HOUSE OF LORDS

Statutory Inquiries Committee

Corrected oral evidence: Statutory inquiries

Monday 18 March 2024

4.05 pm

Watch the meeting

Members present: Lord Norton of Louth (The Chair); Lord Aberdare; Lord Addington; Baroness Berridge; Baroness Chakrabarti; Baroness D'Souza; Lord Faulks; Lord Grantchester; Lord Hendy; Baroness Sanderson of Welton; Lord Wallace of Tankerness.

Evidence Session No. 5 Heard in Public Questions 66 - 85

Witnesses

I: Emma Norris, Deputy Director, Institute for Government; Neil Comrie, Australian Implementation Monitor; Deborah Coles, Director, INQUEST.

USE OF THE TRANSCRIPT

1. This is a corrected transcript of evidence taken in public and webcast on https://parliamentlive.tv.

Examination of witnesses

Emma Norris, Neil Comrie and Deborah Coles.

Q66 **The Chair:** Good afternoon and welcome to our latest session of the Statutory Inquiries Committee, which is investigating the form of statutory inquiries. Today, we are focusing on the implementation of recommendations and the monitoring and follow-up of those recommendations. For that purpose, we have three witnesses, one of whom is joining us remotely from Australia. We are extremely grateful for that, not least given the time difference. Before we get under way with questions, I invite you all to introduce yourselves for the record.

Emma Norris: I am the deputy director of the Institute for Government, and I lead our work on how to make public inquiries more effective.

Deborah Coles: I am the director of the charity INQUEST, which works on state-related deaths. We are involved in the Grenfell Tower inquiry at the moment.

Neil Comrie: Good afternoon. Probably the most relevant issue for me to talk to you about today is my role in the implementation of the recommendations of the bushfires royal commission in Victoria in 2009.

Q67 **The Chair:** I will start with the first question, which is simply looking at how recommendations from inquiries in the United Kingdom are presently implemented and monitored. We invite your comments on that. I should explain that in our private session at the start of our inquiry we heard from Emma Norris on the Institute for Government's report. Would you like to open by commenting on where we are at the moment?

Emma Norris: At the moment, inquiry recommendations are implemented and monitored sometimes, but the challenge is that it is ad hoc. Implementation does happen; public inquires do lead to change. Things such as enhanced CRB checks have been implemented on the back of recommendations made in inquiries, but implementation is not organised or guaranteed. As a result, some inquiries lead to change and others do not. It is worth noting that the 2005 Act makes no provision for the implementation of inquiry recommendations, which is a bit of a gap, given the importance we place in the public inquiry processes and the powers and resources we invest in them. There is some ad hoc-ism in implementation itself.

It can also be quite difficult to find out what has been implemented. There is no formal or transparent mechanism for reporting on or monitoring government's or public bodies' responses to inquiry recommendations. Again, that does not mean that it does not happen; some government departments set out in some detail how they will respond to an inquiry, which recommendations they are taking on and which they are not, and why. But, again, it does not happen across the board. There is no requirement there.

Finally, the Government are under no obligation to set out why they are rejecting recommendations when they do so. It can be quite hard to understand the reasoning behind government responses to public inquiries. At the moment, sometimes positive action happens, sometimes things change, sometimes it is quite easy to follow the trail from inquiry recommendations through to what has happened and why. At other times, it is very difficult to do so.

That is a suboptimal process, because we are investing a lot in public inquiries, and the recommendations that are made are there to prevent recurrence but also because not doing so creates a very difficult situation for the public, particularly people who have been affected by public inquiries. They want to see change and do not see change on a sustained basis. They often find it very difficult to find out what has happened as a result of the time and emotional energy that is invested in inquiries. Inquiries do lead to change, but it is ad hoc. That could be changed with different systems in place.

The Chair: From our point of view, the Inquiries Act provisions end with the publication of the report. That is it, and it is then at the discretion of those at whom the report is directed as to whether they take any action at all.

Emma Norris: Exactly. The Act includes strong powers for the inquiry while it is under way, but once it has reported, what happens next is a bit of a Wild West.

Deborah Coles: I do not want to repeat too much of what has already been said, but certainly INQUEST tries to monitor the effectiveness of public inquiries. Our starting point is that public inquiries perform an important accountability mechanism and have been crucial in shining a light on huge areas of public importance.

The important thing, even for inquiries that are ongoing—I mentioned the Grenfell Tower inquiry—and inquiries that have taken place into terror attacks, child abuse, policing and NHS failings, is that they can and should be a powerful tool for harm prevention. Bereaved families and victims tell us that they go through the inquiry process particularly in the hope of finding the truth and getting their experiences acknowledged, particularly where there has been wrongdoing or harm, but more than anything they look for these processes to result in meaningful change so that other people do not end up going through similar experiences.

What Emma said is absolutely right: at present, we have a concerning scrutiny and accountability gap, and the Inquiries Act makes no provision for the implementation of inquiry recommendations. I was struck when Professor Jay, who chaired the child abuse inquiry, said back in January that the lack of an "in-built follow-up" requirement to check up on the progress of government was a serious weakness and one that she found deeply frustrating.

I must say that it is a frustration that I have noted in your inquiries so far and which many chairs of inquiries have spoken to. We simply do not have the checks and balances in place to see the progress of recommendations. That begs the question: what is the point of these inquiries if those to whom recommendations are made do not have to comment regularly and routinely on what action, or indeed inaction, has taken place?

The Chair: Yes, and it is not just that there is no requirement to implement; there is no requirement to respond.

Neil Comrie: I cannot comment specifically on the UK experience, but I can say that prior to the bushfires royal commission report the scenarios that have just been spoken about were common in Australia as well. That changed dramatically after the bushfires royal commission, when a specific recommendation was made for the appointment of an independent implementation monitor. I can certainly talk a lot more about that.

The Chair: Thank you. We will come on to that.

Q68 **Baroness Chakrabarti:** That dovetails perfectly with our next question, which is about different approaches and models in relation to implementation monitoring around the world. What do you as experts think about the merits and disadvantages of these alternative models? Which do you think might be particularly helpful or relevant to the UK going forward? Perhaps I could come to Mr Comrie first in the light of his previous answer.

Neil Comrie: I can go on for quite a while about this; perhaps you can pull me up if I go on too long. As I said, the situation up to then, particularly in Victoria in Australia, was that, like most western societies, we had a continuous range of inquiries into major incidents. Looking back, it is fair to say that the implementation of the recommendations was spasmodic. In fact, some of the same recommendations kept coming up over the years, clearly not having been implemented in the first instance.

The difference that came out of the bushfires royal commission in Victoria was that a specific recommendation was made, recommendation 66, which was a requirement for an independent monitor, who must report to Parliament. You might say that that was the first robust accountability mechanism that was put in place. I was subsequently appointed as the monitor, and over the next four years I submitted an annual report to the Parliament of Victoria. It was quite a transparent process. The report was made publicly available as soon as it was accepted by the Government.

There are some basic principles that need to be followed to make that role effective, and I am happy to step through them fairly quickly, if that is of interest to you.

Baroness Chakrabarti: Please do.

Neil Comrie: In my view, this whole process has to be transparent and public, otherwise it lacks credibility. It is important that the Government formally accept the recommendations so that everyone, particularly the bureaucracy, is aware that the Government want the recommendations to be implemented. The Government should then appoint nominated officials in each relevant department who are responsible for developing an implementation plan for each of the recommendations. This is where it can be a little tricky, because one recommendation might in fact incorporate three or four separate actions, so it is important that they are all broken down, otherwise some misinterpretation or misunderstanding may lead to a critical part of a recommendation not being implemented.

The implementation plan needs a substantial amount of work to be prepared. The plan should state exactly who is responsible for implementing each one of the action items so that an accountability process is clearly established. If a name or title is attached to the responsibility to implement a particular recommendation, there is a far greater likelihood that it will be carried through than if there is some open-ended requirement for some department or entity to take that action.

A firm timeline should also be set for the action item to be completed so that it is not a neverending process, and the implementation monitor has a timeline by which they can measure progress against a particular action item.

In my view, on completion of the implementation plan, the Government need to formally approve the plan and task those nominated in the plan with the role of implementing the action items. It is important to appoint an implementation monitor to independently monitor the progress of each of those implementation action items and to report, at least annually to Parliament on the progress of that work.

In my role over the four-year period, I found that some action items could be dealt with quickly, but not others. For example, the bushfires royal commission required the undergrounding of 12 quite extensive power lines, which was a long-term process, so it was a case of ongoing monitoring rather than being able to sign it off at the end of the first 12 months.

It is also important that the implementation monitor clearly understands the key purpose and thrust of the report, because if you separate out individual recommendations and action items, again, they can be misconstrued or misinterpreted. I kept going back to the body of the report to see what the commission wanted to see achieved at the end of the day.

It is important that the implementation monitor is a person of impeccable reputation and credibility and is removed from the political process and any bureaucratic pressure. They must be truly independent. It is also important that they have a strong background in the area in which they are reporting so that they have the ability to recognise some of the

technical issues that may be associated with the implementation of some of the recommendations and to challenge, if you like, from their own basis of knowledge, some of the assertions being made.

As I said earlier, the periodic reports—in my case, they were annual—should be released publicly. Certainly the media in Victoria gave a lot of attention to the annual reports and made the public well aware of where we were at at any particular time. I found that the best way for this to work was for each government department or agency with an obligation to implement recommendations to appoint a senior liaison officer to work directly with the implementation monitor. That facilitated a lot of communication. If you have one accountable officer talking to another accountable officer, it takes a lot of the confusion, delays and bureaucratic processes out of the system.

It is also very helpful for a good working relationship to be established between the office of the monitor and the appointed departmental officer. In my view, one of the most effective ways to get a clear indication that things are being achieved is to take what I would describe as a show-me approach: "Don't tell me or give me volumes of reports. Show me".

I will give you an illustration of why that is important. Following the bushfires royal commission, there was an extensive operation to establish incident control centres around Victoria that could be called into action at very short notice in the event of a fire or other major emergency. One agency reported that these incident control centres had all been set up—the equipment was installed, ready to go. I sent a couple of my team members out to do an inspection of one of them, only to find that that was not true at all. The equipment was there but it was not installed; it was not ready to function. I immediately went back and reported that to the committee monitoring the agency's work. That resulted in a dramatic change in the attitude of the people responsible for implementation, because they realised that someone was actually out there looking at what they were doing and signing off on it.

After that, with each of them I have to say that the operational response improved dramatically from that point on. It is that approach of "Don't tell me. Show me what you're doing". It comes back to the individual experience and credibility of the monitor to be able to do that and to judge whether what has been done is effective. That is important. There is a risk in simply accepting written assurances that things have been done without looking for further evidence to confirm that they have been done. In my case, I was not going to sign off that something had been implemented unless I was convinced that it had indeed been done.

Despite what I just said, it is also important in a good working relationship with the agency or department that if you can see that something is not tracking well and is getting behind, you quickly get in touch with the nominated representative of that agency, and point out to them that they are getting behind and that if they do not move to get it rectified, you will have no option but to report negatively on progress in the report. That also had a very positive impact.

I took what I would describe as the "gotcha" moment out of the reporting. A sense of co-operation developed that became a very positive way of doing the business required to get the work undertaken in a relevant time. These are the key principles that I derived from my four years of undertaking this role.

After I finished that role, I was asked to take on a subsequent role following a major inquiry into the Hazlewood mine fire, a very large fire in a coal mine. The same principles applied. I think we can say that, at the end of the reporting period, it was very satisfying to see that the progress made was very satisfactory. It was on the public record and anyone who had an interest in following up would know at any time exactly where the recommendations stood and what work was still required, if necessary, to implement them.

Baroness Chakrabarti: Thank you. That is helpful. I think you are describing almost a second inquiry or a very active policing of recommendations. Could I turn to Ms Coles for her perspective?

Deborah Coles: I was particularly struck by the "Don't tell me. Show me" point. In INQUEST's experience—we monitor inquests, reviews and public inquiries—so often we are told that changes have happened, but it needs interrogation on the ground to see how that has influenced policy and change, which is difficult.

I know I will be given an opportunity to talk about INQUEST'S national oversight mechanism proposal, but, before I do, one of the things I like about the implementation monitor in Australia is that there seems to be a much more developed culture, particularly in the state of Victoria, of the importance of oversight and monitoring what comes out of inquests and inquiries.

It is important for those most affected to have a much more transparent and accountable system. Families who INQUEST works with tell us that very often it is the families who are the drivers of change. They are the ones who will try to pursue different government bodies to try to find out what has changed, because there is nowhere to go to find that information. Corporations and public authorities tend not to tell bereaved people, in our case anyway, what they have done to implement change. Reports and recommendations literally sit on a shelf gathering dust until, sadly, the next time. At the moment, learning is fragmented, piecemeal and ad hoc, as Emma has said.

The other problem is that with delay—as we know, inquiries can take a long time—can come complacency and silence, because the issue that generated the inquiry is no longer on the political or media agenda, and then there is no impetus to drive the change that is needed on the ground.

Emma Norris: I completely agree with Deborah. On implementation monitors and the model that has been used for a number of different commissions in Australia, another characteristic that is particularly

attractive is the use of an individual who has a background in the area in question. Again, speaking to Neil's "Show me, don't tell me" point, having someone who is able to interrogate using their background and expertise whether recommendations are being implemented in a meaningful way is important. There is something about having an implementation monitor or an independent individual who has a strong grip on the area in question that would be a real asset to monitoring and implementation.

The one question I have about the UK system versus the Australian system is that we have quite a large number of public inquiries running at any one time. Would you go for a model where you have an implementation monitor for every one, and what does that look like in terms of resources? Do you pick and choose which public inquiries get an implementation monitor? If so, how do you make that choice, and what does that mean for the inquiries that do not?

On the question of what is out there, there are a couple of other bodies worth highlighting. I talked about this last time in the private session. There is obviously the option of tasking an existing body with implementation. That is what we saw with the RHI inquiry. It worked with the Northern Ireland Audit Office and agreed that the Audit Office would monitor recommendations and publish regular updates on whether they were being implemented. That has the benefit of using an existing body, and there is no need to set up anything new, so you save on resources. It is worth saying that that role was made easier by the fact that 42 of the 44 recommendations were aimed at the Northern Ireland Executive, so the audit office had a focused role, which made it easier.

Another option is to look at inquiries themselves. We are now moving towards a situation with public inquiries where they publish interim reports. There tend to be recommendations that are live throughout the life cycle of an inquiry. We are starting to see the model emerging of inquiries themselves tracking recommendations. We have seen that with the Manchester Arena inquiry, which has monitored recommendations; the inquiry itself is looking at the state of implementation as it progresses. That feels like an interesting option, as we know that, in the past, inquiry chairs have tried to reconvene their inquiries because they want to use their moral authority to try to find out what has happened with recommendations. There is clearly an opportunity to use inquiries themselves.

The main thing I was going to talk about was the role of Select Committees. I can go into what that looks like or hold off until Deborah has had a chance to talk about NOM, because I want to talk about how complementary we think the NOM model is with the use of Select Committees to track implementation.

The Chair: We will come on to that.

Q69 **Baroness Berridge:** Not all the recommendations in our inquiries are aimed at government departments or statutory bodies. I am thinking of the independent inquiry into child sexual abuse, for instance, which made

recommendations to religious bodies. It seems they have struggled to implement the outcomes of recommendations. Would the model that you have talked about, Mr Comrie, or the one that you have outlined, Emma, would work with other organisations that are basically voluntary or third-sector organisations?

Neil Comrie: One key to all this is openness, transparency and a general acceptance that those issues need to be followed through. For organisations that are not government entities, there is no doubt that strong media exposure of the fact that they are not acting to implement recommendations works as a very strong tool to cause something to occur. The fact that these reports are transparent and publicly available simply means that the pressure to address recommendations does not disappear. It continues and the organisations remain under constant public pressure. Particularly if there are victims and victims' families involved, they have an opportunity to know at any time exactly where things are at and to take other means of highlighting perhaps the failure of these other organisations to undertake the obligations that they have made.

Emma Norris: To endorse what Neil said, one of the key changes would be a culture change. If we implemented a system whereby there was a requirement for public bodies to respond to the outcomes of an inquiry, it would create a more general expectation of response from bodies that are identified as having a recommendation to implement. Although you might not be able to require parts of the third sector, or bodies that are outside the public realm, to respond, you would create a culture in which response is part of the norm for public inquiries, which would encourage them to do so. You would also create more transparency around how organisations are responding, which, again, would increase pressure on bodies outside the public sector to be similarly transparent with their response.

That also speaks to the importance of having some form of body whose role is both to monitor the state of implementation and to work with bodies that should be acting to implement, to try to find out what is happening and potentially, in some instances, to provide support. I see no reason why a body like that would not be able to work with the third sector and private sector where that was deemed appropriate.

Q70 **Lord Hendy:** I want to ask you, Miss Norris, about the point you made about implementation monitors having specialist knowledge. A lot of these inquiries have very diverse aspects to them, and to be an expert in all of them would be practically impossible. On the other hand, you cannot have a raft of implementation monitors with special knowledge of fire brigade practice, construction materials, design or local authority building regulations. Is that an argument for maintaining the expertise of the inquiry in the first place, which will have mastered all those techniques? How would that work for a Select Committee that has none of that expertise?

Emma Norris: On the role of implementation monitors and how they work when it comes to public inquiries or royal commissions that are wide ranging, Neil is probably better placed than me to answer that question. What I would say is that, at the moment, you are in the worst of all worlds where you do not even have some form of capability and resource dedicated to implementation. Even taking one step in that direction is better than nothing.

There is a certain level of expertise on Select Committees. The Francis inquiry, for example, had a really positive relationship with the health Select Committee, which was able to do some in-depth dives into the state of implementation stemming from that inquiry. So there is some capability and expertise in Select Committees, but using just Select Committees as the route to accountability and scrutiny of public inquiries does not quite get you to where you need to be. That is not just because of expertise and capability but because of resourcing and time. As you all know far better than I do, the time of Select Committees and the resources available are already under severe pressure, so expecting a Select Committee to undertake all the monitoring and checking of implementation for any given public inquiry is a big ask.

It would make more sense to have an independent body that was charged with doing that. Then, when it looks like there a real problem, where perhaps a critical recommendation is not being implemented or a particular public body or department does not look like it is doing what it said it was going to, that is the point at which it should be passed to a Select Committee, where the kind of scrutiny that a Select Committee can apply—calling the Minister before it—comes into play.

The most powerful combination is that of an independent body that can apply resource and expertise to monitoring with the kind of scrutiny that only Parliament can provide when it looks like things are not going well.

Lord Hendy: Plus the continuation of inquiries in specific circumstances?

Emma Norris: At the moment, our model is that the powers end when the inquiry ends. You are right that a huge amount of expertise is built up during the life cycle of a public inquiry. There are questions, for instance, about the role of an inquiry secretary after an inquiry comes to an end and whether there should be a relationship between them and an independent body that was created for monitoring. How do you make sure that you are using the expertise that you have generated in an inquiry, often over many years, to ensure that those recommendations are being not just implemented but implemented in the way the inquiry intended? There is an opportunity for doing a bit more there.

Deborah Coles: There is a good practical example of one of the problems at the moment. You have referred to the good practice in the Manchester Arena inquiry. Not only did it provide meaning to the victims, but it incentivised action from the recipients of recommendations by scheduling those official monitoring sessions.

At the Grenfell inquiry, we wrote to the inquiry chair asking him whether he would call for evidence to report on the inquiry's recommendations, given that his first inquiry report came out, believe it or not, back in October 2019. He wrote back to say that he did not have the powers to do so. There are a number of very important recommendations from that inquiry, particularly in relation to the risk of further deaths of disabled residents of high-rise buildings—the recommendation related to personal emergency evacuation plans, or PEEPs as they are known. We know that a disproportionate number of disabled residents died in that fire, yet seven years on they are still living with that potential risk.

We talk about the importance of this to the public interest and to those who have suffered what was, as we all know now, a preventable disaster. We looked back at an inquest recommendation following the Lakanal House fire and saw exactly the importance of this follow-up and monitoring of what has happened on the ground. We can see now that, had the recommendation following Lakanal been implemented, we may well not have had the Grenfell Tower fire.

That is a very poignant example. There was an opportunity at the Grenfell inquiry to properly interrogate those processes of monitoring and following up, and it showed us the danger of leaving these issues without proper interrogation. It was absolutely evident to those who have to respond to these reports and recommendations how complacency can build, particularly when you are talking about it being a number of years since the actual deaths happened.

Q71 **Lord Wallace of Tankerness:** We have heard a very comprehensive and helpful description from Mr Comrie about the independent monitoring follow-up. We will hear more about the national oversight mechanism and Select Committees; there have also been references to the use of sub-national audit institutions. Are there any that are particularly suited to or appropriate for the United Kingdom, or is it a question of horses for courses that some inquiries may lead to one kind of oversight post inquiry, and some to others?

Emma Norris: Rather than a horses for courses approach, I would prefer that we find an opportunity to create a set process and series of requirements for post-inquiry monitoring and implementation, otherwise you retain the risk that some inquiries just get missed or that you do not see the kind of traction that you need.

I want to emphasise Deborah's point about repeat recommendations. If there is one thing to emphasise about the failures of implementation, monitoring and scrutiny, it is that we see inquiry after inquiry make similar recommendations because the recommendations of former inquiries have not been implemented. We see it in almost every inquiry in the healthcare space where you have recommendations on the patient voice and blame culture. You see the same recommendations again and again. It is for that reason more than any other that having firm procedures in place that apply to every public inquiry is the most sensible

model. It is also eminently achievable, in my view. I do not think it would take that much to get there.

The Chair: I expect you agree with that comment, Deborah.

Deborah Coles: Yes. It is also incredibly damaging to public trust and confidence in these processes, not least when you consider how much time and expense go into the processes. As I said earlier, from the point of view of those who have looked to these processes to get answers and try to effect change, it is insulting, if I am honest, to go through a process and then learn of somebody else dying or being harmed in a similar way. At its heart, it is about the democratic accountability of the state and the public inquiry processes, so that they function properly and we all benefit as a result.

Q72 **Lord Wallace of Tankerness:** This has all proceeded, quite understandably, on the basis that recommendations will be accepted, but there is a difference between a requirement to respond and a requirement to accept. If, for example, the Government accepted a recommendation but then could not get the necessary legislation through Parliament, you could not subcontract Parliament's role to the recommendations of a public inquiry, however eminent and thorough it may be. How would you deal with the possible disappointment there? There would be a political fallout if the recommendation were not accepted, but do you identify that as a potential problem? How might we address it?

Emma Norris: I completely agree with you. I do not think we want to pursue the course that recommendations should be implemented no matter what. This is partly because there could be barriers to implementation that are entirely beyond the Government's control, as you say, and partly because, in some instances, inquiries generate recommendations for very good reasons that none the less, when you get to implementation, may have perverse effects which the inquiry had not considered and that make them not fit for implementation. That was the case with some of the recommendations that came out of the Shipman inquiry, for instance, which, post inquiry, would have had unintended consequences and so were not implemented for very legitimate reasons.

The key is not whether they are being implemented. The key is knowledge and explanation. That is why one of the other changes that I would like to see—I know we will come on to what we want to see and what any change to the Act should look like—is a reporting duty being placed on public bodies requiring them to set out whether they plan to accept recommendations and, if not, why not. That is the crucial piece: going through the process of thinking it through, having to explain it and providing transparency so that the kinds of people Deborah is talking about—the families and other people who have been affected—know why, if a recommendation is not going to be implemented, it is not going to be implemented. That knowledge would go a long way to overcoming the understandable upset that would ensue where recommendations are not being implemented.

The Chair: We will come on to the point about Select Committees, but presumably your argument is that that is the sort of information that should be put before Select Committees as a matter for them.

Q73 **Baroness D'Souza:** I want to ask about negative evidence, which you have all touched on in some way. If we go right to the end of an inquiry, at least one of the goals would probably be to look at how much of an impact it has had. In the happy event that the recommendations made by committees such as ours are accepted by the relevant authorities, and in the even happier event that they are adequately or fully implemented, what evidence is there that serious incidents of public concern are in fact reduced? That is what I mean by negative evidence; if it does not happen, you cannot really record it. Ms Coles, you touched on this a bit when you talked about the Manchester Arena inquiry.

Deborah Coles: If I understand your question, greater transparency and accountability give you an opportunity not only to track and review recommendations but to follow them through to implementation, policy and cultural change. For us, it is about this: if you have a greater opportunity to learn, you have a greater opportunity to prevent the deaths, injustices and harms that we have seen happen. At best, I suppose, you are trying to develop a culture that is much more able to look at public health and safety issues.

Baroness D'Souza: You have talked about creating a culture, but do you know of any incidents where, because of adequate and timely input, a potentially serious incident has been prevented from becoming a serious incident?

Deborah Coles: I am talking from the perspective of INQUEST. Sadly, our work is where something catastrophic has happened and resulted in death. It is therefore very difficult to give you examples. There is no doubt that our work and that of families—as I said, they often drive forward recommendations from different processes—has been effective in trying to make people understand the importance of taking these things seriously.

On the challenges, we have already referred to the accountability gap and the difficulty we all have in trying to find out in real terms what has changed on the ground. It is not a perfect answer, but if we were able to develop some of the proposals that we are speaking to today, you would, I hope, see more of the change that we all aspire to see here.

Q74 **Baroness D'Souza:** Thank you. Mr Comrie, you mentioned that all your recommendations had been implemented, but that they were useless in effect simply because the equipment that was necessary to stop a bushfire was not properly connected and set up. Do you know of any incidents of bushfires being contained quickly because of recommendations being implemented adequately?

Neil Comrie: Perhaps I could take a slightly different approach. There is a good example coming out of the bushfires royal commission. Prior to 2009, the fire authorities in Victoria—it was pretty much the same across

Australia—had a policy of stay or go, which left it to landholders to decide whether they should try to stay and defend their property or leave. Some 173 people were killed during the fires in Victoria.

Since then, the policy has been changed as a result of the royal commission's work. Now, the very strong policy, which has been broadly accepted by the community and has certainly been implemented strongly by the fire authorities is that people should not stay in any area where there is a threat of fire. Evacuations are now becoming commonplace. That has been a big cultural change not only in the fire services but in the community. The end result has been a significant reduction in the number of people who have been killed or seriously injured as a result of a bushfire in this state.

So I think that recommendations can have a major impact not only on what government agencies do but, getting back to the cultural issue that we talked about earlier, in making a big change in the way the community sees its own responsibility in responding to or preventing natural disasters.

Emma Norris: There are some instances that we can point to where inquiries have led to positive change. I mentioned at the outset the changes that were made to the process for CRB checking, which came on the back of the Soham inquiry. That has certainly been credited with improving child protection. There are also examples of changes made to rail safety that have made crashes and serious misses less likely. Likewise, laws on gun ownership were changed on the back of a public inquiry after Dunblane. So I think you can point to instances where public inquiries have led to changes that have resulted in greater public protection and so on.

However, your question gets to an important point about how we assess the effectiveness of public inquiries. Another challenge in the system we have, where scrutiny is quite patchy, is that it is quite hard to evaluate how effective the recommendations that inquiries are making are. Are they leading to the changes that they are intended to make? If we had a more methodical system for tracking whether recommendations were implemented, it would make it much easier for us to assess whether public inquiries themselves are effective, or whether something in the inquiry process and the recommendations generated are not resulting in the changes intended. That would be a useful piece of information to have, as it might tell us whether the recommendation development process in inquiries needs to change. It gets to an important point about inquiries themselves as well as the scrutiny process that follows.

Q75 **Baroness Berridge:** You referred to the effectiveness of public inquiries. I know that you are also working on the Covid inquiry. There has been quite a lot of comment in the media, maybe beginning with IICSA. Do you have anything to add about whether there are things to do with public inquiries that are more effective than others?

Emma Norris: There are a couple of factors that we have pulled out in our research. One is not waiting until the end of the inquiry to try to achieve change—so the importance of breaking an inquiry into modules, which enables the publication of interim reports, which means that the inquiry itself, as with Manchester Arena, can monitor its recommendations and their implementation.

Speaking to Deborah's point about the political focus on an inquiry tending to be there while the inquiry is under way, publishing interim reports while the inquiry is live makes it more likely that there is energy behind implementing those recommendations. There is greater political focus in that moment, and the sooner you get those recommendations implemented, the sooner—hopefully—you reduce the chances of a repeat event. So there is something about interim reporting and not leaving things until the very end.

The process of recommendation development is important for the effectiveness of an inquiry. There are many different ways of developing recommendations, but some of the most effective that we have seen are where you involve experts in developing those recommendations, such as via a panel or via seminars, for instance. It is a long time ago now, but the Bristol inquiry ran a series of expert seminars with healthcare professionals and others to stress-test its recommendations and make sure that they stood up to expert scrutiny. So there is involving the right kinds of capability.

There is also involving people who understand government itself. In a health-related inquiry, for instance, you need to involve healthcare practitioners and people who understand government and how you get things done in government. So there is something about making sure you have Whitehall and government expertise involved.

There is also a whole literature about the role of the chair, what kind of background they should come from, the benefits and drawbacks of a judicial chair versus a chair who perhaps has expertise in the inquiry area.

Q76 **Baroness Berridge:** My next question is about the national oversight mechanism. What powers would it have, and how do you think it should be established?

Deborah Coles: Can I quickly add something to last point? One frustration we have is the fact that after every public inquiry, from what we have been able to find out, there is never any opportunity for a proper evaluation of how that inquiry went. There is no feedback from those who were most affected. So there is no opportunity to look at what went well, what good practice looks like, what some of the challenges were, and what some of the issues were that perhaps undermined trust and confidence in the first place.

I have been involved in a number of public inquiries, most recently Grenfell and the Sheku Bayoh inquiry that is currently taking place in

Scotland, and it feels to me that, when you have had inquiries that have lasted a long time and have involved many people, it would be really positive to have a review so that when the next inquiry is being set up we do not repeat some of the mistakes or, indeed, if there is good practice that we try to use that, moving forward.

On the national oversight mechanism, we developed the idea of a new independent public body set up by government. The proposal came, I suppose, because of that frustration of seeing inquests, independent reviews and public inquiries making recommendations and there being no opportunity to collate, analyse and follow up exactly what has happened to those reports and recommendations. We feel that a national oversight mechanism would be able to maintain that kind of focus and, we hope, inform that cycle of policy change.

It would be accountable to Parliament, in some way like the Electoral Commission or the National Audit Office, because safeguarding its independence from the government department whose actions it would be monitoring is important. It would have three core functions: collation—creating and managing a publicly available database that would collate all the recommendations coming out of the different processes that I have mentioned; highlighting the agencies that the recommendations are addressed to; and making clear when an agency has responded to the recommendations, so it would comment and look at partial implementation, rejection—or, indeed, not responded to at all, which we unfortunately see too often. It would—we would say it should—be required by law to respond with the correct information, so there would be a duty to respond.

Then it would have a role in categorising recommendations, because, as has already been said, there are a lot of inquiries and inquests into a variety of different areas. That way, it would have a way of categorising the recommendations by type of death or the particular area that it had been looking at. Then you would have areas looking particularly at protected characteristics that have been important. It would be a hub for parliamentarians, coroners and inquiry chairs as well as lawyers, researchers and others.

As a result of that function, it would be able to do that analysis, particularly the thematic analysis, on the information that it collates, and thereby it would be able to issue regular reports to analyse the emerging themes that come out. It would produce an annual report to Parliament that would bring together the information on a whole range of different areas. It would have a follow-up role, which is particularly important, because then it could have that important oversight of recommendations and be equipped with the necessary powers to follow up and alert the relevant bodies as to whether the recommendations have been enacted.

It could also alert Select Committees to its thematic findings. That is the point that Emma and I have been talking about: we would see its role as complementary to a Select Committee.

As well as the powers it would have and the requirement to issue an annual report, we think it is important that it is accountable to bereaved people or victims, possibly through an advisory board, because one of the real challenges is how they, as affected individuals, learn and understand what has taken place on the ground.

Importantly, this proposal has come out of decades of frustration with the repetition time and time again of issues, whether through the inquest process, through independent reviews that are often set up instead of statutory inquiries, or indeed through public inquiries.

Q77 **Lord Faulks:** I am principally concerned with something you have already touched on: the role of Select Committees, and, in particular, the relationship between them and a possible national oversight mechanism, which we have just been hearing about.

Before that, I want to clarify a couple of things with you. Lord Wallace referred to the fact that some recommendation may not be possible, or the Government may not accept them. That of course creates some difficulty in deciding how things are implemented. There is also the fact that not all recommendations necessarily prove to be a good idea and, as time passes, they may not be a good idea. They may also involve very considerable resources, which may prove to be beyond the particular public body's purse, or the Government may not wish to spend them or may wish to spend them elsewhere. That also creates problems in identifying what should or should not be part of the implementation. I would like to hear your comments on those points.

I will pick up Lord Hendy's point about the fact that there are different sorts of recommendations and it is difficult to have the expert on every aspect of the recommendations. Might it be helpful if we made some recommendation that, in a report from a public inquiry, the chair or the report actually suggests the best way of monitoring the particular recommendations in the report?

I will not repeat the question about the relationship with Select Committees, as what we are concerned about is obvious.

Emma Norris: I agree with the point about not all recommendations being implemented, perhaps because the resources are too great or because they are not likely to be particularly effective. There is a whole host of reasons. I do not think that is a problem. It is not a problem if inquiry recommendations are not implemented for good reasons, and there are any number of good reasons why some recommendations might not be implemented.

The problem is that it can be hard to find out whether there are plans to implement recommendations and, if there are not any, to find out why not. I think it is the absence of a requirement for explanation that is the problem. It is unlikely that we would find that, most of the time, the majority of recommendations were not going to be implemented. Given that, there is a need for explanation where recommendations are not

going to be implemented. For those that will be, there is a need for monitoring to ensure that that is happening.

Those two processes combined give space to acknowledge that, very fairly, some recommendations will not be implemented for good reason. In other instances, they should be, and we need to make sure we have the apparatus available to ensure that they are being implemented.

It might be that, through a process of monitoring, a recommendation that you initially thought was perfectly reasonable appears over time to be very difficult to implement. Again, the monitoring process would be a way of surfacing that information and helping to engage with any post-report difficulties in a reasonable way. So the most important point is transparency and monitoring, not that all recommendations should be implemented.

Lord Faulks: So it is monitoring, rather than enforcement, as it were.

Emma Norris: Exactly. Where there is agreement that recommendations should be implemented and a public body or a department has agreed that it will implement them, it is reasonable to see those implemented or for them to provide an explanation if they change their minds. That is what you what you need in place.

Deborah Coles: Equally, if somebody says that a recommendation should not be implemented at a particular time for whatever reason, if you have proper oversight of recommendations, something else may happen two years later that suggests that the recommendation that was rejected should perhaps have been implemented and may need to be reconsidered.

Above all, certainly from a family perspective, we do not have that openness and transparency, or a way of tracking what has happened. Too often, the only way you know that something has not been enacted is when something goes wrong again. I cannot overstate the psychological impact on the families with whom we work of finding out that somebody else has died in a similar way to their loved one, when they have looked to those processes to try to effect change.

The Chair: Can we come back to Select Committees?

Emma Norris: As you know, at the Institute for Government, we have advocated for Select Committees to play a much stronger role in the follow-up on public inquiries. When we first undertook the research in 2017, we suggested that inquiry follow-up should essentially be the remit of Select Committees, and that it should be added as a core task—an 11th task—to Select Committee roles. We suggested that they should work with an inquiry chair to organise a post-inquiry scrutiny process that would probably involve regular monitoring, perhaps on a six-monthly or annual basis, and, where there were concerns about the state of implementation, it would involve moving to public hearings.

That model still makes sense. We are moving to a public hearing model. The example of the health Select Committee after Mid-Staffs provides a good example of how to do that well. However, since we published our work, our view about how the role of Select Committees should look has evolved slightly. There is still an important role there for them, but the Select Committee model should be combined with another independent body.

As I said earlier, you all know better than I do that Select Committee time is at an enormous premium and there are always many more things to focus on than time available. The staffing of Select Committees is also quite limited—there is not a huge amount of capacity to do additional work—so expecting them to do in-depth monitoring of recommendations and whether they are being implemented feels like a relatively tall order. It feels most sensible to have another body charged with that—for instance, the NOM that was outlined. When it identifies areas of concern—perhaps an area that we are expecting a recommendation to be implemented in, but it is not—that can be passed on to the relevant Select Committee, which can consider moving to public hearings at that moment.

It is worth thinking about which are some of the most effective Select Committees. We have looked at that a lot at the Institute for Government, and the PAC is always identified as one of the most effective. When you dig into why it is effective, it is partly down to the existence of the NAO, an independent body that is able to do large amounts of background investigatory work and analysis and to feed that information into the work of the PAC. I would see a similar relationship here. The combination of a powerful independent body that is able to share its findings and analysis with Select Committees provides a really effective model. That is what we are interested in here. I can talk a little about what would need to happen for Select Committees to play that role—what it means to add a core task and so on—but I will take your guidance on whether that is useful.

Lord Faulks: Mr Comrie, do you have anything to add?

Neil Comrie: I am not well equipped to comment on the Select Committee role, but I will just go back to the non-acceptance of recommendations. You will recall that I mentioned that an implementation plan should be developed and signed off by the Government of the day. That, to me, is the place for the Government to decide whether a particular recommendation will or will not be implemented. The reasons for or against can be stated clearly in that plan, so I do not think that is a real problem. Again, that is a public document that is visible to all concerned, and it takes away a lot of the debate that might occur subsequently about whether something should or should not be undertaken.

Q78 **Lord Grantchester:** Can I ask for some clarification on the suggestion that recommendations could be monitored? It is not so much the recommendations being monitored as the lack of action on which

recommendations the Government are accepting. So there are two halves, as it were—not only the monitoring of recommendations, but following up on the monitoring so that action actually happens on what the Government accept. The answer may well have been covered by Mr Comrie's suggestion that an implementation plan is vital for helping the monitoring process.

Deborah Coles: To be clear, our proposal is that the independent body would collate, analyse and follow up. The follow-up function is fundamental, because that is the ability to track what action or inaction has followed. In response to the last question, we see that as building up institutional knowledge. I think Lord Hendy mentioned this. It would then have the power to call in specific experts on particular areas. Clearly, its role would be quite broad, and at different moments it may need to call in people—for example, an inquiry chair who has developed that expertise. At the moment, we are so far off anything like this. We have sought advice from a whole number of people, including the Institute for Government, because we think that this body could address the accountability gap that we have at the moment.

The Chair: So it is essentially an ongoing process, not a tick-box exercise.

Deborah Coles: Absolutely. That is so important.

Q79 **Baroness Sanderson of Welton:** Mr Comrie, you mentioned the implementation plans. We have talked quite a lot about the who and the how, but there is also the when. I think you said at the beginning that you provide the timeline with the implementation plans. I am interested in that. Do the Government accept it? I have declared that I work with Grenfell families on the recommendations from the interim report. There is an issue about how long it takes. You talked about peaks, but there is also an issue with government not wishing to be committed to a timeline. Who decides? I am interested in the timing, as we have not really discussed it.

Neil Comrie: The implementation plan, of necessity, needs fertile minds. Otherwise, things can drag on and just be continually reported on an annual basis. The implementation plan is developed in the relevant government agency responsible for that recommendation, and it makes the commitment to the timeline. It is its commitment that the monitor holds it accountable to. It is not the monitor that sets the timelines.

However, the timelines can vary considerably, as has been mentioned; in my case, the bushfires royal commission was an interim report and, by the time the final report came around, some of the critical issues had already been implemented. If you have a very firm timeline for every action item under a recommendation, if for some reason that timeline is not met, there is a public report on why it has not been achieved. The monitor can make a comment about the reasonableness of that or whether it is an issue of concern. Again, that becomes public knowledge and brings focus back on to the agency or department concerned to get

on with the job and meet the timelines that it put forward and committed to.

Baroness Sanderson of Welton: Thank you, that is helpful. So the point is that there is an expectation from the department that it should put a timeline on each recommendation. That is interesting, because we do not necessarily do that.

Deborah Coles: We do not do that. I think the frustration and probably exasperation of Grenfell families is due to the fact that we are waiting for the second inquiry report—again, we are not quite sure when—at a time when we know that some of the recommendations to government in the first inquiry report are still not enacted. Some positives are the fact that the London Fire Brigade now reports that it has now met all the improvements required in the recommendations and recognised—this is a bit about culture—that this is an ongoing issue for it and that it needs to make sure that the changes that have been made are ongoing and that it keeps reviewing their effectiveness.

With regard to the Government's response to the other inquiry recommendations, for families to see that that is still an issue seven years on creates real mistrust. At a time when we are talking about an inquiry into an event that has devastated so many lives, the fact that we still have people whose lives are at risk as a result—I talked before about the situation for disabled residents—is a real betrayal of the families who looked to the inquiry. With the Manchester Arena and Covid inquiries, I understand that, with their interim reports, you can call people back to report publicly on what has happened. The frustration with the Grenfell inquiry is that that is not happening.

Q80 **Lord Aberdare:** We have heard lots of good ideas about ways of improving our implementation and monitoring system. I think Ms Norris was just getting to the point about how we might make that happen. The role of this committee is to look specifically at the implementation of the 2005 Act. Would it require legislative changes, or are there other options going part-way or for the short term that could move some of these things forward without having to change the law? I would like to come to Mr Comrie at the end, because he might have some experience of how they set up the implementation monitor system.

Emma Norris: You would ideally make one addition to the Act: to include a reporting duty on public bodies to set out their responses to recommendations, whether they plan to take them forward and, if not, why not. That would take us a long way forward and would be the basis for any monitoring body, whether it is a NOM, a Select Committee or otherwise. That information needs to be there in public, so I would add that statutory reporting duty into the Act.

Lord Aberdare: Whose duty would that be, given that the inquiry may have disappeared?

Emma Norris: I would place that duty on the public bodies in question.

Baroness Chakrabarti: For example, the Secretary of State who set up the inquiry.

Emma Norris: That change is quite important to ensure that you are surfacing the information you need to undertake the monitoring. When it comes to the role of Select Committees, that does not require any legislative change. We would like to see inquiry scrutiny added as an 11th core task to the role of Select Committees. That can be done relatively easily, as I am sure you know, via the Liaison Committee; there is no formal process for it. As you know, core tasks are not binding; they are intended to act as a guide for Select Committees' work. None the less, having this named as one of the core tasks of Select Committees would, I think, encourage them to take this role as seriously as possible.

There would also be something quite powerful about adding that core task this year. We know that, in the wake of a general election, there is likely to be a lot of turnover in the chairs and members of Select Committees, so adding that core task at this point would just help set expectations about the tasks of Select Committees.

So you could combine an addition to the Act with something a bit easier, which would not require legislative change, by adding an 11th core task to the role of Select Committees.

Lord Aberdare: Does Deborah Coles have anything to add on that? I am a little sceptical about the ease of persuading Select Committees to take on additional core tasks. You have already made the point about the difficulty of managing their workload.

Deborah Coles: Obviously, we feel the independent public body recommendation could be extremely effective, but that would probably need to be done through legislation. The Inquiries Act could be amended to give inquiry chairs the express power to hold evidence sessions on the implementation of their recommendations. Obviously, we saw that being done really effectively in Manchester, but, as I have already given you the example, the chair of the Grenfell inquiry said that he could not do that because he did not have the power to do so.

Baroness Chakrabarti: Sorry, could you develop that a bit more? Why did he think that he did not have the powers to do so?

Deborah Coles: Because of the Inquiries Act powers.

Baroness Chakrabarti: Was that because of his remit?

Deborah Coles: The inquiry powers did not give him the power to perform that role.

Lord Addington: Do you mean the powers for that individual inquiry?

Deborah Coles: Yes, the Grenfell inquiry.

Baroness Chakrabarti: What was the difference between Manchester

and Grenfell? Was it just a matter of the interpretation of the Inquiries Act?

Deborah Coles: It has to be an interpretation, because clearly it was done, and done very effectively, in Manchester.

Lord Aberdare: Was that quite informal? Was it driven by the chair?

Deborah Coles: It was very much driven by the chair, who I believe gave evidence to you.

Neil Comrie: On that question, in Victoria, the state parliament legislated for the creation of the bushfires royal commission Implementation Monitor and also provided for a reporting mechanism.

I will also make another small comment. There may be some concern about the resources involved. To undertake that work over four years, my team consisted of four people, one of whom was an office manager, so there need not be a particularly large contingent of people tasked with this role. I think it can be handled by a small team of people with appropriate expertise.

Q81 **Lord Addington:** My question follows on. How would any new model of implementation monitoring complement the existing Inquiries Act 2005?

Emma Norris: What you can take from the 2005 Act is that we consider public inquiries to be incredibly important mechanisms: we choose to invest in them a series of significant powers, including the ability to compel evidence and force witnesses and to impose legal sanction on those who refuse to comply. We choose to run public inquiries under the statute as the gold standard for inquiries into issues of real public concern. Given the kinds of powers and resource that the Act signals, it is entirely consistent to say that we must follow up on that investment by taking seriously the need to understand how government and public bodies intend to respond and ensure that those response are implemented. So I see a consistency between what the Act sets out and indicates about the importance that we apply to public inquiries, and the need for monitoring and implementation afterwards.

The point I made about introducing a duty for the lead department would give the information necessary to understand whether it intends to implement recommendations.

Lord Addington: In departments, not only do you have political change and personnel change, you even have the powers of departments changing. Someone may say, "No, that was the Department for Skills, but the Department for Skills does not exist anymore", since skills has been put in with something else. How would you try to get something which means that it has to follow into government? We have already talked about political will and the fact that people do not want to spend the money. Would you have a model for something that would follow the issue, as opposed to the department?

Emma Norris: That is where Deborah and INQUEST's proposal for a NOM becomes so important. As you say, if you went for a model where inquiries indicate on an ad hoc basis what they think implementation and monitoring should look like, or if you say that it should be the responsibility of the lead department to monitor whether recommendations are being implemented, the huge risk is that, as you say, there are enormous levels of political and official turnover in department and, add to that electoral change, there is an instability there that could compromise monitoring. That is where creating an independent body, which is not subject to that same level of churn and instability and could act as a form of institutional memory for inquiries, becomes even more important.

Q82 **Lord Aberdare:** This may be a silly question, but it seems to me that some of the problems arise from the fact that, as soon as the inquiry has submitted its report, the inquiry no longer exists. Could something be done about that to say that an inquiry should have some sort of continuing life or role or responsibility after it has submitted its report?

Lord Addington: Or some form of legal weight.

Deborah Coles: That is a problem across public inquiries, independent reviews and non-statutory inquiries. I noted that, in the Bichard inquiry, the inquiry chair said that they would have a session in six months' time to monitor progress, so they said at the conclusion of the inquiry that it would do that. I think the Zahid Mubarek inquiry, which is a long time ago now, had a small group in the Ministry of Justice that would keep on monitoring what had come out of the recommendations of that inquiry.

But your point is well made, and I think that is at the heart of the issue. The inquiry stops, and at that point it is left to whoever to see what happens. When one considers the public and human investment in these inquiries, it seems quite remarkable that we do not have something more developed than just having individuals who will take these things forward.

Lord Addington: So, effectively, you need something like the families and so on campaigning on behalf of the issue, which has driven the political weight and the continuing story forward to make these things bite. Often, that seems to have been more important than any official inquiry. The fact that you have something that brings it back to the political issue means that a political cost is extracted for not doing this. Would you agree that that keeps it in the attention and means that there is a price to be paid for not doing it? Do I exaggerate?

Emma Norris: I think that is exactly right.

Deborah Coles: So much of this is about political will, at the end of the day.

Q83 **The Chair:** We cannot just see these things as discrete; there must be that will to act upon the recommendations and give effect to them in a structured manner.

I have two final questions. You may feel that you have already answered the first one, in which case feel free to say so. What is the impact of recommendations not being monitored?

Deborah Coles: At worst, talking from an INQUEST perspective, similar deaths and similar harms and injustice will carry on. I mentioned earlier the psychological impact for people of seeing an inquiry set up because of something terrible happening and then seeing the fruits of that inquiry disappear into the ether or left on a shelf and it being left to individuals to keep this alive. As I said earlier, that is really damaging to trust and confidence, and it is a wasted opportunity, because these inquiries should be able to result in meaningful change, and proper transparency and accountability.

The Chair: It is about not just avoiding recurrence, but the psychological impact on victims and survivors.

Emma Norris: I completely agree. The only thing I would add is the potential for wasted resources. If inquiries do not need to change, have we spent those resources well? We talked earlier about how difficult it is to understand how effective inquiries are if you do not have adequate monitoring arrangements in place.

Q84 **Baroness Berridge:** On the psychological area, I want to take you right back to the beginning of the system. We heard from a representative of the Scottish contaminated blood inquiry on the effect on families and their ability to get an inquiry in the first place. There are proposals in the Victims and Prisoners Bill to have an advocate for victims of national disasters, but is there an obligation on certain statutory bodies to relieve the pressure on already traumatised people to get a public inquiry in the first place?

Deborah Coles: Families are incredibly aware of what they want answers to. Families and victims often have to campaign for years, and parliamentarians, in a way, have helped to generate the impetus to set up these inquiries. Not only do they often take a long time to get set up, but it takes a long time for families to see the results. The Post Office and contaminated blood are good examples.

We are currently involved in the Lampard inquiry into deaths in mental health settings in Essex. It was initially set up as an independent review, but because of a lack of candour and co-operation from Essex trust and the staff there, they converted it into a public inquiry. The terms of reference consultation, which was completed months ago, is still sitting on the Minister's desk awaiting agreement. Those families, many of whom we are working with, have become disillusioned with these processes because they have taken so long even to get off the ground.

You are right that there should be an earlier response, but often inquiries are set up because events before have failed. There has been a failure in inquests, and the Lampard inquiry is a good example of that.

The Chair: Presumably it takes a long time to get it set up, it is set up

and the recommendations happen, which reinforces your point about the impact on victims and survivors.

Baroness Chakrabarti: It is also about wider disillusionment in society.

Deborah Coles: The Post Office scandal is another good example of that.

Q85 **The Chair:** If you could make one recommendation for change to the Inquiries Act, what would it be? You may feel that you have already answered this, but let us see what your one change would be.

Emma Norris: I made the point that I would include a statutory duty so that people are required to set out what changes they are planning to make. If they are not planning to make changes, why not?

I want to come back to Lord Aberdare's point about whether it is realistic for Parliament and Select Committees to take on a new role, given that they are already overloaded, as I said. That is why I am suggesting that we limit their role to coming in only when something is going wrong. It is worth saying that, in these instances, Parliament will always be the scrutineer of last resort. If another body—for instance, a NOM—fails to see action, it is likely to pass that on to Parliament.

To emphasise the point that Deborah just made, public inquiries also have a kind of public element. In the cases that the inquiry looks at, people have often experienced real harm. It is right that Parliament acts on their behalf when it looks like action is not being taken where it was promised.

The Chair: On your point about Select Committees, another option would be to have a dedicated Select Committee dealing with inquiries.

Emma Norris: That is right. I have talked about this a lot with some of my colleagues and, personally, I would not go for a dedicated committee, just because of the sheer number of public inquiries that we have. It would be really difficult given the resource constraints. I think the Francis committee shows the value of having a focused, expert committee working on the area in question. Inquiries like Covid are clearly cross cutting and do not sit neatly with a single departmental Select Committee, but I would probably use a lead committee model there: you have one departmental committee in the lead that uses its guesting powers to invite members from other committees to take part in the scrutiny sessions to make sure that you are bringing in their expertise and interests.

Deborah Coles: I think I mentioned my one change to the Inquiries Act, and that is to give inquiry chairs the power to hold evidence sessions about the implementation of recommendations and follow-up.

The Chair: I thank our three witnesses, because this has been extremely valuable and addressed issues that came up in our earlier evidence-taking sessions, on how to follow up on inquiries and the impact and significance they may have. I thank our two witnesses who were here in

person and Mr Comrie, who joined us from Australia—particularly given the timing. We can let him get back to bed now. Thank you all very much indeed.