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Assessing Inquiry Recommendations: Independent Inquiry into Child Sexual Abuse Case Study

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Introduction

Within the UK, whenever our society is faced with a problem, there is invariably a call for an inquiry. The hope is that the resulting inquiry will produce recommendations that, when actioned, will ensure that the issue "never happens again". Unfortunately, history shows that this hope is a forlorn one. The issue, or some derivative, does happen again. We are therefore left with the question 'why'? There are many possibilities. This paper will examine one and it is that the recommendations made were poorly constructed and, even if they were successfully implemented, they were unlikely to have prevented a recurrence: the resultant waste of resources in such Sisyphean activities is enormous. This paper looks to propose a more scientific approach that could be used to peer review recommendations before implementation.

What prompted the writing of this paper was the debate over whether there should be a new inquiry into what have been referred to as "grooming gangs".

Background

For decades there have been reports of groups of adult males having sexual relations with girls who were below the legal age of consent. These events are referred to colloquially as "the grooming gang scandal". Under the laws of England and Wales these activities would seem to meet the criteria of the offence of 'statutory rape'. There has been much debate about the scale of these activities, while public discussion has been more muted. Some suggest that the debate has been suppressed. On 31 December 2024 Elon Musk responded on his "X" platform to a posting that stated, "out of political correctness, the government did everything it could to cover up the crimes". Musk's response stated: "The government officials responsible, including those in the judiciary, need to be fired in shame over this". This intervention was the catalyst that reignited a wider and more heated debate which called for Government action. This included the call for a new inquiry, subsequently endorsed by Baroness Casey (see Casey, 2025: 151). On 14 July 2025, the Prime Minister announced that a full national statutory inquiry would be set up.

In the past, even a House of Commons Select Committee has expressed some cynicism over the value of inquiries (see: Public Administration Select Committee, 2005, HC 51-1: para 11). However, for the purpose of this note it is assumed that the actors are acting in good faith and are genuinely looking to draw lessons from the past. This applies to both those calling for inquiries and the Government's response. Recommendations from inquiries are often seen to be viewed as if they were 'oracles from Delphi'. Their recommendations are seen as being definitive and are therefore not open to being questioned. This position is justified on the grounds that highly capable people have taken a great deal of time and effort to understand the issue and to recommend ways to resolve it. Therefore, the question must be one of whether the conclusions of these inquiry teams deserve such reverence. The reverence shown to inquiry teams can however be directly compared to the work of academics. These are also highly capable people who have taken a great deal of time and effort to understand an issue and to recommend a way forward. In the case of academics, they have one considerable advantage over inquiry teams; they are experts in their subject, which is not the case in most inquiries. Yet despite this expertise every academic paper is peer

reviewed to ensure its validity. I would offer that there are grounds to propose that inquiry recommendations should be peer reviewed before they are endorsed and implemented.

In addition to a doctrinal case for peer reviews, there are also examples of inquiry reports that are flawed (Lauder, 2013). Flaws can be divided into two main groups. The first group consists of inquiries that do not initially reach an 'acceptable' conclusion: an example of this are the three inquiries conducted into the Hillsborough Football Stadium disaster (April 1989). The second group are inquiries that make recommendations that, when implemented, lead to the next disaster. An example of this are the events leading to the Victoria bush fires of 2009 (Teague, 2010). For these reasons, if the genuine purpose for the inquiry was to learn and prevent, all recommendation should be scrutinised before they are implemented.

This paper does not look to offer an opinion on what type of investigation should now take place in the case of the grooming gangs. What it does look to do is to analyse whether the recommendations made by the 2022 Independent Inquiry into Child Sexual Abuse (IICSA) adequately address the concerns raised by Musk's X posting and are likely to achieve the desired new end state (DNES).[1] In terms of the grooming gang scandal, the DNES that would seem to be desirable is that those involved and implicated in the statutory rape of children are brought to justice and the probability of it, or something similar, happening again be reduced to a minimum: for clarity in the paper, I have labelled the DNES of those asking for a new inquiry as 'our DNES' as this paper is looking at the need for a new inquiry from their perspective.

Aim

The aim of this paper is to outline a provisional methodology to enable a more scientific analysis of enquiry recommendations in order to determine the probability of them producing a desired new end state (DNES). Its purpose is to save resources that would be wasted by implementing recommendations that are unlikely to achieve their purpose.

This paper will first set out the proposed methodology, it will then apply the methodology to the IICSA recommendations, and finally it will discuss what this reveals.

Methodology

It is critical to note that there are two ways of reading recommendations depending on the worldview that you hold and how this influences the way recommendations are formulated. These differing worldviews have been labelled the Perfect World Paradigm and Normal Chaos.[2] The key assumption within the Perfect World Paradigm is that the system is perfect except for a few flaws: in this case, the inquiry just needs to identify those flaws and correct them. The second world view (Normal Chaos) is that our systems have complex dynamics that will go wrong if not carefully managed. While they might seem to be stable, any minor change can have major unintended

negative consequences. Therefore, any change (no matter how minor it may seem to be) needs to be mapped from that change through to the desired outcome to ensure that it does not create those negative consequences.

In earlier work (Lauder, 2013) I explored the general mental model exhibited by those conducting inquiries as revealed through the recommendations they made. In summary, my work revealed the belief that if everything works as planned, the right result will be produced. This mindset means that those conducting inquiries believe that if they can identify faults within the system and correct them, then the problem will be resolved; this approach might be labelled the 'sticking plaster methodology' and is consistent with the Perfect World Paradigm.[3]

On the other hand, Charles Perrow's (1984) work on Normal Accidents and work on complex systems would suggest that this was a false premise. Those who strive to produce consistent results (such as where quality and safety are the goal) lean more towards a Normal Chaos mindset even if they do not call it that. For this reason, I have drawn the conclusion that any inquiry team that fails to take system theory into account is at best likely to produce ineffective recommendations and at worst are likely to produce recommendations that are the source of the next crisis (Lauder, 2013: 200).

At a minimum, those formulating inquiry recommendations need to think about the unintended consequences that might emerge after a recommendation has been implemented; this is thinking in terms of action and reaction within any system. At the next level they need to view organisations, and what they deliver, as complex interactive systems where simple cause and effects relationships are hard to map. This means that effective recommendations are hard to produce.

The methodology that I propose to analyse recommendations is in two parts. The first step judges the formulation of the recommendations. It takes what we have learnt about objective setting within performance management and looks at a recommendation as if it was setting an objective. This is justified on the grounds that both recommendations and objectives look to articulate further action or a desired end state in order to make changes to a system.

The second step looks to determine the probability of the recommendation resulting in the desired outcome that I refer to as desired new end state (DNES). I refer to this idea as 'distance'; that is the distance in terms of the number of steps needed for the recommendation to produce the outcome desired. Let us look at each of these steps in turn.

Objective Setting

Performance management provides us with a guide as to what an effective objective might look like. At its simplest, these are called SMART objectives. Here SMART stands for Specific, Measurable, Achievable, Relevant, and Timely.[4] The basic premise is that the more ambiguous an objective is, the less likely it will be successfully implemented.

Also, in general terms, performance management takes a systems approach to management. At its most basic this considers the relationship between inputs, outputs and outcomes. Inputs are the resources added to a system.

Outputs are the direct and intended result of the inputs. Outcomes are the desired consequential effect of one or more outputs. All three of these can and should be measured if they are to be SMART. Inputs are measured in terms of what is being added. Outputs and outcomes should be articulated in terms of what success would look like. Finally, to be SMART, the objective needs to set the timeframe for the action and it should be specific about who is responsible for acting. In summary, each recommendation needs to be examined to determine whether it clearly articulates the following components:

- Who needs to act.
- With what urgency do they need to act.
- What action is required (input).
- Details of the action required.
- What process or entity is the subject of the action.
- What change is to be achieved directly (output).
- How will the output success be measured.
- How will this change affect the wider system (outcome).
- How will the outcome change be measured.

On this basis the top-rated recommendations would show a full understanding of what is wanted (the objective), how it is to be achieved (the action), what it will cost, how success will be measured, who is to act and how this action will contribute to the outcome required. The rationale for the action would be clear as would be the key decisions needed, the potential unintended consequences would be understood, and the key constraints would have been considered.

Using a standard academic methodology, each component would be 'coded'. Coding would be used to determine which of the components is present within a recommendation. Once the results of this exercise have been produced, it is possible to rate the formulation of the recommendations.[5]

Recommendation Rating

The rating system looks at the formulation of the recommendation. The ratings range from poor to excellent based on the clarity of the action required and its links to measurable outputs and outcomes. If there are no clear actions or outputs and outcomes then the recommendation is deemed to have failed. If no action is recommended at all then it is a non-recommendation and, if the action is potentially harmful, it is a bad recommendation.[6]

This first step provides a relatively quick way to systematically analyse and rate recommendations. This methodology provides objective criteria that aids a subjective judgement on the merits of any recommendation. The next step focuses on the 'Achievable' criteria within SMART; it looks to determine the amount of work required to implement a recommendation and the link between it and the DNES.

Distance

In simple terms, 'Distance' is connected to the probability of success. The question here focuses on whether the recommendation itself is implementable and whether the desired new end state (DNES) will be supported. In his book Normal Accidents, Charles Perrow asserts that the more complex a system is, the more likely it is to go wrong. This idea is also at the heart of risk management probability calculations; these are founded on the premise that the more times a set action occurs, the greater the probability is that it will not go as intended. I have therefore extended this logic to the implementation of recommendations; I would, in general, assert that the more steps required to implement a recommendation, and then for that action to have the desired effect (outcome), then the less likely it is that the new end state will be achieved.

In terms of distance the recommendation can be judged in two dimensions. The first is the ease with which a recommendation can be implemented. The second is the probability that, if implemented as written, it will lead to the change desired whether this changed state is articulated or just assumed. This will be illustrated by my analysis of the IICSA recommendations. When looking at recommendations we see some that are easy to implement but have a very weak connection to the DNES. There are others that obviously require more work to implement but are more focused on producing the desired outcome. At this stage in the development of the methodology many of the judgements about Achievability will be subjective; in due course it may be possible to develop something more objective. There is one feature that will enhance the Achievability and that is if the inquiry team has taken the Quality Assurance (QA) and Quality Control (QC) aspects of their recommendation into account.

It is generally accepted that if organisations or processes are not managed, they will slowly dissolve into disorder. QA is the term used for the systematic processes that organizations use to determine if a product or service meets specific standards. QC are the processes by which they ensure that the quality is maintained or improved. This is generally referred to as QA/QC and, in summary, this concerns that the right things are done right every time in order to produce the right result. QA/QC is required in both the implementation of change and in the future maintenance of the system. It should be noted that there can be QA/QC processes both within an organisation and external to it. Any review would need to consider how these components operate and coordinate to ensure the desired outcome is produced.

Finally, we need to look at the size of the system in terms of the number of people involved. In general terms and as a basic yardstick, the more individuals there are in the system, the more likely it is that an error will occur. A full analysis would involve an understanding of each step, the criticality of the step and the QA/QC systems in place to prevent mistakes, slips and errors from occurring (Reason, 1990).

An analysis of Distance may be conducted at a superficial level or in great depth depending on the rigour required. In time, additional or alternate tests may be suggested but for the purpose of this proof of concept, these criteria will suffice.

Analysis of IICSA Recommendations

I shall now look at the 20 main recommendations from the IICSA report to see whether they are likely to contribute to our desired new end state (DNES). While there are a further five recommendations contained within the IICSA report that specifically pertain to "the child sexual exploitation by organised networks", these are not the focus here. This paper is not intended to be a full analysis of the IICSA, but it does seek to use it as a case study of poor recommendation construction and to point to the issues that a full analysis would need to address.[7]

Recommendation 1: A single core data set

– One of the ubiquitous recommendations from inquiries is that communications be improved and so it is with Recommendation 1. Communications are the Achilles Heel of all systems. This recommendation looks to improve communications by creating a single core data set for England and Wales. There must therefore be immediate scepticism as whether this recommendation is the Silver Bullet its authors hoped it might be. The government's record for successful data systems is not encouraging. Having said that, let us take this recommendation on its own merits.

  The desired output of this recommendation can be seen to be "one single core data set … covering both England and Wales … (and detailing) factors that make victims more vulnerable to child sexual abuse or exploitation." The recommendation does give an output and way that output should be measured. It does not however consider the barriers to success faced by many such government systems. This recommendation may therefore only be rated as fair.

  What is not clear however is how this data is to be used to deliver our DNES. The Distance between the UK government accepting the recommendation and this resulting in the minimising of grooming gang activity is so great as to justify the assessment that it is highly unlikely that it will, in itself, result in our stated DNES.

Recommendation 2: Child Protection Authorities for England and for Wales

– Another very common recommendation is to set up a new body to oversee the issue of concern as is the case with Recommendation 2. The activity recommended is clear, it is to set up a new body for England and for Wales. Their role to "improve practice in child protection" and to "make recommendations", in output terms, is very vague. It is therefore likely that it will be years before this body has resolved the boundary issues between itself and the existing agencies and started to have any real effect within its area of responsibility and, as such, the recommendation can only be rated as poor.

  Experience shows that new bodies add complexity to structures which in turn increases the probability of a future failure. Studies into both safety orientated systems and quality assurance systems both look to simplify rather than complicate their system and processes because complexity is a source of many failures.

  There is a secondary recommendation embedded within the text. It tasks the agency to "monitor the implementation of the inquiry's recommendations". It should be noted that this only requires activity but

not a result and therefore the government can claim success without the main issue (child exploitation) being addressed.

There are also many tasks implicit in this recommendation. This means that there is considerable distance between the nominal implementation of the recommendation and our DNES. This means that it is highly unlikely that it will be successful in the short or medium term.

Recommendation 3: *A Cabinet Minister for Children*

– Recommendation 3 proposes another change to the organisational structure by creating cabinet positions in England and Wales with a specific responsibility for children. While this type of change is relatively easy to achieve, these roles are often little more than symbolic. This recommendation is therefore rated as poor. The distance between a position with such wide-ranging responsibilities and a specific problem (such as the grooming gangs) is so great that the steps required are too numerous to state here. Therefore, unless those appointed to these posts make a specific intervention, the creation of the posts by themselves is unlikely to deliver our DNES.

Recommendation 4: *Public awareness*

– Recommendation 4 looks to deliver increased public awareness (output); it also lays out what the programme should do (inputs). The recommendation does not however indicate what the inquiry team hopes this will achieve. In the case of the grooming gangs, media reporting would seem to indicate that the public were fully aware of what was happening, and the failure was with the authorities who did not seem to act on these public concerns. The inquiry team does not articulate how they would expect the public or the authorities to act differently or how this awareness would lead to our DNES. Therefore, the recommendation is rated as weak and it is deemed highly unlikely that this will lead to our DNES.

Recommendation 5: *Pain compliance within Custodial institutions*

– Recommendation 5 (the use of pain compliance within Custodial institutions) has no bearing on our DNES and will therefore not be examined further.

Recommendation 6: *Children Act 1989*

– Recommendation 6 appears to be relatively straightforward to enact in that it asks the Government to amend the Children Act 1989 to a specific end and, as such, it can be rated as fair. However, how this recommendation aligns with our DNES is not clear. Therefore, it is questionable as to whether it will make any significant contribution.

Recommendation 7: *Registration of care staff in children's homes*

– The intent of Recommendation 7 appears to be relatively simple; it is the registration of staff working in this field and as such, it can be rated as fair. However, the implementation becomes more complicated as it seems to involve the setting up of an independent body (or co-opting some existing body) not only for the registration task but also the other duties laid upon it (these seem to equate to it becoming a 'professional body'). As this is all rather vague, I would lower the overall rating to poor.

What is not so clear is how this recommendation aligns with our DNES. How the registration and monitoring the standards of staff would prevent staff from acting inappropriately is harder to identify. There can therefore be seen to be considerable distance between this recommendation and our DNES.

Recommendation 8: *Registration of staff in care roles in young offender institutions and secure training centres*

– Recommendation 8 (the registration of staff working with young offenders) has no bearing on our DNES and will therefore not be examined further.

Recommendation 9: *Greater use of the barred list*

– Recommendation 9 concerns the more effective use of the Disclosure and Barring Service to prevent those with a history of child abuse from working with children. While it may expand the role of the service, this is all about the QA/QC procedures they use to ensure that all those who pose a risk to children are successfully barred from working with them. Implementing the recommendation should therefore be relatively straightforward however the recommendation does not provide any measures of success, it can only be rated as poor. Due to the lack of any consideration of QA/QC arrangements, the distance between the recommendation and our DNES is likely to be great.

Recommendation 10: *Improving compliance with the statutory duty to notify the Disclosure and Barring Service*

– Recommendation 10 is linked to Recommendation 9 as it calls for "steps to improve compliance by regulated activity providers with their statutory duty to refer concerns … to the Disclosure and Barring Service". This can therefore be seen as a QA/QC matter. Common with the use of the PWP, the inquiry team set out additional inputs that need to be added to the process. Again, this only works when the assumption is that the system only needs these changes to be perfected. As this is unlikely to be the case, I would rate the recommendation as poor and would state that I think that it is unlikely that these input changes alone would bring about our DNES.

  An alternative approach would be to give the process owner clear measurable outcomes and let them reengineer the process to meet those targets. This would be consistent with a Normal Chaos approach. This is seen as making it more likely that the intent of the recommendation will be achieved.

Recommendation 11: *Extending disclosure regime to those working with children overseas*

– As Recommendation 11 concerns "working with children overseas" and has no bearing on our DNES, it will not be examined further.

Recommendation 12: *Pre-screening*

– Recommendation 12 that "all regulated providers of search services and user-to-user services to pre-screen for known child sexual abuse material" has no bearing on our DNES and will therefore not be examined further.

Recommendation 13: *Mandatory reporting*

– The action required by Recommendation 13 (introducing a statutory duty for certain individuals to report child sexual abuse) is clear and should be achieved relatively easily. It lays down in detail what the legislation should include (inputs measures). There is also an obvious link to our DNES. The major flaw with this recommendation is however the ability of the system to ensure that those who have the duty to report fulfil that duty. As the recommendation only focuses on inputs, it can only be rated as weak.

  The successful implementation of this recommendation is likely to come down to the QA/QC processes in place to ensure compliance. As there are many reports of those in authority failing to take appropriate action,[8] there must be questions over whether such a duty will result in the action that the inquiry team hopes it will. In relying on this recommendation, the authorities need to be clear about the barriers they foresee, and how these barriers will be overcome.

Recommendation 14: *Compliance with the Victims' Code*

– Recommendation 14 concerns how the authorities react to allegations of child sexual abuse judged against their duties set out in the relevant Victims' Code. This borders on being a non-recommendation as it is an admonishment of the various inspectorates for failing to conduct inspections of whether those under their auspices had correctly fulfilled their duties. This is again another QA/QC issue with the process. For our DNES to be satisfied it does not require a one-off inspection but continual reviews to ensure that those with duties fulfil those duties. The question then becomes one of how do those to whom the inspectorate report ensure that the inspectorates continue to fulfil this responsibility.

Recommendation 15: *Limitation*

– Recommendation 15 should, in theory, help the victims of the grooming gangs to receive justice as it removes some of the current obstacles. They are detailed in terms of the revised inputs but are not linked to any outputs. As such, the recommendation is rated as weak.

  The changes in legislation are however just the first link in the chain and, without a detailed examination of the whole chain, it is not possible to determine what difference these changes will make. Those advocating for a new inquiry will need to see how the chain is constructed before they can be sure that this recommendation would lead to their DNES.

Recommendation 16: *Specialist therapeutic support for child victims of sexual abuse*

– While the intent of Recommendation 16 is to be applauded and it may help the victims of the grooming gangs come to terms with their ordeal, it is not likely to deliver our DNES and therefore will not be considered further.

Recommendation 17: *Access to records*

– In its construction, Recommendation 17 is relatively simple and should be easily achieved. It specifies the need for a code of practice whereby detailed records of child sexual abuse are retained for 75 years. However, while

the inputs are set out in detail, the purpose of this action (output or outcome) is not. As such, the recommendation is rated poor.

In terms of distance, the link between retaining these records and how this will help the authority identify victims and prosecute perpetrators has not been made. In practice there will be a complex web of organizations and processes that will need to work effectively if this recommendation is to deliver our DNES. Within its current state of development, this is unlikely in the short-term.

Recommendation 18: *Criminal Injuries Compensation Scheme*

– While Recommendation 18 may help the victims of the grooming gangs to gain compensation, it is not likely to deliver our DNES and therefore will not be considered further.

Recommendation 19: *Redress scheme*

– While Recommendation 19 may help streamline the redress scheme in England and Wales, it is not likely to deliver the DNES and therefore will not be considered further.

Recommendation 20: *Age verification*

– Recommendation 20 seeks to have legislation introduced that requires online platforms to implement more stringent age verification measures. In overall terms the introduction of legislation should be relatively easy compared to ensuring compliance. Age verification systems for internet use have been widely touted but are rarely adopted due to civil liberties and other practical issues. I would rate it as weak as it does not articulate what outcome this would achieve.

  In addition, the link between this recommendation and our DNES is ambiguous. I cannot see anything other than a tenuous connection between the two. Therefore, even if the legislation was introduced, I cannot see it helping bring about our DNES.

Summary

Nearly half of the 20 recommendations analysed did not directly address the issue of concern. One (#14) was simply an admonishment of a failure. Seven recommendations (# 5, 8, 11, 12, 16, 18, 19) have no link to the issue that those calling for a new inquiry wish to address. Recommendation 20's link is also thought to be very tenuous which brings the number of relevant recommendations down to 11.

Of the eleven relevant recommendations, two are rated as fair (# 1 and 6), three as weak (#4, 13 and 15) and six as poor (# 2, 3,7, 9, 10 and 17). In all cases there could be seen to be a great distance between the successful implementation of the recommendations and our DNES being realised.

Discussion

This will be in two parts. I will first discuss the utility of the analytical method and then I will discuss what the method has exposed within the IICSA main recommendations. I must first acknowledge some of the obvious limitations of the current analytical process. The method is immature as an analytical model and will need refinement in the future: having said that, at present I cannot find an alternative. The qualitative analysis carried out on the recommendations would be enhanced by being conducted by a team: this needs to be done before any definitive judgement can be made on the quality of the IICSA recommendations. Having set out these limitations, it is still clear that the method has merit as it does enable a systematic review of any set of recommendations. It does bring clarity to what the recommendations are proposing, how they are constructed and how they might contribute to the system under examination. It is however acknowledged that the methodology would benefit from further research.

The utility of the method can be illustrated by the issues that it has highlighted amongst the 20 main recommendations made by IICSA. It is clear from the wording of the 20 recommendations that they were seen as patches required to fix deficiencies in the system under examination; this is consistent with a Perfect World Paradigm worldview. The question then becomes one of whether resolving the 20 issues identified would perfect the system. This is clearly not the case as the IICSA review produced a long list of other recommendations. It is therefore possible to state with certainty that even if the 20 recommendations in question were implemented perfectly then even the IICSA review team did not have the expectations that this, in itself, would produce the desired new end state (DNES) that they desired let alone the DNES wanted by those calling for a new grooming gang inquiry.

The analysis also helps to highlight three types of recommendation that are, by their nature, performative. I label these the politically expedient, the input focused and the 'Hail Mary'. I use the term performative in that they could be more about an intention to impress rather than the delivery of an outcome. The politically expedient are ones that proved a quick-win for those implementing the recommendation. An example of this would be Recommendation 3. In this case the Government should have no difficulty in creating cabinet posts and therefore will be able quickly to claim that they 'are enacting the recommendations of the inquiry' whether this has any real effect or not. Recommendations 8 ("introduce arrangements"), 10 ("take steps to"), 11, 13 and 20 ("introduce legislation") may also be considered to be in this category.

The second are recommendations that are input based. Governments often resort to claim action on an issue in terms of what they are doing (inputs) rather than by what they are achieving (output or outcomes). This is often articulated in terms of the money being allocated to solving an issue. From the analysis of the IICSA recommendations it is clear to see the focus on inputs that detail the action required rather than the results to be achieved. With the exceptions of Recommendations 1,2, 4 and 6, this is the case for all of the IICSA recommendations.

Finally, there are the 'Hail Mary' recommendations. The term comes from American football where the label is used for a very long forward pass which has a very small chance of achieving success. It is typically seen as an act

of desperation. I have previously used this term to refer to very broad recommendations that look easy to implement but have only a tentative link to the new desired end state; in terms of the Hail Mary, the act is clear, but the desired outcome is unlikely. In the IICSA recommendations seven recommendations (#2, 3, 4, 12, 13, 17 and 20) would seem to merit this label. In summary, any review of recommendations needs to be alert to those that are in danger of being largely performative.

Also clear from the analysis is a near total absence of QA/QC considerations. With this omission, the scope for failure becomes more apparent. There should be a two-part questioning of every recommendation. The first should ask what needs to be done to implement it as written. This starts to elucidate the distance needed to be travelled. The second question assumes the successful implementation of the recommendation and then asks, 'What now needs to happen for this (the successful implementation of the recommendation) to bring about the desired new outcome?' If it is not possible to answer the second question, then one has to question the value of expending the time and other resources needed to implement the recommendation.

Finally, it should be noted that these recommendations only apply to England and Wales. There must therefore also be a question as to whether similar grooming activities might also be taking place in Scotland and Northern Ireland and whether those under a similar threat in these regions deserve the same degree of consideration and protection from the State.

Conclusions

In conclusion, this paper has looked at a prototype analytical framework by which the validity and efficacy of inquiry recommendations can be assessed. While the framework needs to be developed further, and the protocols for its use need to be refined, it does already provide a more objective way of analysing recommendations. It is clear however that this methodology would benefit from further development. The long-term desire would be that if such a methodology was adopted not only by those peer-reviewing recommendations but also those producing them, then the quality of recommendations being made would improve and so similar failures would be less likely to happen again.

This paper used the IICSA recommendations as a case study to test the methodology. As proof of the methodology's validity, it did raise some issues with those recommendations. The most concerning of these is whether their implementation was likely to lead to those involved and complicit in the statutory rape of children being brought to justice and the probability of it, or something similar, happening again being reduced to a minimum. The conclusion that I would draw is that, even if fully implemented, the IICSA recommendations are unlikely to produce the desired new end state (DNES) by those calling for a new inquiry and therefore their call for a new inquiry would seem to be valid. The form that this inquiry should take is for others to decide.

Notes

1 In Crisis Management this would equate to the term 'New Normal'.

2 For a fuller explanation see: https://www.crimeandjustice.org.uk/imprisonment-public-protection-failure-perfect-world-paradigm

3 See https://www.crimeandjustice.org.uk/imprisonment-public-protection-failure-perfect-world-paradigm for a more detailed explanation.

4 It should be noted that in any discipline such as performance management there will be variations on a theme and so it is with the idea of SMART objectives. However, for the purpose of this note, the articulation of SMART set out above is adequate for my purpose

5 These rating are based on my previous work, see https://www.alto42.co.uk/analysing-recommendations

6 This includes recommendations that could have overlooked potential unintended consequences that outweigh the benefits foreseen. For example, The Haddon-Cave Report (2009) focused on flight safety. It failed to balance this facet of military flight operations against the safety of the people on the ground who the team were supporting. The report failed to acknowledge that aircraft from the Armed Forces will be lost on operations and that there was a balance of risk judgement to be taken in these circumstances.

7 My full coding of the recommendation is not included in the paper due to space constraints. For those wishing to look at the coding exercise can find it on my website (https://www.alto42.co.uk/_files/ugd/81e556_89da1b36edc248559a9558c07de594f7.pdf)

8 For example, see Charlie Peters' work on GBN.

References

Casey, L. (2025). *National Audit on Group-Based Child Sexual Exploitation and Abuse*. London: Home Office.

Haddon-Cave QC, C. (2009). *The Nimrod Review*. (HC 1025). London: The Stationary Office Limited

Lauder, M. (2013). *It Should Never Happen Again: The Failure of Inquiries and Commissions to Enhance Risk Governance*. Farnham: Gower Publishing.

Perrow, C. (1984). *Normal Accidents*. Princeton, New Jersey: Princeton Press.

Public Administration Select Committee (2005). *Government by Inquiry: Volume I*. (HC 2004-2005 (51-1)). London: House of Commons.

Reason, J. (1990). *Human Error*. Cambridge University Press

Teague, B. (2010). 2009 *Victorian Bushfire Royal Commission*. Melbourne: Government Printer for State of Victoria.

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