

Summary note of engagement event, 7 October 2025

On 7 October 2025, Committee members met informally with people with lived experience of public inquiries.

The event was a roundtable informal group discussion with participants who, among them, had experience of the blood contamination inquiry, the Scottish hospitals inquiry and the COVID inquiries.

This note summarises the discussions that took place. Key points included:

- The Committee heard that public inquiries are absolutely fundamental to Scottish society. The value of inquiries lies with their legal power to compel witnesses.
- However, there are vast differences in what they can achieve, depending on the manner in which they are run.
- Some participants noted that “it feels like there is an industry around public inquiries, there’s always another one coming”, and they take place at great personal cost. There is a perception of lack of accountability in the public sector.
- One participant noted that “we don’t have access to justice generally”, and they would have preferred a court process much earlier, but this was not possible because of the costs. Even though they had counsel who was willing to take the case pro bono, they were advised they would need several hundred thousand pounds to cover the Government’s costs if a judicial review did not find in the participant’s favour.
- Public inquiries are seen as the only viable route to change, when the government or organisation does not admit there is an issue. Some participants also noted that organisations involved may have an interest in an inquiry not taking place.
- It was noted that apart from cost-effectiveness, there is a balance to strike between thoroughness and speed. Thorough inquiries can reveal important lessons about what went wrong, however, victims may die in the meantime.
- The example of the Penrose inquiry into contaminated blood was discussed, in comparison with the equivalent UK inquiry. It was noted that the Penrose inquiry took two years to report, partly due to the Maxwellisation process and the high number of letters sent out. The inquiry, which was set up after 8 years of campaigning, and reported after another 8 years, “felt like a whitewash”, partly due to the tone set by the Chair at the start of the inquiry, when he stated that every penny spent on the inquiry was a penny not spent on NHS

treatment. The difference between the Scottish and UK inquiries came down to leadership.

- The Scottish Hospitals Inquiry is still ongoing, while issues with patient safety should be addressed today to prevent further disasters. Time is of the essence in this regard, and there is a degree of “kicking the can down the road” when it comes to public inquiries. The length of time inquiries take mean core participants are dying during the process – “we are here to stop it happening in the future and we failed”.
- It was highlighted that having representative groups for victims, such as in the case of the UK Covid inquiry, risks certain voices not being heard at the public inquiry, and essential questions not asked.
- Some participants noted that once campaigns for public inquiries started, they snowballed very quickly, and they found themselves facing “a sea of lawyers”.
- In the case of the Penrose inquiry, it was noted that the inquiry administration would not engage with campaigners. During the actual inquiry, participants did not feel like they mattered and the inquiry felt “hostile”. The opposite happened in the UK inquiry. Witnesses who were victims were able to impress upon the inquiry the sincerity of their experience.
- It was noted by some participants that inquiries can be adversarial, and this approach can make people act more defensively.
- Participants’ experience with and support from inquiries varied. Some felt they were almost handheld through it, and felt heard and supported by solicitors, who made efforts to meet with victims and their families and answer their questions. Others had only one initial meeting with the inquiry counsel, and were then faced with intimidating actions by inquiry counsel just prior to giving evidence, which left them shaken and unable to give the evidence they wanted to at the inquiry.
- Legal representation is essential and participants noted they would not have been able to go through the inquiry without that support.
- The involvement of civil servants was discussed. In the case of the Penrose inquiry, it was noted that when the inquiry was set up, there were still senior civil servants in the department of health who were party to what happened. The equivalent UK inquiry revealed correspondence between the First Minister and Health Minister at the time, with a civil service report stating that “the disaster was unavoidable”, in contrast with the UK inquiry report, which concluded that the disaster “could have largely, but not entirely, have been avoided, and it should have been”. A note from the then Health Minister’s office referred to the inquiry as a PR exercise. One of the recommendations of the UK inquiry was a review into the work of the civil service, and one participant noted that it would be incumbent on both governments to look seriously at that recommendation in terms of how the civil service acts in relation to these issues.

- It was noted that civil servants and other witnesses are being coached prior to giving evidence at inquiries, to deliver specific messages, and “it is very obvious when they give evidence what the messages are”. This does not create a situation of honesty or parity between participants, with victims not usually having any prior experience of public inquiries or other similar settings.
- There is no equality of funding between core participants – the legal representation of health boards, for example, is covered by a centralised, uncapped fund, while individual participants must apply for funding and do not have the expertise to prepare and develop questions that will bring up the truth – “it leaves us on the back foot every time”.
- Participants are more likely to come forward with good and valuable evidence if they feel valued and involved. Payment of expenses is part of that.
- In relation to the structure of inquiries, in the case of the Scottish contaminated blood inquiry, the Chair worked closely with a senior medical adviser. The equivalent UK inquiry set up panels of advisers.

Suggestions for improvement

- Three areas were highlighted as particularly important for public inquiries:
 - Good terms of reference
 - Good leadership
 - Good evidence and involvement of all core participants.
- Core participants should feel valued and involved in the inquiry. The atmosphere at the inquiry and a trauma-informed approach can support this – “put the victims front and centre in the venue (in front) rather than at the back behind lawyers”. There could be standard rules of practice around support provided at inquiry venues.
- The use of a panel of experts was generally regarded as positive and a better alternative than groups of lawyers having to get acquainted with very specialised information (for example, the requirements of hospital ventilation).
- Interim reports are helpful. In the case of the UK Infected Blood Inquiry, the interim reports, which set out useful facts and information, allowed people to receive compensation efficiently and effectively. Interim reports can be helpful to start to effect change and prevent further deaths.
- The Committee heard that, while it is still public money, there may be merit in setting up a centralised budget for public inquiries.
- Funding should be equal for all core participants, with limits on budgets for all sides.
- There should be restrictions on the coaching of witnesses.

- Some core participants felt that inquiries, particularly those of a more technical nature, could be expert led rather than judge led. This would shorten the time it takes to conclude them.
- While inquiries should be concluded more timely, that comes with limitations. There is a risk that narrowing the focus can lead to the right questions not being asked and lessons missed.
- A public inquiry should be the final option. The Committee heard there is a need for “other options first”, for organisations to be open and transparent, and, in some cases, there is a need for regulators.
- A Parliamentary Committee could be set up to oversee inquiries and their progress, similarly to the Public Administration and Constitutional Affairs Committee’s role in UK inquiries.
- Ultimately, recommendations must be implemented to prevent further disasters. The case of the Piper Alpha inquiry was highlighted, which prevented offshore accidents taking place since the implementation of its recommendations.