lasting political benefit from the high profile inquiries of recent years. In a more reactive, hand-to-mouth sense politicians may enjoy improved credibility - or at least the deflection of hostile focus - through redirecting scrutiny towards the shortcomings of professional groups. In some instances there has been a positioning even of ministers as more one of us the 'public' than 'them' the negligent professionals, sharing the disquiet of the average parent, patient or consumer. Such an alignment appears to have become established for Health ministers, for example, and may be confirmed by every further measure 'for the patient' and 'against the professionals'. Setting up an inquiry can be the most dramatic demonstration of such a political commitment to pursue the public interest, and this commitment is then demonstrated by professionals being forced to apologise and change their ways. Indeed a sense of being part of a 'public' may only be constituted through elevating professional interest groups whose interests are allegedly antithetical.

Contemporary inquiries do not mainly concern political integrity directly and it is certainly unclear that inquiries can successfully restore it. The 'political game' has become more complex and unpredictable and there is a sense in which the original function of inquiries has become a more basic one of short-term crisis management. The most basic and immediate function of an inquiry may be more reactive than strategic. It is to demonstrate that the particular seriousness and significance of an issue has been recognised by politicians and that 'something (significant) is being done'. Such a function can be considered one of 'public reassurance' (Drewry 1996), even if it is actually unclear exactly who is demanding reassurance and what it constitutes. In this sense it is responsive to what is described as the 'tiresome cliché' that has 'been invented, namely [the call for] a "full public inquiry", as if there was some sort of half-baked inquiry which might suffice on occasion...' (Clothier cited in Prins 2004: 21). Perhaps surprisingly this fundamental function of inquiries is not explored in any of the intellectual discussion and academic writing on inquiries, as if it were so self evident as to not merit attention. Yet it may be an important starting point for understanding, as it locates inquiries in the realm of the symbolic where there is less concern with outcomes and possible consequences than that the 'right thing' is being seen to be done at that moment. Whilst it may appear obvious that politicians must always be seen to be 'doing something', it is arguably a more recent development that reactive action is a relatively automatic given. At the heart of political leadership is resistance to calls for 'something to be done', and, indeed, many demands for inquiries such as over the killings at Deepcut barracks continue to be denied. Even in an age where 'something must be done' the most substantial, unpredictable and expensive way of doing so must necessarily be applied only selectively.

By contrast, one function that inquiries seem unsuited to is restoring trust and credibility to the professions that have been at the heart of so many contemporary inquiries. The resort to inquiries related to political and state conduct suggests political integrity. Inquiries can thus potentially fulfil a function of restoring trust to the body politic. The same cannot generally be said of the more common targets of contemporary inquiries, which in matters of public risk are usually groups of professionals and experts. If the general argument was that the mistake was quite exceptional and culprit just a 'bad apple' that proved a rule, there is the possibility of restoring trust and authority. But this is not the general argument and tenor of contemporary inquiries. Incidents are generally held up to be symptomatic of a wider culture of neglect, incompetence or putting profit before safety. Our faith that incidents will not happen again is highly conditional, as it is not based on renewed trust in professional integrity but that they are now subject to close and continual scrutiny and external regulation. At its most extreme the culture of inquiry suggests that every doctor is a potential Shipman, and this is the inescapable message of regulation ensuring that doctors do not routinely murder their patients. Whilst the political function and benefits of public inquiries have become uncertain and unclear, they might be regarded as positively dysfunctional for many professionals and the regard in which they are held by the public. Mistrust may even be internalised by the professions themselves; as President of the GMC, Professor Sir Graeme Catto, explained (BBC Online 2005): 'Shipman was a considerable exception but, nevertheless, we need to tackle the problems that his case throws up'.

Section 5: Troubles with Inquiries

“Huntley alone was responsible for, and stands convicted of, these most awful murders. None of the actions or failures of any of the witnesses who have given evidence in the inquiry, or the institutions they represented led to the death of the girls...however; the inquiry did find omissions, failures and shortcomings which are deeply shocking. Taken together these were so extensive that one cannot be confident that it was Huntley alone who ‘slipped through the net’”. (Bichard Inquiry Report: 1)

‘It has not yet been established why psychiatric patients kill others...However many inquiries and their reports imply there is something the psychiatric services can do to prevent this happening. The implication is that if a gold standard of care was provided, psychiatric patients would either not kill other people or do so less frequently. This is far from certain...’
(Petch and Bradley cited in Prins 2004: 36)

A Robust Instrument of Change

As inquiries are inclined towards finding systemic fault in professional and corporate culture so this report is inclined to emphasize problems with inquiries, as it seeks to help think through their implications in the context of an increased orientation of society around risk. Yet it is useful to take note also of their strengths and remind oneself that they continue to be held in high regard in many quarters, albeit with inevitable caveats. Problems with inquiries from the government’s perspective have actually been relatively peripheral and technical; ‘the government considers that inquiries have been successful overall’, only that some have been marred by procedural difficulties and problems of length and cost (PASC 2005: 8). There are indeed aspects of inquiries that can be positively highlighted beyond the extent to which they can be considered to successfully fulfil their function that will be considered in the final section.

The organisation of most inquiries is very impressive, all the more so in an age where the rigorous, ‘no matter how long it takes’ pursuit of understanding by official bodies might be seen as a rare commodity! Those chosen as inquiry chairmen evidently take their responsibilities extremely seriously and apply both the forensic minds and capacity for organising large amounts of information acquired through usually vast experience of the legal profession. Certainly there do not appear to have been any badly run inquiries. The only significant procedural criticisms of inquiries is Howe’s (1999) attack on the Scott Inquiry, but the accusation was of breaking numerous unwritten rules regarding representation of the accused, for example, not that it was in any way incompetent. Howe attacked the Scott Inquiry for his sitting alone without the benefit of independent experts, the aggressively inquisitorial nature of proceedings and the lack of legal representation for witnesses being treated in such a manner. Inquiries can generally be relied upon to thoroughly investigate the circumstances and background to incidents, calling upon hundreds of witnesses and masses of evidence if necessary. Phillips’ BSE inquiry is a model in this regard, and the discussion of the scientific issues related to electromagnetic fields in Stewart’s inquiry into mobile

phone safety was exemplary (although at odds with other parts of the report intended to engage concern).

Once set in motion, inquiries typically become significant institutions with the force necessary to be taken seriously and take advantage of the opportunities this affords. The former civil servant at the heart of the Philips inquiry, Richard Packer (2006), goes into fascinating detail about how it was able to resist political pressures to assign easy blame for the 'mad cow' crisis. The way that Packer himself was subsequently blamed he regards as separate to the inquiry itself and its conclusions; it was rather the product of media spin by the Prime Minister's press secretary, in his estimation. The independence of inquiries is not tokenistic and any suggestion that inquiries are somehow an easy means of just 'kicking an issue into the long grass' of a compliant and suitably ineffectual committee are wide of the mark. Partly as a result, inquiries amass enormous quantities of material that stands as a significant resource for research and reflection. As they have increasingly concerned themselves with the professional culture within which accidents and tragedies take place the picture they paint is one that is not just specific to the particular incident but can tell us about professional cultures more generally. Academic Eileen Munro (2004: 85) notes how the Climbié Inquiry report remains 'best source of information about what is going on in front-line work', for example. At the same time it should be emphasized that this benefit is not unique to public inquiries but is the case with other comparable instruments such as Royal Commissions and Select Committees. As has been suggested, public inquiries' more exposed character can make careful (slow!) investigation harder and 'public' pressures of inquiries more difficult to resist.

Arguably the strongest claim on behalf of inquiries is their role in bringing about organisational change. Howe (1999) strongly believes on the basis of his own experience that inquiries can play a valuable role in drawing attention to serious organisational deficiencies and bringing about reform. This was perhaps clearest in the case of the early public risk inquiries such as Ely and Aberfan. These were significant challenges to the established way of doing things; it was extraordinary at the time to witness the shock at Coal Board officials being treated without deference and properly challenged to account for their role in the Aberfan tragedy. There is a strong case for arguing that these early public inquiries played a significant role in bringing about a wider change in political culture to a head. They accelerated the end to deference – the challenge to what Moran (2003) more substantially calls 'club rule'; the cosy, informal, anti-democratic means through which British society was run and self regulated. Inquiries' robust independence from political control attracted strong, pioneering and sympathetic individuals like Howe and Blom-Cooper, which helped determine a capacity for real independence from other significant institutions and from easy reliance on traditional assumptions about how 'things should be done'.

An obvious qualification to any positive regard for public inquiries is that their positive impact in relation to public risk obviously varies from inquiry to inquiry, depending on the issue and context. In the context of the Philips Inquiry there was an opportunity to thoroughly investigate a controversy that otherwise might have been left at the level of caricatures about strange farming practice and incompetent scientists and politicians. Although the media largely ignored the inquiry's more substantial aspects this is hardly the fault of the inquiry, and much of what is in the report stands as an historical record of who, what, and even why? On the other hand

an inquiry such as Bichard's into the Soham murders was dealing with children and risk, and concerned itself with the question of how Huntley managed to be where he was, as if the answer to this question effectively addressed public concern and established 'the facts' of two murders. Like other inquiries the Bichard Inquiry did not consider the wider implications of its actions and messages - which in this case can be seen as damaging. The Soham inquiry further promoted the sense that child murder is not unusual but, at the same time, can be prevented through regulation – regulation that effectively assumes that anyone working near children is a risk unless 'proven' otherwise. In a sense the question is one of whether inquiries are pushing against a grain that needs challenging - as was the case in the 1960s - or might actually be affirming new barriers and restrictions, as has been the case more recently with inquiries such as into the Soham murders.

Disparate Criticism

It was noted at the beginning of this report that inquiries have attracted little attention as their active role in not just responding to tragedies, but shaping our understanding of events goes largely unrecognised. Clearly, if they are not recognised as important instruments in their own right they are unlikely to be at the centre of substantial critique. Nonetheless there are a wide, and disparate, range of criticisms made of inquiries in the limited literature on the subject, some of which resonate with wider perceptions. Unsurprisingly, they reflect the preoccupations and perspectives of those making them, notably: government, inquiry chairs, researchers into disasters and responses, and the professions directly affected by investigation and recommendations.

Although they do not actually reflect the range of criticisms made of inquiries, Elliott and McGuinness (2002) attempt a characterisation that distinguishes three different ranges of criticism and these are useful to set out before we turn to examine significant issues in their own right.

A first group of criticisms concerns *impartiality* with bias arising from the character and skills of those appointed to investigate, notably the conservative social background and training of senior judges (Elliott and McGuinness 2002: 17). Although difficult to specifically substantiate, there is a popular assumption that inquiries can be disregarded because those from 'the establishment' will inevitably whitewash the role of their fellow institutions and individuals. From this perspective the process may just be an exercise in taking the impetus out of concerns by being seen to do something – whilst being certain that little of consequence is likely to result.

A second set of criticisms identified by Elliott and McGuinness (2002) concerns their *process*, particularly regarding the extent of terms of reference. On one side this would include the criticism that inquiries are 'left censored' (Perrow 1999), focusing upon failed systems rather than successful ones. More popularly this would concern an extension of the criticism of inquiries as 'in-house establishment exercises'; that they do not consider the wider systemic character of the specific mistakes they identify. Thus we might expect that inquiries would only ever blame a (lowly) individual rather than the organisational system which allowed their mistake to occur.

A third set of criticisms identified by Elliott and McGuiness (2002: 16) concerns their *underlying purpose*; ‘that the real purpose is not understanding and remedy but to collect evidence in order that blame can be apportioned and scapegoats identified’. The question of blame is perhaps the most sensitive substantial issue with inquiries. It is central to the declared process of inquiries that they are inquisitorial not accusatorial and this is to be reflected in every aspect of inquiry proceedings. Yet it is acknowledged that it is difficult to separate out the cathartic function from assigning blame.

Non Implementation and Repetition of Recommendations

Turning now to look at some of the specific criticisms, perhaps the most basic and common criticism of inquiries is that they can be ineffectual, particularly that their recommendations are not actually implemented. For example, there are currently complaints that the introduction of the Contact Point database has been postponed. This was intended to link up professionals in child welfare and was recommended by Laming’s 2003 report into Victoria Climbié’s death, which concluded that the death could have been prevented with better communication. Yet such criticism has a limitless character as it can always be suggested that implementation is not complete and that a real change in operational culture has not been brought about. These complaints also appear blind to recognition of how, in historical terms, inquiries recommendations and much of the subsequent implementation has generally gone much further than ever before. More importantly, such complaint can be seen as the product of the ever-increasing expectations of redress and reform encouraged by inquiries.

There is also a keenly-felt concern about the implementation of inquiry recommendations from within inquiries. Consider the opening statement at the Hillsborough Inquiry by Lord Justice Taylor (1989 cited in Elliott and McGuiness 2002: 16): ‘After eight previous reports...it seemed astounding that 95 people could die from overcrowding before the very eyes of those controlling the event’. Taylor was determined not to see a repeat of such failure and he, effectively, reorganised the whole basis and character of Britain’s national game. Determination to ensure that an inquiry ‘really does make a difference this time’ is an impulse that helps make sense of expansion in the range and scope of inquiry recommendations.

Time and Expense

The second most basic criticism is that they are time consuming and expensive, a concern that can be identified with government but is not exclusive to them (PASC 2005). The enormous cost of the Bloody Sunday inquiry, in particular, has given an edge to such criticism and informed the new Inquiries Act. It is not simply significant expense in itself that has focused criticism, but that so much goes to the legal profession who can appear as unnecessary intermediaries in the process of fact-finding and subsequent reform. Yet it is not clear that much more can be said about the problem of expense other than to endeavour to keep costs down in the future. Further, the perception of lawyers as parasitical is in danger of being ill-informed and caricatured, and the substantial consequence of such criticism is similarly unclear as

the expertise of the legal profession can clearly not simply be dispensed with. Complaints about the allegedly excessive time taken by some inquiries (also brought into sharp relief by Bloody Sunday) can appear similarly insubstantial and inconsequential, and must be balanced against the need to appreciate that thorough investigation is necessarily time-consuming.

This is not to say that temporal issues are not important, however, particularly when they have a bearing upon the substantial questions intrinsic to what an inquiry is trying to achieve. Inquiries reconstruct a course of events that led up to a particular outcome, and draw upon the recollections of participants to do so. When an inquiry is set up so long after the events in question as was the case with the Marchioness inquiry, for example, such a task is especially problematic. Inquiries confront the problem of being too responsive and susceptible to a mood of retribution as they are typically initiated soon after an event; inquiries are reactive to post tragedy demands as part of their cathartic function. For some experts in the rail industry, for example, inquiries react without enough evidence and seem uncomfortable with sticking to a holding position until the facts can be properly established (an approach which they obviously regard as invariably preferable). Yet there are potential problems with a longer period of reflection also. The passage of time is not simply susceptible to problems of recall but, more importantly, extended reflection tends to increasingly fix the significance of past events as an inevitable end point of an inexorable chain of events. Memory is selective and with the passing of time what become established in the mind as key moments tend to exclude all else. Reading the Philips Inquiry report, for example, one is immediately struck by the range of conflicting things going on through the long course of the BSE crisis that simply do not bear much relationship to the standard narrative of incompetence that has been subsequently established. The issue of time, or rather timing, is also important in another sense, as inquiries are inevitably shaped by when they take place and what is taking place at the same time, or just recently. The coincidence of the Bradford and Heysel stadium disasters in 1985 ‘placed issues of crowd “control” and “safety” firmly together within Popplewell’s investigations’.

Too Many Recommendations?

A third and perhaps more important criticism that engages with a significant development with modern inquiries concerns the expansion of their reach. Recommendations are inevitably in danger of too general and unrealistic character. Where inquiries are most routine – in healthcare – they are in greatest danger of becoming ritualistic exercises with little clear purpose. As experts in this field complain, there comes a point where there is nothing more to say when comparable incidents are routinely investigated: ‘Inquiries have ceased to yield new messages at a national level’ (Stanley and Manthorpe 2004: 11). The lack of coordination between different agencies and individuals, in particular, is a criticism that has been repeated so many times that it may have lost meaning. Further, as an external demand, by what measure are we to know when more ‘joined up’ operations have been achieved?

Inquiries are serious instruments conducted rigorously, as noted above. But particularly in an age of highly active government where outcomes and targets are routine this tends to determine that inquiries will not be content with modest

conclusions and outcomes. There appears to be a process of self justification experienced as a belief that ‘they have to come up with something’, as one rail expert with experience of inquiries suggested. This might also be a simple matter of: ‘If we don’t produce extensive recommendations how can we justify the resources that went into it?’ *The number and extent of their concluding recommendations appear to have become a measure of their seriousness and significance.* Further, there may be an escalating process whereby once one inquiry has made a big media impact through radical demands subsequent inquiries appear compelled to do likewise or sense that theirs has been a failure. Whilst there is ample superficial evidence, further research is required to test whether an understanding has indeed emerged that inquiries should necessarily be expected to conclude the status quo needs change.

Logically such a tendency is in conflict with a task of simple fact finding that, presumably, might find in a particular instance that nobody was at fault and there is nothing to be done that would be guaranteed to ensure improvements. It is perhaps worth posing the question, at least rhetorically, *why it is that inquiries never conclude that the investigated incident or concern was actually unforeseeable, accidental, does not require significant changes and should not be regarded as significant and perhaps even did not justify the holding of an inquiry in the first place?* Contemporary inquiries appear to make numerous and wholesale recommendations which are neither costed nor differentiated, a characteristic that makes them useless according to rail industry professionals, for example. They contrast the derision with which believe they would be greeted were they to issue such wide ranging, catch-all recommendations.

Executive Control and Independence

The PASC (2005) report on ‘government by inquiry’ is concerned with the diminishing place of the legislature and that the executive should not have exclusive control over commissioning inquiries into political (mis)conduct. A subsequent report (PASC 2008) authored by chairman Tony Wright has called for parliamentary commissions of inquiry. In an important proposal, Wright argues that, ‘Proper parliamentary scrutiny should include the ability to establish and undertake inquiries into significant matters of public concern. Parliament has, in the past, conducted investigations of this kind and as the great forum of the nation, should be expected to do so.’ The central concern here is the diminishing role of parliament that accelerated during Blair’s ‘presidential’ premiership and the consequent need ‘to hold the executive to account more effectively’ and ‘promote effective parliamentary accountability’. Wright suggests that establishment of Parliament’s right to ‘initiate inquiries where it rather than the Executive sees fit’. His criticism is not of inquiries themselves but who has the right the call them and the implications this has for the balance of political power.

Although not drawn out by the PASC there is perhaps an underlying, more fundamental democratic concern which is not so much with who commissions inquiries but the implications of resort to, unelected, expertise. The technocratic language of risk is one means through which the contemporary political process can be accused of ‘hiding behind expertise’ and failing to confront decision-making that is necessarily difficult and subjective. In the first place there is a general issue raised by

the political resort to expertise, but there is also a more specific one related to their subsequent lack of political accountability. Inquiries are formally independent. Posed in a different way we can say they are also unaccountable, at least directly. In this context it is striking that some inquiry chairs have allowed themselves to become representatives, even promoters of causes and issues associated with their inquiries. William Stewart has become a champion of precautionary safety around technology, and Michael Bichard sustained a media profile around implementing new child protection legislation, for example. This is not so much a personal criticism of individual ambition and ego, but should be recognised as an unsurprising development given the character of inquiries and the context in which they are operating. It is understood that inquiries require a determination on the part of their chairs to ensure that recommendations are implemented and (wider) lessons learnt, and the high profile of highly independent inquiry chairs certainly passes with little comment.

There is no such thing as complete independence. Inquiries have sustained a determined independence from politicians and so too from other 'establishment' influence, despite the radical criticism that this is not the case. We certainly seem an age away from how an academic was appointed to the Court of Inquiry into the sinking of the Titanic because of his favourable inclination towards the Board of Trade, as McClean and Johnes (2000) suggest. Ours is an age of corporate manslaughter and there is an assumption that the higher one targets within the organizational hierarchy the closer one gets to the real source of blame. Yet some inquiries can be seen as far less independent of some of the causes associated with, and apparent victims of events. Whilst we might laud this in some cases such as Aberfan, the merits of promoting others such as campaigners against mobile phone radiation is more questionable and actually quite different. Certainly it cannot be simply assumed it is right that the causes associated with inquiries should be promoted and that Inquiry chairs should do so with impunity.

Routinizing the Accidental

A criticism that is of continued relevance is that they are 'left censored' as Perrow argued in his famous book on 'normal accidents' (1984). Inquiries are only concerned with what goes wrong rather than what, more often, goes right. Accidents should be seen as 'normal'. There is a strong historical case, recognised particularly in the United States, that it is through the experience of things going wrong that improvements are made and further progress assured. This does not suggest that accidents should be celebrated but nor should they necessarily be held up for anxious soul-searching from this perspective. The consequences of such a focus can be wildly unbalanced impressions, such as the sense that fatal train accidents are an intrinsic part of Britain's incompetent rail system. In fact, as indicated earlier in this report, they have decreased relentlessly to be almost statistically eliminated (casting an interesting question mark over Perrow's thesis!).

We can also identify a comparable process of routinizing not just the accidental, but the bizarre. When these exceptional events involve the basest of motives and perversity – such as the mass murders carried out by Harold Shipman, apparently fulfilling a bizarre thrill of power over life and death – we must seriously question

upon what the assumption that this is relatively commonplace is really based, as well as the implications of doing so. The idea that there is a proclivity to extinguish life among medics whose profession is based on the ethos of saving it, might be described as positively bizarre itself. Nonetheless, measures have been taken to ensure that 'another Shipman' is somehow less likely to occur. These are measures, it should be recognised, that are not without consequence, as is any reorganisation. One measure in this field has been making access to pain killing drugs more difficult for GPs, which is likely to lead to greater suffering. This issue very clearly contrasts inquiry-based proscription with maintaining trust in the judgement of medical professionals to know when it is right to administer drugs and in what quantities. Whilst we may decide that we do indeed wish to hold up such experiences as the Shipman murders as meaningful and indicative, the serious implications of doing so should be acknowledged rather than pass without comment.

Hindsight

Arguably the most commonly made substantial criticism made of inquiries concerns the inescapable problem of hindsight bias. Beyond the general problem of looking back at the past there is something particular to the way that inquiries work towards a report that 'makes sense' of events for a general audience. Inquiries involve constructing events into a chain, even a narrative. Whilst reports obviously vary, enormous effort goes into making them readable documents which can be read by the non-specialist. But there may be a price to be paid for this accessibility. The tendency of inquiries and their reports to construct events into a singular narrative exacerbates the tendency to routinely suggest an inexorable chain of events at odds with the actually chaotic and multi-causal character of real incidents like train crashes.

Assigning Blame

It has become normal to call for a 'full public inquiry' in response to a range of negative experiences. The demand appears less driven by a desire to explore the circumstances that led to a particular outcome than gain recognition for victims and insist that no such thing should 'be allowed' to happen. The assigning of blame may be intrinsic to meeting this demand.

The unjustified attribution of blame is a danger acutely visible to those controlling proceedings. According to Howe (1999: 296) the continual 'risk is that' whilst formally concerned only with establishing responsibility in the causal sense, 'they will infer culpability when they ought not do so'. In the current ICL inquiry the whole subsection on the 'nature' of inquiries concerns avoiding direct blame attribution. In concrete terms this means clearly establishing that there should be 'no determination of liability'. Section 2 of the new Inquiry Act explains that the role of inquiries: 'is not to rule on, and has no power to determine, any person's civil or criminal liability'. But it is one thing to declare that liability will not be determined and quite another to suggest that establishing blame can be so easily avoided by a process that is intended to establish causal responsibility and satisfy the public that 'the right thing' has been done. If the inquiry report itself does not single out those to be blamed directly enough, it is likely the media and campaigners will step in. In this sense whilst

inquiries create the circumstances and opportunity for blame allocation they do not necessarily do so themselves.

Reorganising...Undermining Expertise

Many recent public inquiries have been more concerned with events seen to undermine trust in professional practice than in the body politic. This has given greater weight to the spotlight on incidents of incompetence and left the impression that there may be a wider problem with the working cultures and practices of the professionals under fire, such as the police, social workers or the medical profession.

Inquiries have consequences. They establish a public picture of responsibility - either individual such as with Huntley and Shipman or, more commonly, a wider picture of corporate and professional cultures 'gone wrong', such as allegedly complacent and uncaring surgeons, or greedy train company executives. Inquiries also directly change the way in which people do their jobs, which are increasingly less left to the discretion of their professional expertise and are instead subject to external regulation that tells them they are not to be trusted. This is one of the problems highlighted with inquiries and social care, for example (e.g. Butler and Drakeford 2005). Clearly there are cases where professional complaints are essentially complaints about being subjected to unwanted pressures and accountability, but this cannot be a general understanding of all expert complaints about the impact of inquiries.

The spectre of investigation and practical reorganisations from inquiries are part of a range of measures that encourage defensive professional practice. Perhaps the sharpest experience is following a train incident where staff will, understandably, and under company instruction, only speak with the numerous investigating bodies accompanied by legal representation. The free flow of information necessary to investigation has been destroyed by the culture of blame and recrimination of recent high-profile train inquiries. But inquiry and risk culture more generally also stimulate changes in everyday working practice. Examination of referrals by social workers in the wake of high profile inquiries shows that they: 'were classifying any degree of risk, however small, as a child protection case' lest they be accused of having failed to spot danger by a subsequent inquiry. Perversely, this is a: 'rational approach to the management of personal risk' under the circumstances (Munro 2004: 83). It is not only public inquiries that have driven such reshaping of professional practice but they are an important component of it alongside the spectre of litigation and 'internal' censure.

It is useful to consider that there may be circular, self fulfilling process at work. One of the reasons for mismanagement in social services, for example, is its falling authority and status which, in turn, can be traced at least partially to the way in which social workers have been publicly castigated through inquiries. The picture painted in social care inquiries is of an acutely demoralised profession that can make it dependent on those less than well qualified or motivated. Inquiries are bound up with a wider risk culture that questions our trust in those charged with managing society and, without thinking through the consequence, suggest that the problem is leaving them alone to do their job as they see fit. Risk is bound up with regulation, as if a

doctor can be regulated without undermining their self confidence and capacity to learn from mistakes.

As a concluding remark, whilst it is useful to set out the range of different perceived problems with inquiries we should recognise that some are more important and substantial than others. Certainly some of the issues with inquiries are more important to thinking about them in relation to public risk than others. Some of the criticisms appear dated – left behind by the way in which inquiries and indeed British society has changed. Criticisms that inquiries are biased towards ‘the establishment’ and that they are empty exercises guaranteed not to really upset the status quo do not engage with the very different reality of contemporary inquiries. The character and impact of inquiries vary considerably but there is a general tendency for inquiries to take quite different sides and align themselves more exclusively with those perceived to be victims and against those perceived to have power and control. Their fact finding role may have become subordinated to that of providing public catharsis, a task that now is bound up with recrimination. Inquiries have been inclined to target professional cultures for encouraging incompetence, what is judged to be complacency, or simply for being closed off from public scrutiny and understanding – something which in the past would have been regarded as inevitable and even important to the maintenance of professional morale, understanding and learning.

On the other hand there is a sense in which the problem seems less with inquiries themselves – which, after all, also have notable benefits – but with the empty and ritualised call for a ‘full public inquiry’ following all manner of negative events and experiences. Yet this recognition brings us full circle, as the increased resort to inquiries, their targeting of professional cultures, sweeping recommendations and increased public impact may have been instrumental in normalising this reflex and creating the expectation of redress. Public inquiries were originally intended to restore trust in the body politic and the state. They are now less concerned with restoring trust in these domains but certainly cannot be considered to have successfully helped restore trust in the professional domains with which they have been concerned in recent years.

Section 6: Public Inquiries and Public Risk Management

Chairman: To complete the overview, when you were sitting you were sainted; you were this fearless forensic investigator?

Lord Hutton: Yes.

Chairman: The moment you reported, you were an establishment lackey?

Lord Hutton: Yes

(Public Administration Select Committee 2004, cited in Sulitzeanu-Kenan 2006b: 646)

Assessing Inquiries

The public inquiries discussed in this paper were intended to help restore confidence and learn lessons following incidents deemed to be of such magnitude by government that only an independent public investigation would suffice. To do this they 'borrow authority' from senior judges, who are appointed as chairs of the process based on their perceived competence and independence. The holding of an inquiry signals that government is taking a problem very seriously, to the extent that it will be treated in a non-partisan, even non-political fashion. Whilst the number of inquiries has increased, it remains the case that they are not resorted to lightly, involving as they do the ceding of control over a major issue of the day.

Inquiries are distinguished from other forms of investigation such as Royal Commissions by their self consciously public character. Nothing is hidden from public scrutiny and this openness is central to the function of public inquiries. The preparedness of authority to not only hold an independent investigation but ensure it is completely transparent is central to the *raison d'être* of inquiries. Beyond establishing the lessons of particular incidents, they are intended to restore public trust in authority to manage future crises and even restore trust in authority more generally. Complete openness is not a guarantee that public confidence will be regained but it is an essential prerequisite.

Public inquiries are shaped by an attempt to appease what are perceived to be public sensibilities as much as they are by professional knowledge. Public inquiries can be rigorously independent of government but it is part of their rationale to connect with public concerns over a particular incident. They are likely to prioritise the perceived needs of victims and their families rather than those of relevant professionals, despite the fact that recommendations are likely to have dramatic consequences for professional life. Such considerations appear irrelevant to inquiries charged with investigating particular incidents irrespective of their implications for professional life. These implications include demoralisation and the entrenchment of defensive and formalised practice, which themselves is likely to lead to further incident in the future. Yet the focus on professional practice associated with inquiries is a quite different one. There is an assumption that left to their own devices and without external pressures and regulation professionals will 'continue in their complacent ways'.

The public inquiry can be understood to be making it possible for us, as citizens, to pass judgement and draw satisfaction from the fact that lessons have been learnt, the guilty punished and procedures appropriately amended. But to what extent can we rely on the inquiry to allow the 'technical' truth to emerge unhindered? The public

orientation of inquiries subjects them to competing pressures – in some cases (such as with the Bristol Royal Infirmary inquiry) greater than the demand for a factual account. There is some evidence of this in the way inquiries appear to often conclude with clear conclusions and culprits, and wide-ranging recommendations at odds with the very particular character of a single incident. Contemporary inquiries are notorious for issuing extensive and undifferentiated recommendations. Subsequent complaints from professionals about their feasibility suggest the impractical character of many inquiry recommendations and, in turn, that they are more concerned with public appeasement than improving professional practice.

A central issue in assessing inquiries is whether their different functions and faces are compatible. There is a recognized problem with reconciling the *inquisitorial*, fact finding function of inquiries with a potentially *accusatorial* blame attribution that follows from their cathartic function for victims and the public at large. What is less recognised is a related potential contradiction between the openness of inquiries and their basic function of establishing an accurate account of what happened, and why. As we have become accustomed to the norm of public openness it can be forgotten that it may be problematic in relation to forensic investigation which may benefit from an at least partially closed character.

Judgement requires basic technical knowledge of relevant systems but it is likely to also involve an appreciation based on experience of the real contexts in which professionals act and decisions are made. The subtleties of professional practice and context account for much of the complexity of public inquiry proceedings and their consultations with expert witnesses. There is a case for regarding ‘in house’ reviews of mistakes and accidents as likely to be more fruitful than one held in the full glare of publicity and political pressure. Practices that might invite public miscomprehension or even possible legal action (such as what can be termed ‘near misses’ among air traffic controllers, for example) can be potentially discussed more openly. Further, the majority of us are not qualified to understand and therefore pass meaningful judgement on the conduct of a particular medical procedure, or the significance of a missing bolt on a train track. Distinguishing a negligent error from eventually unavoidable mistake or accident in a particular professional field is no easy task and must firstly be considered by peers. This is not to suggest events are not subject to wider, lay consideration *following* expert assessment.

Do Public Inquiries Work?

Clearly this is a very difficult question and one which depends upon the criteria and objectives to be used. We might firstly ask whether it provided an accurate and balanced account of how an accident or miscalculation took place – hopefully one that avoids excessive hindsight bias. We can consider whether an inquiry effectively neutralised public concern about the issue over which the inquiry was held, or we can ask whether it stimulated changes that lessened the chance of a similar incident recurring the future. Or more broadly we can ask the perhaps more important question of whether they are an instrument that effectively neutralises or exacerbates public risk perception. Does holding an inquiry tend to reassure public feeling that a reoccurrence is now less likely, or do they draw unwarranted attention to events that are freakish and accidental in character rather than being symptomatic of any wider

problem? Considering their impact is no less thorny a problem. Even where the consequences of inquiries have been dramatic and an apparently unqualified success judgement can remain difficult. Lord Justice Taylor's Hillsborough Inquiry led to the establishment of all-seated football stadia. They now seem a 'safer' environment and certainly there have been no major incidents subsequently. But the same changes can be described as a process of transforming Britain's national game from a 'tribal' pursuit of working class males into a family-oriented, more middle class leisure interest. Many club supporters groups do not consider this a good thing and call for the partial return of terracing amidst the general complaint that formally vibrant atmospheres have been destroyed. At their 2008 party conference, and nearly 20 years after the Hillsborough tragedy, the Liberal Democrats passed a motion to bring back 'safe standing' in view of the improvements to ground safety during the intervening period. Further, it should be added that the idea that it is because of the inquiry's recommendations that no major incidents have occurred at 'safer' stadia does not make logical sense, any more than if an incident does subsequently occur it will be because of Lord Taylor's inquiry.

It is equally unclear whether inquiries perform an effective cathartic function for the victims and their families whose grief is at the centre of the rationale for inquiries. Interview material from the Aberfan inquiry suggests that, at that time and in those circumstances, the process was properly cathartic for the families and community. And today the recognition involved in allowing an inquiry seems more important than ever. But expectations, among other things, are far higher today compared with the 1960s and the search for justice, even retribution, may now be elusive. In the moving parental account of Edwards and Edwards (2004: 39) they explain that 'The inquiry process did not meet the needs of our family' and led to an 8 year campaign and eventual judgement from the European Court of Human Rights. Attaining 'closure' appears more problematic than in the past. In cases such as around the sinking of the *Marchioness* on the Thames, inquiries become part of an ongoing campaign rather than a cathartic moment. In such a context it may be that inquiries play a significant role in encouraging further efforts to gain recognition by the relatives of the victims of tragedy.

Judging the effectiveness of inquiries may require moving beyond considering them in general, and instead looking at them in particular. Inquiries need to be considered in their context and sometimes this is what we do spontaneously. Consider the example of the various inquests and investigations into the death of Princess Diana which although not formally public inquiries were perhaps received as such and were certainly very public in character. Following a 2 year long French investigation, a 3 year official police inquiry chaired by Lord Stevens concluded in 2006 that there was no evidence that the couple were murdered. A subsequent, epic 6 month coroner's inquest under Lord Justice Scott Baker concluded similarly. It was evident to most observers that nothing factual could be further learnt and that no cathartic function could be served, as it actually became principally a vehicle for the pursuit of Mohammed Fayed's conspiracy theories about the British security services. In different terms the justification for a public inquiry into the Soham murders remains unclear, and the families of other murder victims might wonder why their loved ones are not similarly deserving of an inquiry. Where there are no victims or even a clearly identifiable problem such as is the case with nanotechnology and mobile phones, it seems clearer that a public inquiry is inappropriate and even that any form of inquiry

is likely to create more problems than it solves. By contrast, there is a case to argue that an event as extraordinary as the mass killings by Harold Shipman necessitated an exceptional response. The very large number of victims' families in itself suggests that a public inquiry was indeed appropriate. In such a case a key issue to address is reflection on the signals and messages being sent out and the danger of suggesting that the exceptional is potentially routine.

It is not only the specific context in which inquiries take place that should inform our assessment, but the wider circumstances at the time each takes place. The socio-political context in which inquiries take place has changed dramatically even over the course of the 40 or so years that they have been more regularly investigating matters of public risk. Many of the criticisms traditionally made of inquiries have been overtaken by events. Hutter (1992) rightfully observed that it was unusual for official railway inquiries to go beyond the immediate circumstances of the accident, for example. Elliott and McGuinness (2002: 18) note how this has changed through the Southall and Ladbroke Grove accidents, as the tide swung against blaming the individual and towards blaming corporate actors. This change is only one dimension of a much larger shift that is important to consider when assessing contemporary inquiries.

In thinking about the changed context in which public inquiries should be judged Aberfan can be seen as the first truly modern inquiry that was determined to allow real public access to faults within 'the system'. Notably, the report was only published in full against considerable pressures from the Welsh Health Authority. Such pressures indicated a far more closed and deferential culture, where public scrutiny was extremely limited and attempts to break these barriers down readily dismissed. Howe (1999: 303) recalls that: 'Richard Crossman's decision to publish our report in full was described by Anthony Howard as "perhaps the bravest action of his career"'. The dangers of attributing blame were outweighed by the fact that it was only through an inquiry that there was any possibility that a venerated institution like the Coal Board might be in any way held to account. Public inquiries in the 1960s were pushing against a closed door in a way that more recent ones are railing against a much more open and defensive one – even if similar rhetoric of vested interests is often employed. Employers and public institutions are as routinely mistrusted as they were unquestioningly venerated in the past. This is not to suggest that inquiries are now always easily grated, even supposedly routine NHS ones. It was only through their vigilance and determination that Edwards and Edwards (2004) discovered that the NHS was obliged to hold an inquiry into their son's death and embarrassed them into doing so. But it does mean that contemporary inquiries cannot be seen to positively challenge ingrained assumptions and institutionalised barriers to justice to the extent that they might have in the past. Indeed, some contemporary risk inquiries can be seen as no longer usefully questioning restrictive assumptions and practices, but actually adding to the problem. The Soham inquiry, for example, codified the idea that child abduction and murder is an imminent threat and should inform the basis for how we organise aspects of society.

Testing their Utility: Blame Avoidance and ‘Kicking into the Long Grass’

There is only one study that directly examines whether inquiries ‘work’, as in managing to fulfil any of the functions attributed to them. Sulitzeanu-Kenan (2006b) tests the hypothesis that public inquiries can be effective blame avoidance mechanisms through which ministers can evade and deflect responsibility. Although this study only considers the effectiveness of inquiries in direct political terms rather than in relation to the management and implications for public risk, its findings illuminate the wider question of the role of inquiries.

He has two specific hypotheses:

1. ‘The immediate appointment of a public inquiry once an affair becomes public will result in lower responsibility attribution to the appointing minister, compared with the same situation without an appointment
2. (a) PI reports enjoy higher credibility than non-PI evaluations (that is, an institutional factor main effect on credibility judgement)
(b) The effects of PI reports on responsibility attribution are greater than the effects of non-PI evaluations (that is, an interaction effect of institutional factor and evaluation content factor on responsibility attribution)

A sample of 474 survey respondents were broken up into different groups and presented with vignettes describing different scenarios and outcomes around a single inquiry incident. The experimental event of the withdrawal of the anti-arthritis drug Opren, which prompted calls for a public inquiry in 1985, was the issue around which people’s attribution of responsibility was explored. The most interesting experimental manipulation was to present different groups with either what he terms a positive or negative account of the background to the drug’s withdrawal. In one account it was stressed that the drug was approved in good faith, there is always a degree of risk, and that it was withdrawn when new findings came to light. In the other, it was implied the Department of Health may have been imprudent with their premature approval and that there was, quite possibly, a series of subsequent mistakes that invites review.

The study suggests four different ways that inquiries may allow blame avoidance; they may:

1. ‘Remove the issue from contestation and create a sense that action is underway
2. ‘buy time’ for government to take remedial action
3. Align ministers on the public rather than ‘wrong doers’ side
4. Block alternative investigative procedures’

Sulitzeanu-Kenan found that inquiries in their own right did not offer significantly improved political opportunities; ‘...reports did not exert more influence on responsibility judgements than political speeches’ (p.641). In themselves, the esteemed independence of inquiries does not produce a distinctly improved credibility:

‘The appointment of a PI does not seem to affect (or reduce) responsibility attribution to the appointing office holder (hypothesis 1) and the general trust enjoyed by judges does not seem to increase the effect PI reports on responsibility attribution, compared to textually equivalent public evaluations made by politicians’ (p.643)

The evidence from this study suggests that the impact of inquiries is conditional upon the type of message they communicate: 'Public inquiry reports enjoy relatively higher levels of credibility only when they are critical of the government' (p.644). In his terms they have only 'conditional credibility', dependent upon the content of their report. He sees evidence for this in the 2003 Hutton Inquiry as the quotes from Hutton, with which this section began, indicate. Positive perceptions of Hutton's inquiry were conditional upon it being seen to maintain robust independence and a critical stance towards the government that appointed it, characteristics that were seen to evaporate once the actual report was published. An overly positive report tends to diminish credibility irrespective of specific issues involved and perhaps because of this Hutton's report did not result in improved political fortunes for Tony Blair. An inquiry only 'works' in so far as it is seen to remain highly critical. What is not clear, and is grounds for further research, is whether inquiries need be critical specifically of the incumbent government, or whether attacking a particular service such as health or the police in the charge of government has the same effect. One can speculate that politicians might be able to deflect or at least evade some attack by positioning themselves for an inquiry and against the train company, surgeons or others at the centre of scandal.

Sulitzeanu-Kenan's study challenges the central, 'fact finding' purpose of inquiries. He finds no evidence to support the assumption that establishing exactly what happened would remedy an a priori state of factual ignorance that is recognized as such by the public. Actually the public do have widespread access to information and, more importantly, are likely to have already decided on who they think responsible before the inquiry concludes. Their support for the inquiry is then conditional upon it concurring with their own assignment of blame. From another perspective, the findings indicate that it may be something of a delusion to imagine that inquiry findings in themselves really make much difference in the public realm; whilst this would not be so significant if an inquiry were not 'public' it is highly pertinent given their purported cathartic function. Sulitzeanu-Kenan (2006b: 647) concludes that in real, social terms the role of inquiries is not one of 'fact finding' but 'providing confirmation'. The stark picture that emerges is that public inquiries are only significant in so far as they confirm the picture of blame that has already been assigned by the public, and otherwise – for example in relation to simply establishing the wider factual picture – they are irrelevant.

From the perspective of politicians, public inquiries do not successfully seem to attribute responsibility, nor is there evidence that they are able to better influence public opinion because of their perceived independence. This is not to say that deflecting responsibility is not the motive for resorting to an inquiry, however, as politicians can simply be wrong and assume that it will perform such a function. In reality, the resort to an inquiry is never lightly undertaken and might be understood as a 'least bad' option, when faced with very difficult circumstances. In explaining why inquiries are resorted to, he also suggests there is a kind of pact whereby the government is allowed to buy time in managing a difficult issue and other players like the media and victim groups accept this on the basis that a critical report will be the likely outcome. In this sense there is a kind of pact around allowing a 'ball to be kicked into the long grass'.

Overall it should be remembered that this remains a general finding based on an experimental scenario, however. A crucial issue that can't be considered with such an approach is the changing social, political and cultural context. There is a logical case to suggest that inquiries would be more effective in restoring trust and stimulating change in the very different circumstances in which inquiries such as Aberfan and Ely took place. It is only much more recently that it is unsurprising that public credibility is contingent upon the expression of mistrust towards government, as now appears to be the normal case in Sulitzeanu-Kenan's study. There is case to suggest that inquiries have become increasingly less effective and purposeful as the context in which they operate has changed. They can even now be seen to reinforcing a sense of mistrust against professional groups rather than playing a role in restoring it, as they once did.

New Forms of Pre-Emptive Inquiry: The Royal Society Nanotechnology Review

Following the experimental evidence of Sulitzeanu-Kenan there is a useful real life experiment that might be seen as a possible alternative to the public inquiry and allows reflection on their role. The recent nanotechnology inquiry conducted by the Royal Society and Royal Academy of Engineering has been regarded in some circles as innovative, even exemplary, perhaps suggesting a new way forward. It is a concrete example of the fashion for moving public engagement with scientific decision-making 'upstream'. Put more basically, as one of the participants suggested, it was 'an opportunity to try something different, through creating an early entry point for public dialogue' (Rogers-Hayden and Pidgeon 2007: 359). It is particularly relevant to this discussion because it can be seen as an experiment in the management of a (future) public risk, rather than something only relevant to public inquiries in general. It was innovative in being an in-house, expert review but one that invited participants whose main contribution would be precautionary misgivings about the implications of the technology. It was also unusual in soliciting public views through surveys and workshops, despite the enormous methodological problem of interviewer effects involved in investigating something which is unknown; clearly it was likely that interviewees will have been invited to identify problems with nanotechnology by the very nature of the exercise and questions.

The two academies were approached by government 'to identify what health and safety, environmental, ethical and societal implications or uncertainties may arise from the use of the technologies, both current and future' (RS/RAEng 2004: vii). The subsequent report indicates that the inquiry was looking to identify problems, as well as 'opportunities and uncertainties'. The inquiry took a year and its report was published in 2004. The government published an official response in 2005. In the manner of public inquiries, the final report made extensive and wide-ranging recommendations (21), on everything from possible adverse effects to regulatory and social and ethical issues. Whilst it might be considered a departure for such an august body as the Royal Society to conduct an open scientific review alongside social scientists and consumer advocates, it should be recognised that such a 'public engagement' orientation has been powerful since the mid 1990s. The earlier GM Nation review was conducted similarly, bringing on board (and even conceding significant influence to) advocates of precautionary scepticism from the social sciences and campaign groups. Reflecting on this experience in the light of the issues

raised in Sulitzeanu-Kenan (2006b) above, there may be an unconscious adaptation to his contention that inquiries are only credible if they are consistently critical.

In one sense the RS/RAE nanotech inquiry is not a direct replacement for standard public inquiries, but there is an important coincidence of the function which both are seen to serve and this provides some basis for comparison. It was explicit that an inquiry was desirable because nanotechnologies 'might suffer the same fate as GM food'. In a sense this exercise was seen as engaging with public mistrust, in this case through early engagement with concerns, and addressing mistrust is a core objective of public inquiries generally. Like the Stewart Inquiry, in particular, the nanotechnology review appears to have been calculated to absorb possible public concerns by allowing them open expression, in what might be termed *anticipatory catharsis*. What is striking is that the way seen to prevent a recurrence of the GM or BSE scenarios is now through publicly and very defensively anticipating all manner of, inevitably speculative, risks. On such a basis it made sense to engage groups of campaigners and social scientists inclined in this direction to help create some consensus.

Such a forum where those promoting concern about technologies sit alongside scientists and engineers can only really be constituted around such an agenda and is likely to involve the former pressurising the latter to realise the 'social and ethical implications of the projects they are working on' (Rogers-Hayden and Pidgeon 2007: 358). What remains unclear in such circumstances is what, and whom, the non-scientific participants represent – particularly when addressing a technology with which the public is not yet familiar, let alone worrying about. Partly because it was not a public inquiry but also because it was addressing an issue that is, as yet, not of significant public concern, the nanotech inquiry made little media, let alone wider public impact. Its significance may lie more in consolidating a defensive orientation among those at the forefront of the technology than in affecting wider opinion either way.

A worry identified particularly by non-scientific participants was that they might be part of a process that was minimising debate and controversy; that it might be an exercise in showing that debate was taking place whilst not really taking into account the extent of concern among non-scientific participants. What might be considered an opposite but more tangible concern was expressed by one of the participants in the interviews conducted by Rogers-Hayden and Pidgeon (2007: 355). Their worry was that 'there is a danger in opening a dialogue that the media will seize upon it and it will become alarmist'. As they remark, 'In this sense, the claim was that while early public dialogue has the potential to shape the agenda of public discourses, it might contribute to an amplification of concerns about risk...' Whilst this is an 'important question...; it is 'one about which we know very little at present.' More pithily they ask, '...is it impractical, or even unnecessary, to spend time entertaining Drexlerian imaginaries and visions?' (p359).

They note that some scientific participants saw the exercise as one to 'get in first and set the record straight', but it is difficult to see how such a task can be undertaken through the speculative flagging up of possible future difficulties. It may make sense to 'get in there first' with, for example, accessible everyday examples of how nanotech might make life easier whilst being 'no big deal'. From the perspective of

engaging public risk we can suggest that in so far as there was any sense to early speculation about public acceptability it would have been to think imaginatively about how any possible anxieties might be engaged, asking questions such as whether the very grand, 'nanotechnology' is a good description ('genetically modified' was not!) and how the 'opportunities' offered by the technology can be communicated effectively. But evidently this is not considered a realistic way forward today. Policy orientation remains conditioned by the public engagement approach even though it is difficult to identify any way in which it has been successful.

Overall, procedural issues and comparisons in the light of the nanotech review may be less important than the substantive issues it raises about how different instruments are being used to the same end of accommodating to perceived public mistrust. Judgement on the wisdom of such an approach will remain subjective and reflect individual views on science, technology and other matters. But regardless of opinion it is unclear both logically and empirically how an exercise in elevating the problems with a new technology before it has even been widely applied in society will increase acceptability or trust. There appears to be a vague sense that: 'if we show *we're* sceptical that will take the sting out of public scepticism...maybe even get them to like us', but seems put forward more in hope than expectation. In whatever form discussion is flagged up – public inquiry, a review inquiry such as the above, or any other forum - raising anxieties is likely to help consolidate them more widely but is by no means assured to somehow bring the public closer to those who calculate that it will.

Contesting the Demand for Public Inquiries and Considering their Costs

The study of Sulitzeanu-Kenan (2006b) establishes the possibility that public inquiries in themselves are not necessarily important. Certainly, from the perspective of challenging public risk the key point about inquiries may not be the instrument itself, but engaging with the now routinized demand for them. The demand captures and expresses key assumptions of risk culture that need to be put under scrutiny. The assumption that 'nothing bad should happen' and that someone must pay a heavy price if it does, has become a kind of 'right' comparable to access to welfare and health services. By contrast, a reactive political culture of risk gives no thought to the longer term implications of further safety and precautionary measures, as if they are without cost.

The next call for a public inquiry may follow an experience as clearly important as 9/11, the BSE crisis or an extraordinary horror involving hundreds of families such as the Shipman murders. On the basis of probability it is far more likely to concern the abduction and murder of a child, for example, than necessarily rare major tragedies. It is also more likely because of the precedent set and the contemporary cultural expectation that 'all wrongs will be put to right'. An important aspect of risk and precautionary culture is that extra safety measures and precautions are seen as costless and precaution is thereby a matter of basic common sense, as in: why take the risk? Costs in both financial and social terms have been eradicated from the imagination in a more precautionary environment. Government is, of necessity, still concerned with financial costs and this explains part of the impetus for the new Inquiries Act. Yet a profession such as social work that has been at the sharp end of inquiry culture is

conducted in the shadow of possible investigation and this shapes how everything is done in a way that encourages self protection. 'Defensive medicine' and the wider reign of 'clinical governance' is as much the product of inquiry culture as it is of the spectre of litigation. Negative consequences in the rail industry are equally stark.

It would be no easy task to challenge the demand for a public inquiry - to ask for clear justification that takes into account the implications and likely consequences, rather than only narrower procedural or financial grounds. Publicly contesting the purpose of routinely reflecting on tragedy has never been tried. Some related evidence from focus groups suggests that, confronted by a wider context and implication people recognise problems of reacting to issues too quickly and narrowly. Focus groups on trains and accidents, for example, find that when confronted with the cost of safety systems and how such costs could save far more lives used elsewhere people readily accept the terms in which professionals must make decisions. To question the demand for inquiries would be a very public and useful way to raise discussion about key assumptions around public risk.

An important aspect of a risk-centred culture is an imbalanced overestimation of some risks and an underestimation of how easily and at what cost they might be ameliorated. A singular and short term fixation on possible risk determines a neglect of the consequences of devoting time and resources in an attempt to somehow abolish the problem. Longer term implications, in particular, tend to scarcely figure in contemporary risk reduction regulation and initiatives. It is as if precautionary regulation and restriction is without cost or consequence; reflected in the apparently self evident mantra: 'why not be on the safe side?' Yet in reality there are inevitable, if unforeseen consequences to prohibitions, restrictions and regulation. These may be particularly pernicious in the domain of risk because so much that is the target of attack concerns the mistrust of people and social institutions. This one-sidedness is exemplified by the ready demand for inquiries which are called for without consideration of their social and professional costs, or their wider messages and signals about trusting those around us. Whilst in one sense acting to an impossibly demanding standard of human conduct that accepts no mistake or human error, the inquiry imperative may only mask a more cynical and retributive impulse that generalises the worst assumptions about other people. As much consideration should be given to considering such wider social costs when we think about holding an inquiry as is devoted to their narrower financial ones.

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