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Finance and Public Administration Committee

Tuesday 3 June 2025

Session 6

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Tuesday 3 June 2025

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FINANCE AND PUBLIC ADMINISTRATION COMMITTEE
19th Meeting 2025, Session 6

CONVENER

*Kenneth Gibson (Cunninghame North) (SNP)

DEPUTY CONVENER

*Michael Marra (North East Scotland) (Lab)

COMMITTEE MEMBERS

Ross Greer (West Scotland) (Green)
Craig Hoy (South Scotland) (Con)
*John Mason (Glasgow Shettleston) (Ind)
*Liz Smith (Mid Scotland and Fife) (Con)
*Michelle Thomson (Falkirk East) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rebecca McKee (Institute for Government)
Mary Morgan (NHS National Services Scotland)

CLERK TO THE COMMITTEE

Joanne McNaughton

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Finance and Public Administration Committee

Tuesday 3 June 2025

[The Convener opened the meeting in private at 09:30]

10:29

Meeting continued in public.

Scottish Public Inquiries (Cost-effectiveness)

The Convener (Kenneth Gibson): Good morning, and welcome to the 19th meeting in 2025 of the Finance and Public Administration Committee. We have received apologies from Craig Hoy and Ross Greer.

Under our public agenda item, we will take evidence on the cost-effectiveness of Scottish public inquiries. I welcome Rebecca McKee, a senior researcher from the Institute for Government, and Mary Morgan, the chief executive of NHS National Services Scotland.

We have received a written submission from Mary Morgan, but we have not received one from Rebecca McKee, so will you take a couple of minutes to talk through what the Institute for Government does in relation to public inquiries, Rebecca?

Rebecca McKee (Institute for Government): Thank you for inviting me. I will provide a bit of background information. In 2017, the Institute for Government published a report on public inquiries, but our thinking has moved on a bit since then. Since January, I have been doing some research on the subject with Emma Norris, who is our deputy director, because it feels as though the political context has shifted. Across the United Kingdom, 20 public inquiries are on-going, and inquiries are costing more, so more attention is, rightly, being focused on them.

We have been looking primarily at the UK Government, but lessons can be drawn across, given the way in which the Inquiries Act 2005 applies to public inquiries in Scotland. I will try to speak with that in mind as much as possible.

We have conducted numerous interviews and have held round-table meetings, one of which was held jointly with Inquest and Dr Emma Ireton, from whom the committee heard last week. We have also looked at other jurisdictions and carried out case studies. For example, we published one on New Zealand's public inquiry reform in 2013 to see what lessons can and cannot be drawn, and we have looked at the Dutch model, as the Dutch Safety Board ran the Dutch Covid inquiry and carries out lots of other types of inquiries and reviews.

Our researchers have looked into the framework of inquiries. We have been thinking about how we can get past the distraction of the issue of statutory versus non-statutory inquiries and reimagine the framework in order to get more quickly to the challenges that lie underneath. We have been looking at the decision-making process of, primarily, the UK Government, including how ministers are supported to make decisions when beginning a public inquiry and how chairs and teams are supported to set up an inquiry, given how important that process is at the beginning.

We have also looked at monitoring and implementation, which speaks to the cost-effectiveness issue that the committee is considering. Without there being any formal mechanisms for monitoring and implementation, we have been looking at the feasibility of the available options.

We hope to publish a public report in the coming months. We feel that a package of reforms is needed to address the questions of cost, time and effectiveness, so we are thinking through how all those reforms might work together.

The Convener: That is very helpful. You touched on the fact that 20 public inquires are on-going—in 1997, there were no more than five—and there are two new ones this year. Do Governments jump too quickly to a public inquiry in order to assuage public concerns and almost kick the issue into touch?

Rebecca McKee: There are multiple reasons why there is a lot of public and political pressure to hold a public inquiry, particularly a full judge-led statutory inquiry—that kind of language is very pervasive in the UK context.

One problem is the lack of guidance and instructions to support ministers to choose the right option. When there is an issue of public concern that ministers want to consider, a public inquiry can feel like the easy option, so there needs to be much better guidance on the suite of available options. Other countries are often better at providing such guidance. For example, the guidance in New Zealand sets out that ministers should consider whether an inquiry or a review is the most appropriate option for a particular topic, whereas, in the UK, the jump to a public inquiry happens a lot more quickly.

The Convener: You touched on whether an inquiry is statutory or non-statutory and whether it

is judge led. UK-wide figures over the past 30 years show that, in the past decade, 23 out of 24 public inquiries have been judge led, with the figure being 18 out of 23 in the previous decade and 20 out of 33 in the decade before that. Do you think that, unless a public inquiry is now judge led, it is not considered to be the gold standard that those who clamour for such inquiries demand?

Rebecca McKee: There is definitely a perception issue. Our research has not looked at the effectiveness of different types of chairs, for example—we might consider that in the future—but there is definitely a perception issue. A judge-led inquiry seems like the gold standard and the most forensic way of getting at what you might think you want to get at. There is no guidance and support at the beginning to allow ministers and officials to take a beat and think through who the right person for the role would be. Should it be a policy specialist? Should there be a panel of multidisciplinary experts? Should it be a judge? That might well be the right person.

It is quite interesting to consider not just who chairs the inquiry but who is involved in the process of writing the recommendations. A judge might be the right person to chair the inquiry, but who should be involved in testing and writing the recommendations?

Those are all issues to consider in relation to the potential jump to a judge-led inquiry.

The Convener: Mary Morgan, you have said that increased consistency in how inquiries are conducted would likely lead to better cost-effectiveness. If inquiries are judge led, they might be consistent but there will not be a positive impact on costs, because one of the concerns with judge-led inquiries is that they seem to take much longer in undertaking the evidential aspect of the inquiry and publishing their report. Do you share that concern, given the implications for the health service?

Mary Morgan (NHS National Services Scotland): What Rebecca McKee said was interesting, because we experience many of the things that she spoke about. In our submission, we touch on many of those subject matters, so it is really good to hear that those are being looked at from that perspective.

We speak from the position of experience, and we have experience only of judge-led inquiries, which, as we have highlighted, take quite a different approach. For example, we find that the terms of reference are very clear but an expected timeline is not set out and clarity on budget setting is not provided from the outset.

It is also very much up to the individual judge to decide who core participants are and how they are led into the inquiry. For example, in the on-going UK Covid inquiry, initially, NSS and Public Health Scotland were separate core participants and had separate legal teams, with separate associated costs. However, in more recent modules, we asked the inquiry judge whether we could share our legal team and legal counsel, even though we would remain separate core participants. That makes such inquiries a bit more cost-effective, but it is up to individual inquiries and inquiry teams to decide how those aspects are taken forward.

We also said that inquiries are long—

The Convener: I was going to come on to that issue next.

Mary Morgan: In my experience, inquiries are very long. In the UK and Scottish Covid inquiries, we are talking about things that happened five years ago, as I did when I was a witness at the UK Covid inquiry last Thursday, and there are still a number of modules to be undertaken in that inquiry. Likewise, in the Scottish hospitals inquiry, we are speaking about things that happened a long time ago, and the infected blood inquiry and the Penrose inquiry both looked at things that happened many, many years ago, so contributors might be very elderly or have deceased.

Inquiries can go on for a very long time, but we are not driving that—the inquiries are responding to members of the public who have been affected by the subject matters, so they take a very long time. Interim findings and reports are helpful, because at least that means that some recommendations can start to be dealt with without having to wait for the end of the inquiry, but there is no consistent approach in that regard, either.

The Convener: That is great—you have more or less answered the next two questions that I was going to ask. However, I will go back to the issue of timescales. You talked about work being undertaken in modules. Is it your view that, if different aspects of an inquiry can be looked at in parallel, as opposed to there being a two-dimensional process in which issues are considered one after the other, that can reduce the timeframe for an inquiry?

Mary Morgan: I am not sure that it can reduce the timeframe; it is about cutting up the chunks of evidence.

The Convener: Will that, in itself, not be helpful in reducing the timeframe?

Mary Morgan: It is helpful for us to be able to focus our resources on a particular subject matter. For example, a previous module in the UK Covid inquiry looked solely at procurement, which meant that we could define the specific resources that we required to answer questions in that module. Equally, my most recent evidence was on the test

and protect programme, so there were some boundaries, which meant that other people could be released to carry on doing their work.

If an inquiry is very broad, without well-defined modules, areas or topics that will be looked at in a particular order, we have to respond to the inquiry in a much broader way, which means that we, as witnesses, are less able to be helpful. After all, we are there to help inquiries to find the answers to the questions that are asked.

The Convener: That is helpful. I am just exploring different ways of carrying out inquiries timeously and, frankly, less expensively.

Your written submission states:

"NSS suggests that current processes for monitoring public inquiry costs are inadequate ... Costs are not reimbursed or reported consistently. There is no oversight of costs incurred."

Mary Morgan: We frequently receive freedom of information requests that ask how much we are spending on inquiries. The costs that are included in the documentation for the committee's inquiry relate to the costs that are incurred by inquiries—the costs of their structures rather than the costs that are incurred by individual public bodies, which can be difficult to ascertain.

Inquiry judges and inquiry teams have the opportunity to reimburse individual core participants or other participants for their costs associated with that public inquiry. However, public bodies are expected to consume the costs of participating in an inquiry, so we are not reimbursed for our costs—they come out of budgets for our baseline functions.

In relation to outline costs that NSS has incurred, we have set up a team to help us to respond to such inquiries. The costs of the direct team and our direct legal costs associated with two inquiries are laid out, but that does not include the costs that would be incurred by me in preparing a witness statement and travelling to London to give evidence, for example. Such costs can be quite considerable for a range of staff. The opportunity cost of prioritising inquiry work over and above day-to-day activities is also not included.

The Convener: That is what I was going to ask about next. What has been the opportunity cost for NSS of participating in public inquiries over the past decade or so?

Mary Morgan: That is measured in the impact on service delivery—that is really where it is. Our antimicrobial resistance healthcare associated infection team is involved in witness work for the Scottish hospitals inquiry, the UK Covid inquiry, the Scottish Covid inquiry and another one. I wrote to all the inquiry judges to ask them, in considering the timescales for questions and the witness requirements, to please be cognisant that the team has to deliver services at the same time.

The Convener: Is there any measurement of the impact on patients? Each inquiry is almost a bubble, and all the resources funnel towards it, but that clearly impacts on the rest of the work that your organisation has to do. What is the balance between the needs of an inquiry and the needs of the service?

Rebecca McKee: Setting up our dedicated inquiries team was really helpful, because it has organised the approach. We learned that from the Penrose inquiry and, in part, from the UK infected blood inquiry. We set up that team to maintain strong administration, to keep us right on the requests for statements that were coming through and to take away some of the work from front-line workers. Many of the staff who are required to give witness statements or attend as witnesses at inquiries are senior staff, and they have worked weekends and evenings to maintain their service while doing that.

10:45

We have not undertaken a formal measurement of the impact. We have supported people as best we can, employed additional staff where we can and found other ways to ensure that the legal requirements of inquiries can be met and the service can continue. That can be at a personal cost to the individuals who are doing that.

The Convener: Has the Institute for Government looked at the impact on service delivery when an inquiry is set up and soaks up a huge amount of money from a specific area, whether it is policing, the national health service or whatever?

Rebecca McKee: No, we have not looked at that yet, but, after listening to what Mary Morgan said, I think that that is a really interesting part of the puzzle. We have focused primarily on the actual inquiries and the relationship with Government.

The Convener: An inquiry is not done without an impact on other areas, which is an issue. If it is an NHS-based inquiry, the NHS is more or less expected to fund it from resources that would otherwise go into doctors, nurses, medicines and patients.

Rebecca McKee: Yes. That speaks to one of the other thematic issues, which is that, because public inquiries are ad hoc organisations, although some organisations such as NSS will have developed good methods of engaging with inquiries, for each new inquiry, that is a new relationship. Although an organisation can have its

structures internally, it will have to develop those for each new inquiry.

That goes back to one of the issues that we have been looking at, which is about how to do that lesson learning, knowledge sharing and even training so that, at the start of an inquiry, you say, "If you're going to engage with that public body, they have this team already," or, "This is what we learned previously."

The Convener: There will always be an impact on services, given the time involved and so on. Is there an argument for having a separate fund for public inquiries so that, when the Government announces a public inquiry, organisations can dip into a specific fund to try to mitigate some of the impacts on the NHS, justice services or whatever?

Rebecca McKee: There are questions about the funding of inquiries and of participants, but we have not looked at that yet, so I do not have an answer. However, in New Zealand, to drive down costs, they have pulled back on some of the funding and made it much harder to access so that people have to request more funding for core participant legal teams and things like that. I guess that there is a question about what is the right answer for the context. However, we have not looked at that.

The Convener: The NSS written submission states:

"clarity in the scope of inquiries' terms of reference and timelines at the outset is key to cost effectiveness."

Do you agree with NSS on that?

Rebecca McKee: Yes. There are several stages, but that setting-up phase, when there is a lot of political pressure to get going on an issue as quickly as possible, is where, from the people we have talked to in the round-table sessions and interviews, and in our research, we heard that time is not taken to think through the purpose and what the inquiry is trying to achieve, or what the correct model is. If the model of public inquiry is chosen, you then need to consider the exact scope. That can be, politically, a very difficult decision to make, but it has to be made then because, if it is not, the inquiry will be left to muddle through on its own.

The Convener: Can you think of any examples where the terms of reference were spot on and helped delivery of a tight inquiry? In contrast, can you think of inquiries where the terms of reference were woolly, which led to an unsatisfactory approach that ran off in different directions and stuff like that, rather than focusing on what the core purpose of the inquiry was meant to be?

Rebecca McKee: Off the top of my head, I cannot think of exactly two perfect examples of that, but, on the whole, in our round-table session, it was felt that, with most recent inquiries, the terms of reference were not desirable or as effective as they could have been. Sometimes, that is because they were developed quite quickly—sometimes even before a lot of the inquiry team members were on board—and that consultation process and conversation about what was achievable and desirable was not had early on. Off the top of my head, I cannot think of specific examples, but I can find some.

The Convener: Mary, do you have any examples of anything like that? Do you feel that inquiries should stick to the terms of reference that have been set? I understand that, on occasion, the terms of reference can change during an inquiry and can be widened or deepened.

Mary Morgan: I cannot, off the top of my head, think of an inquiry that has been widened or deepened.

The Convener: There have certainly been calls for that.

Mary Morgan: The question is: why is a public inquiry held in whatever form? Until I was asked to come here today, I did not realise that there are different opportunities for public inquiries, such as panel approaches and the sort of things that Rebecca McKee has spoken about. I just thought that a public inquiry meant a judge-led statutory public inquiry, and that was what we needed to do.

Inquiries are there to represent people and deliver answers—yes, for ministers but predominantly for the members of the public who have been affected—and to learn lessons. As with any investigation, even an organisational investigation, if things are found or discovered, or more answers need to be explored, there can be an agreement between ministers and the judge to change the terms of reference if they feel that something will be left unanswered.

I do not believe that we have paid particular attention to that, except in that the central legal office, which is part of our organisation, will have looked at any changes that were made. I think that there was one inquiry—possibly the Penrose inquiry—that had a change of judge, and the terms of reference were slightly changed at that point. When a new judge comes along, that provides an opportunity to consider what is possible at that time.

I think that there was a particular issue with the timeline for that. The inquiry had originally been expected to report within a timeline, and I understand that that was changed when the new judge came along. Although such changes are of concern for us because we might need to offer or to lead evidence, it is not within our remit to influence at that level.

The Convener: On the surface, public inquiries are pretty straightforward. They are about what happened, why it happened, who is to blame and how we prevent it from happening again—however, look where we are.

Mary, in your written submission, you state:

"Section 28 of the Fatal Accidents and Sudden Death etc (Scotland) Act 2016 introduced a requirement that those to whom FAI recommendations are directed at must provide a response to a FAI's Determination within 8 weeks. The response must set out what changes have been made or are proposed, or the reasons why no action is being taken."

You suggest that

"a similar requirement could be introduced in law requiring participants in public inquiries to report to Parliament with their written response to the inquiries' reports."

You say:

"this was a positive step which occurred in the UK Infected Blood Inquiry."

Can you talk us through your thinking on that a wee bit?

Mary Morgan: In the infected blood inquiry, there was a list of recommendations, but there was also a recommendation or requirement for a response to be given to the judge saying what had been done. Obviously, recommendations are made to Government, so the Government provides a response on what has actually been done. That closes the loop—it is as simple as that. When we are given a list of recommendations, how do we know that those recommendations have been taken forward unless the loop is closed and someone says, "This is how it's being dealt with"?

Some recommendations will take a long time and a lot of resources to implement. Some recommendations might already have been implemented in the course of the inquiry, because we cannot wait four, five, six or eight years to make changes to how we operate. That is why it is helpful to have interim reports. There has been an interim report from the Scottish hospitals inquiry, and the UK Covid inquiry produced a report on module 1, on pandemic preparedness. That means that, although the inquiries are on-going, mechanisms to effect change and to meet the recommendations can be under way.

That is an important part of closing the loop—it is that simple.

The Convener: Rebecca McKee, the number of inquiry recommendations has ranged from one to up to 290. Between 1990 and 2024, 54 inquiries made 3,175 recommendations. Mary Morgan made an interesting point about interim recommendations. What are your thoughts on that?

The Thirlwall inquiry, which is investigating the circumstances surrounding the actions of former nurse Lucy Letby, conducted a review of past inquiry recommendations on healthcare issues and found that many had not been acted on. Recommendations are made, the Government accepts them and then nothing seems to happen.

Rebecca McKee: There are two points there. One, which again speaks to the cost-effectiveness and the effectiveness of inquiries, is that we have examples of where we potentially would not have had repeated tragedies or disasters if recommendations had been taken up. The Thirlwall inquiry is one example. Another is that, if the recommendations from the Bristol royal infirmary inquiry in 2001 had been taken on, it is likely that the Mid Staffordshire inquiry might have been avoided. There are a few examples of that. We can perhaps go on to talk more about the implementation side.

On the number of recommendations and interim reports, I think that interim reports have been extremely helpful where they have been used. That again speaks to the importance of the flexibility of our inquiry system. Any reforms need to support that flexibility by allowing chairs to know their subject area and then decide that an interim report is extremely helpful, because they want to make early recommendations. A chair might want an inquiry to be open while people are working on implementing the recommendations—so that, for example, people can be called back in to ask them how that is progressing—rather than reporting at the end of the process, closing the inquiry and not having anything in place to monitor the implementation.

The Convener: Professor Cameron, who gave evidence to the committee two weeks ago, talked about the Jersey child abuse inquiry. He said that they went back two years after the inquiry had concluded to see what recommendations had or had not been implemented. In his experience, that is the only time that that has happened.

You will be pleased to know that this will be my last question before I open up the discussion to colleagues around the table. Do you feel that that should be de rigueur for public inquiries?

Mary Morgan: We have said that we think that that would be appropriate. I have said that closing the loop is important. Convener, you said that one thing that inquiries are there for is to find out who is to blame, but I think that that is an aside. Inquiries do not set out to find out who is to blame; they aim to find out about the lessons and so on.

The Convener: But that is what people who call for the inquiries are often seeking.

Mary Morgan: Absolutely, but inquiries do not have that power. They can criticise and so on, and

people might be looking for that but, as I understand it, inquiries are not necessarily there to blame.

The Convener: I was just trying to put it in blunt language. Often, when something has happened, folk think, "I want to know who did it and why they did it and make sure that it's not going to happen again."

Mary Morgan: Very often in a public inquiry, the outcomes are multifactorial—it is not about one individual, one organisation or one thing. Lots of things could have been done better or could be done better, right through inquiry findings.

It is really important that, when an inquiry is set up, it is set up with the end in mind. I do not mean that we should pre-empt inquiry findings; I mean that provision should be made on the understanding that the inquiry will come out with recommendations and those recommendations might need to be resourced with people, money, funding, technology or whatever.

We also need to bear in mind that the world will change during the period of the inquiry. While an inquiry looks back at something that happened five or six years ago, the world will move on. My experience is that inquiries do not always look at the contemporaneous world. For example, the Covid inquiry is asking about the length of time that it took to introduce testing platforms five years ago but, because of innovation and new information technology and so on, that process has moved on, so it will not be the same as it was five years ago.

We need a way of somehow taking that into account to ensure that, when recommendations are made, they are contemporaneous and concurrent and that they take cognisance of the world as we know it right now. We also need to have the end in mind when an inquiry is set out, so that we know that recommendations will come—the reason why we set up an inquiry is to learn lessons and make recommendations—and that resourcing and a mechanism to implement the recommendations that are taken into account.

11:00

The Convener: So, effectively, it is about decision-making processes as much as anything else.

Mary Morgan: Yes.

Rebecca McKee: Where we are getting to with our ideas and recommendations is that there are different options. The Telford inquiry is another example of an inquiry that went back 18 months or two years later and did a review. Also, Sir Brian Langstaff has kept the UK infected blood inquiry open. We have seen that chairs and inquiry teams have created opportunities to go back. You might have a highly motivated chair who can do different things, which is important.

Rather than say that inquiries must go back two years later and have a look, there should be a requirement for some kind of monitoring implementation to be in the final report or agreed before the inquiry ends. That could involve going back in 18 months or two years, or it could be the chair staying on for another few months to hold another hearing. It could be passing that over to an implementation monitor, which is the approach that has been used with some inquiries in Australia. There are options that are more suitable to different types of inquiries that deal with different types of public bodies or parts of Government.

The Convener: There should perhaps be an obligation on Parliament to look at that to ensure that the profile is not lost.

Rebecca McKee: Yes—there is definitely a role for Parliament. I am wary of suggesting that Parliament take on a monitoring role for every inquiry, given that there are 20 on-going inquiries and that they are very complex and on different topics, but there is absolutely a role for Parliament to be part of the monitoring, implementation and scrutiny process.

The Convener: Thank you. I will now open up the session to questions from other members. Liz Smith will be first, to be followed by John Mason.

Liz Smith (Mid Scotland and Fife) (Con): Before I ask my questions, it is important that I put on record that I am heavily involved with the Eljamel inquiry in Scotland.

Ms McKee, you gave a very interesting answer to the convener. You said that you feel that, when it comes to some public inquiries, the terms of reference are not always absolutely accurate, because they have to be dealt with very quickly. Can you give us some examples of where you feel that the terms of reference have maybe not been as accurate as they might have been?

Rebecca McKee: I will give the same response that I gave to the convener. I will need to triple-check my references before I put on the record the name of any inquiry, but, yes, I can do that.

Liz Smith: That would be helpful, because one of the issues—it is a genuine issue—in the Eljamel inquiry relates to constitutional differences. What would happen under the legislation in Scotland is different from what would happen under the Inquiries Act 2005, meaning that the terms of reference of a Scottish public inquiry would not necessarily tie up with the terms of reference of a UK inquiry. However, if evidence emerges that UK bodies were involved in some aspects of the

Scottish situation and, therefore, by definition, should be investigated, ensuring that the UK and the Scottish inquiries are aligned will become a very important matter. I think that that has happened with the Covid inquiry, and it has certainly happened with the infected blood scandal inquiry. Do you have a view as to how a Scotland body would be able to have a really good, strong working relationship with the UK body in respect of the terms of reference?

Rebecca McKee: That is not an area that we have been looking at, I am afraid, but it is a very interesting question.

Liz Smith: Do you think that it is important that they have such a relationship? There are bodies across the UK that will have an impact on what might happen in any part of the UK. Therefore, if different legislation governs the public inquiries in different jurisdictions, surely it is important that there is co-ordination with the UK body.

Rebecca McKee: Yes, co-ordination, transparency and decision making are important in this area. If there is an aspect in which those elements need to be aligned, it would seem that open communication and co-ordination would be important.

Liz Smith: Would a circumstance in which you could foresee a possible change to the terms of reference, such as their expansion, be information coming to light from a different part of the jurisdiction that was being investigated?

Rebecca McKee: Yes. Again, I note that, in looking at that exact mechanism, we are going slightly beyond my expertise, but that would sound right to me. That comes back to when you are setting up an inquiry. If there is a better process for that early decision making in which a minister can more transparently get across the justification and the narrative for the inquiry and exactly what it is meant to do, it is easier to make a case for changing the terms of reference later on, as and when new information comes to light, because that process is clearer.

Liz Smith: Is the better process that you have mentioned simply about transparency, or does something else have to happen?

Rebecca McKee: No, it is about having bolstered support. From what we have seen, the Cabinet Office holds such a role, but, from reading the Scottish Parliament information centre briefing, I do not think that an equivalent function exists in the Scottish Government. The Cabinet Office set up a dedicated team a few years ago, but it is underfunded and underresourced for the rather big job of supporting ministers in that early decision making, and sometimes it can be bypassed in the decision-making process.

We looked at New Zealand, which has overhauled its system. The Department of Internal Affairs has played a very important role in supporting decision making. It has knowledge of past inquiries and can pull all that information together and then point ministers to and show them the range of options that are available. The department also helps with the drafting of instructions for terms of reference, for example.

Liz Smith: Last week, one witness suggested doing exactly that, as she felt that someone who was starting out on a public inquiry would gain from the considerable experience that exists as a result of other public inquiries that have taken place. I understand that that work could be done by the Cabinet Office. Is that correct?

Rebecca McKee: Yes, it is currently done by the Cabinet Office. There is an argument about whether that role should go to the Ministry of Justice and then link in with some of the other things that are going on there, depending on the exact role to be carried out.

Liz Smith: Might there be some scope for cost reduction in following that approach?

Rebecca McKee: Yes. Having better decision making up front will have a knock-on effect on the rest of the inquiry. The other thing that the New Zealand Department of Internal Affairs does is that it acts as a corporate host, which I think is a really interesting model. It assists with some of the early set-up stuff, such as getting rooms together—it uses Government buildings for some things, which is something to think about—setting up inquiry websites and also getting together the secretariat teams and supporting them. I think that it was Lord Hardie who, in the session last week, talked about how long that process can take. That is something that we hear time and time again. Judges or whoever is leading the inquiry teams often find that difficult to do, even if they have worked on inquiries before, as that is not what that they are trained to do.

Another related example is data sharing. Setting up inquiries involves doing many technical things. Therefore, I feel that having in-house expertise that does not cross the line of independence of what the inquiry is doing but is there to support setting up the process would, by removing some of that time sink at the beginning, give space to consider other aspects, such as knowledge sharing, learning lessons and looking at more innovative methods for the inquiry to use in its processes.

Liz Smith: Thank you. That is very helpful. Mary Morgan, what is the reason for the growth in the number of public inquiries?

Mary Morgan: I have absolutely no idea. Clearly, things go wrong, and ministers, and the

public, want that to be examined. Some of the inquiries feel duplicative to us. We had the Penrose inquiry and now we have the UK infected blood inquiry. We have the UK Covid inquiry and the Scottish Covid inquiry. Some of that is a timing issue—it is not by anybody's design that that has happened.

I cannot answer that question, because I really do not know.

Liz Smith: Would you agree with one of our previous witnesses who suggested that perhaps one of the reasons for the growth in public inquiries is the perception that Government agencies have been failing to address specific questions, leading to frustration among victims or people who are demanding a public inquiry that their questions are not being answered in channels in which they should have been answered? I think that we can all name public inquiries that are examples of that. Is that a serious problem?

Mary Morgan: I have not looked at the issue, but my personal experience—and, I think, that of the organisation, is that any public inquiry is much bigger and much greater than individuals or individual groups not getting answers through other means such as fatal accident inquiries and whistleblowing. It seems much bigger than that, and there are much broader findings. The whole country was affected by Covid. No one escaped it, and some were affected more than others. There are lessons that need to be learned, irrespective of whether the public inquiry route or one of the other mechanisms would be appropriate for considering that.

Liz Smith: I am asking that question because it is very important to establish exactly why there has been a growth in the number of public inquiries, because that has a cost implication. However, if it is the case—I am not saying that it is—that one reason for their increase is that complaints have not been dealt with in the forum in which they should have been, we need to take that very seriously. If were are talking about an issue that should have been dealt with by a health board or whoever, it might not have gone to a public inquiry.

Mary Morgan: That might not be the case. It might be the case that the complaint has been dealt with appropriately and that actions have been taken but those affected have been dissatisfied with the outcomes and continue to seek more in that regard.

Liz Smith: Okay. Thank you.

The Convener: Good point.

John Mason (Glasgow Shettleston) (Ind): Some of the suggestions that you and other witnesses have made, such as sharing lawyers and setting up the rooms more rapidly, might save a little bit here and there, but I do not see how that would make a radical change to the cost of, and the time involved in, an inquiry. I have suggested to other witnesses that we might be able to look at it the other way round. We could tell people that they have three years and £5 million to do an inquiry and that they should just do the very best that they can within that framework. Would that be a major disadvantage, as compared with the open-ended approach that we seem to have? I put that to Ms McKee.

Rebecca McKee: The question of budgets and timelines is interesting. They do that in New Zealand. They have a budget and a timeline, and those are decided early on in conjunction with the different bodies that are involved in the set-up. When I have been testing that recommendation in the UK context, there has been a lot more pushback, some of which I think is valid. Some of the delays are to do with Government or other bodies that are involved in the inquiry not being ready and not having their papers and documentation in order. Sometimes that has caused big delays, which then creates a very uncomfortable situation when it comes to negotiating with Government on extending timescales, as it might have been the Government that has caused some of the delays. That was one of the examples that was given to me, and it can add several months to the length of an inquiry.

Let us say that timelines and budgets are set at the top but we are unsure whether the rest of the system will be able to meet those. If we fail to meet those aspects, that becomes a massive issue of public trust, which is already a massive issue for public inquiries in this country. Instead of that approach, we have been looking at the case for putting in place a new framework, which would require changes to the Inquiries Act 2005. Similar to the New Zealand model—it has made a compelling case for its reforms—you would have only statutory inquiries. That would get you past any debate about the distinction between statutory and non-statutory inquiries and what is and is not the gold standard. Everyone would have the same powers, but they would not need to use them.

11:15

The New Zealand model comprises royal commissions, public inquiries and Government inquiries. Although they have the same powers, they are explicitly designed as slightly different models in order to deal with topics of different levels of severity, so the costs and the timelines are significantly different. For example, New Zealand has held 10 Government inquiries. On average, those take 10 months and cost 3.5

million New Zealand dollars, and they were on subjects such Special Air Service operations in Afghanistan and drinking water contamination.

New Zealand has had one public inquiry, which is the next step up, on the performance of the then Earthquake Commission. The inquiry took 18 months and cost 3.9 million New Zealand dollars.

Royal commissions are reserved for the issues of highest severity, such as the Covid-19 inquiry. An inquiry into historical abuse in care was an outlier because it took a long time but, on average, those inquiries take 20 months and cost 16 million New Zealand dollars. Those costs are quite a lot less than those of some of our inquiries, but there are other reasons for that.

We feel that it is about having a suite of options. Setting timelines and budgets is one thing—although I think that there could be problems there. When ministers are setting up an inquiry, they should have a suite of options that are designed to do slightly different things, so that the narrative and justification have been set and they are supported in making their decision. In that way, it would not look as though they were opting for a non-statutory inquiry that would not have the powers or the teeth. That would enable a more compelling case to be made.

John Mason: Am I right in thinking that some of that would require new legislation, because the Inquiries Act 2005 is what lies behind most of this?

Rebecca McKee: Yes.

John Mason: Do you know whether the Scottish Parliament has the power to change the 2005 act?

Rebecca McKee: I believe—if I am correct—that the 2005 act was adopted under the Inquiries (Scotland) Rules 2007. I am not sure about the interrelationship between those two or whether the Scottish Parliament has the power to change the 2005 act.

John Mason: I can follow that up elsewhere.

Rebecca McKee: Without going as far as changing the 2005 act, there are other ways in which a suite of options could be set out. For example, the "Cabinet Manual" of the Cabinet Office in New Zealand is very detailed in setting out exactly what all the options do, whereas "The Cabinet Manual" that is produced by the UK Government's Cabinet Office is not very detailed in setting out the options. Rather than changing the 2005 act, one option would simply to be more explicit about what the different types of model can do, and when they have been used or could be used in the future.

John Mason: Yes, because it seems that, sometimes, public pressure builds up and the minister eventually gives way and accepts the need for a public inquiry.

You have already been asked about the issue of terms of reference, so I will not go back over that, but I was interested to read this week that the families of the Chinook helicopter disaster would like there to be a public inquiry so that they can get hold of files. However, they simply want to get hold of those files, so I do not know that a public inquiry is needed. Is that a bit of an outlier? Is it the case that people call for a public inquiry when they want something else?

Rebecca McKee: That is part of the wider question about how we address state failure. The duty of candour legislation, which my colleagues are looking at, sits in the same area. If we can get that kind of stuff to work early on, that helps. The case that you mentioned is potentially an outlier in that it is about getting access to archived records that the Government has said that it cannot release. Therefore, the families see a statutory inquiry, with the powers that that holds, as being the mechanism that is available to them to that end.

John Mason: Although a military secret would, I presume, still not be revealed under a public inquiry, would it?

Rebecca McKee: That is right. The policing inquiry and some other inquiries have run into that problem of what can and cannot be disclosed.

John Mason: Ms Morgan, given what you have said, do you think that the public have become less tolerant over the decades? Is it the case that, whereas, in the past, we just accepted that a mistake had been made, nowadays, there is more of a desire to blame somebody, to get revenge or to dig into things more?

Mary Morgan: I think that people are generally much better informed about what they should and can expect. They are, quite rightly, more demanding of the public service and the services that they receive from people. They are more demanding and perhaps more aware of what the right thing to do is and what their rights are, and they are much better organised.

John Mason: That is fair.

One of the things that the 2005 act says—in section 17, I think—is that the judge or whoever is leading the inquiry must avoid "unnecessary cost".

I will start with Ms Morgan this time. You have been involved in a few inquiries. Do you have a view on that issue? Do you think that public inquiries are avoiding unnecessary costs, or do you think that unnecessary costs are being incurred?

Mary Morgan: I have nothing to measure them against other than the costs that are in the committee's papers, which seem like an awful lot of money.

It is very difficult, because there are two—or even three—sets of costs. There are the costs of the inquiry that are visible, that are reported against and that can be accounted for in Parliament. There are the costs that are incurred by organisations and core participants that are not included in the inquiry costs. Those costs are declared in organisations' accounts, such as the accounts of NHS National Services Scotland. There are also the costs that relate to individual departmental budgets as departments release staff and so on, which are difficult to identify. As has been said, there is a lack consistency in relation to which costs inquiries will and will not reimburse in that space.

The people who lead public inquiries might well be asked to keep costs as low as possible, but they do not have a budget line to measure that against. Their job is to complete the inquiry in a highly competent way, and they will do what it takes to make that happen.

John Mason: Whereas in the NHS, for example, a surgeon simply has to work with the equipment and the staff that are available to them.

Mary Morgan: We would bid for more, but we have a budget for X, Y and Z, and we make choices about whether to spend a bit more here or there in order to do that.

John Mason: I would like to ask you about the figures that you quoted in your submission. You said that it has cost NSS £3.1 million to respond various inquiries since 2021-22. Later in your submission, you mentioned a figure of £9 million for legal services. Is the £9 million the amount that you were refunded and the £3 million the amount that you were not refunded? Could you explain that?

Mary Morgan: I think that the £3.1 million is for the two inquiries that we mentioned. Those are direct costs for NSS, which come out of the NSS budget. That includes the costs of my core team. As well as providing support for the Covid inquiry, I am supporting the board in relation to the Eljamel inquiry. That represents good knowledge management and good sharing of resources. The £3.1 million figure reflects our legal costs and our counsel costs for those two inquiries.

The £9 million cost is the cost of the services that the central legal office has provided to other NHS boards and other core participants in inquiries. That is the cost of supporting territorial health boards with the infected blood inquiry and the cost of supporting NHS Lothian and NHS Greater Glasgow and Clyde in the Scottish hospitals inquiry, for example.

The £3.1 million is the cost to NSS alone. I assume that each of the territorial boards or other boards that are core participants will have their own teams and their own ways of dealing with the inquiries, but that £9 million is the cost that has been attributed to the CLO and counsel.

John Mason: How much of that has come back from the inquiries?

Mary Morgan: None.

John Mason: None of it—so that £12 million has come entirely from the NHS budget.

Mary Morgan: Yes.

John Mason: Ms McKee, does anyone check on the extent to which the section 17 provision, on avoiding unnecessary costs, has been adhered to?

Rebecca McKee: Not that I am aware of, but I know, from having spoken to various chairs and secretaries, that they are very mindful of it. It is interesting that, although there is a requirement to be mindful of the costs, there is no requirement—and I am not sure that there necessarily should be—to think about newer, innovative ways of cost cutting. That comes back to the fact that there is not a broader research hub that can draw lessons from different inquiries.

For example, some people from a law firm to whom we spoke mentioned the fact that, in most of their other activities, they regularly use artificial intelligence tools to help with disclosure and so on, alongside paralegals, but when they do the same work for an inquiry, they do not use those tools. That is often because there is pressure to get an inquiry going quickly, which means that people do not think through how the process should be designed. There are no embedded ways of working and processes that can be brought from one inquiry to another, because there is no centralised resource that would enable people to think, "How can we do this more quickly? That worked well there, but it didn't work well there." That simply does not exist in an ad hoc inquiry.

As well as looking at section 17 of the 2005 act, those who are involved in inquiries need to look at other methods and ways of bringing down the costs, the timescales and the work involved.

John Mason: Do you think that that is happening within the UK Government?

Rebecca McKee: Not to the extent that it needs to. The team in the Cabinet Office is brilliant, but it is underresourced and underfunded to do that work in addition to dealing with all the inquiries that are currently going on.

John Mason: On the Covid inquiries, it strikes me that we all lived through Covid and we all know roughly what happened. They are spending a lot of time going over things, in both Scotland and the UK, that we all know about already. I wonder how much we are gaining from that. Is there a saving to be made given that, if a lot of information is in the public domain, we do not have to go through it all again?

Rebecca McKee: It is about the purpose and aim of an inquiry. Last week, your witness Dr Emma Ireton talked eloquently about the different purposes of inquiries. Often, inquiries now try to do all of it—the lesson learning, the correcting of the record, the finding of blame and the justice catharsis part of it. The Covid inquiries are examples of inquiries that are trying to do all those things, so they will inevitably be protracted and expensive. The UK Covid inquiry also ran a public engagement process.

It really comes down to being clear about the purpose and the aims. Otherwise, inevitably—

John Mason: That goes back to the terms of reference that are set at the beginning, does it not?

Rebecca McKee: Yes. It is about the decision-making process, being supported to make politically difficult decisions early on, justifying exactly what the purpose of the inquiry is, and being honest and transparent with the public about what it will and will not look at and achieve.

John Mason: Okay. Ms Morgan, I take it that you have been involved in both Covid inquiries. Do you feel that a lot of new stuff is coming to light or are they just going over things that we all knew about already?

Mary Morgan: There is a deeper level of—I was going to say "interrogation", but that would be the wrong word—questioning and asking, and the joining up that is being explored at the moment is bound to be valuable. The module 1 findings and recommendations on preparedness are already being taken up and thought is being applied to what we could do better in the future. It is not really for me to say whether that depth is right or wrong, but the inquiries seem to be doing a thorough job and the teams are keen to get answers given their terms of reference.

John Mason: Okay. Thank you.

Michelle Thomson (Falkirk East) (SNP): Good morning, and thank you for joining us. We have talked a lot about costs and governance. My first question is for you, Mary, given that you have been involved in a multitude of things across the NHS in your role. Are you involved in any pieces of work that do not have any governance or properly monitor costs in the way that you have set out?

Mary Morgan: Our costs are very closely monitored. Following the year end, we are closing last year. Costs are a big thing.

I work in health. There may be other areas that are not at the same level, but I suspect not.

Michelle Thomson: Okay. My next question is for Rebecca McKee. Picking up on a point that my colleague John Mason focused on, I note that we have all said that we must be mindful of the cost. Where, if anywhere, is real pressure coming from to move it beyond being mindful of the cost? Is there any pressure? The House of Lords committee is looking at it, but I am thinking about what happens internally within Government.

Rebecca McKee: There is definitely pressure, especially on timelines. The problem is that, when an inquiry is on-going, its independence is sometimes quite a difficult thing to manage. I am not aware that there is a budgeting oversight mechanism for all inquiries. A centralised, corporate host model could provide support for budgeting while maintaining the independence of inquiries.

Michelle Thomson: Do you agree that no other public sector project would incur expenditure of, potentially, £30 million with no governance whatsoever and no stage gating around costs?

Rebecca McKee: Yes.

11:30

Michelle Thomson: I am interested in the culture. Mary Morgan, it was interesting that you said that, until you were preparing for this evidence session, you had not realised that there could be other, different types of inquiries. You thought that they were all judge led and statutory.

Rebecca McKee, from your perspective, how did we get here? It is as if everybody is a winner when people and politicians demand an inquiry—lawyers are happy because they make a lot of money, and the Government is happy because it has made the issue go away. However, it is a long time until we know whether the people who were greatly affected by the issue at hand are happy—that could be years down the line. Culturally, how on earth did we get to the point that we are at today, based on your work and the research you have been doing?

Rebecca McKee: One of the important cultural aspects is the way that public inquiries have become incredibly legalistic in their culture. They have become a lot more like courtrooms, and that has bled into non-statutory inquiries as well. They are often seen as a shorter, sharper method. We

often look at the high-level, forensic inquiries such as the Covid inquiries as a comparator, but the same legal firms work on both types and they have started to dictate that culture. I went to see the Covid inquiry as an observer the other day and I was surprised, not having viewed such an inquiry in person before, just how legalistic the process is and how forensic the questioning of witnesses is, which adds to it.

That has happened over time as legal firms have been involved. We have had multiple inquiries close together, with several inquiries a year, and learning has developed on how an inquiry should be run. The legal firms have developed amazing expertise in the area and they have big teams. That means that they can come in and help to get things going from the beginning, which sets the tone. However, in some areas, inquiries do not need to be run in that way whereby things become adversarial rather than inquisitorial. There is flexibility in the 2005 act to run inquiries differently.

Where there is learned behaviour, a need to set things up quickly and all the other things that I mentioned, we develop a legalistic culture that adds to the time and cost. A report that the National Audit Office published a few years ago said that about 36 per cent of the cost of an inquiry relates to legal staff. That seems to be a big part of this.

Michelle Thomson: We can see how that would work for the law firms that are involved as part of the prevailing culture of how we do inquiries. Because they are done in that way, the law firms that are most likely to get the work are—guess what?—the ones that can claim previous experience, so it becomes self-perpetuating. Is that correct?

Rebecca McKee: Yes. A lot of legal firms have built up large teams of people who work on inquiries and they are involved in all the different aspects of it. They are there as the main legal counsel for the inquiry and as core participants. The way that inquiries now tend to be run is that people are asked to submit their own statements, which they want to have legal backing for and checks on, so lawyers are involved in a huge part of the process. As you said, they have developed expertise in how inquiries are run. They are very effective if that is the model that we want to have, but it is not always the most appropriate or effective model for every type of inquiry.

Michelle Thomson: We are aware that other bodies have looked at the running of inquiries. I mentioned the House of Lords earlier, but you mostly face into the Cabinet Office, as you said. From your perspective, is there an appetite on the part of the UK Government to look properly at this? Clearly, things are now completely out of hand. Is there an appetite to look to change it? That would potentially involve annoying some law firms that are on this pretty lucrative path.

Rebecca McKee: There is definitely an appetite. As you said, we are at a point where things are out of hand, given the costs, the number of inquiries and the way that public trust is going. The UK Government can see that a couple of very big inquiries have reported recently or will report soon and, if those recommendations are not implemented, it will become a big problem. As I mentioned, the duty of candour also ties into this. A look is definitely being taken at the wider state failure question and how we can address it.

Michelle Thomson: Thank you.

Michael Marra (North East Scotland) (Lab): I will start by putting on the record my involvement with the Eljamel inquiry, which involves representing constituents.

Mary Morgan, I have a brief question that relates to the issue that my colleague John Mason raised regarding the £9 million of legal services provided to NHS Scotland boards. Do you bill those boards for the services that you provide?

Mary Morgan: Yes. There is fee recovery. The central legal office operates like a private firm but within the NHS, and it has particular expertise to support the boards. The staff are all employed by us, but we recover the costs from boards, including mine. It bills me, even though it is part of my board.

Michael Marra: What services does it provide?

Mary Morgan: It provides a full range of legal services. There is an employment team; a litigation team, which also covers public inquiries, interestingly enough; a property team; and a contracts team.

Michael Marra: Last week, we heard evidence from a member of the Faculty of Advocates who said that he is representing a group of NHS boards in a couple of on-going public inquiries, including the Covid inquiry. The £9 million figure does not represent the entirety of the budgetary impact for the NHS boards that are involved in inquiries. They draw certain services from you, but they engage other services externally as well. Is that correct?

Mary Morgan: They will take legal advice and they will have solicitors to the inquiry in the same way that I have my solicitor for whatever inquiry is being dealt with. The CLO, on their behalf, will source senior and junior counsel for inquiry work and they will have their advocates sitting in the inquiry to liaise with the counsel to the inquiry.

In the infected blood inquiry, NSS was a core participant separately from the territorial health

boards, which were represented as a group that formed a single core participant. They had different legal teams and different counsel from us. More recently, in the Covid inquiry, we have had shared counsel.

In the Eljamel inquiry, it is predominantly NHS Tayside that was impacted. It will have its own lawyer, which we will provide from the CLO, and we will charge it. We will also find it senior and junior counsel, or maybe one counsel if that is what is required. We will pay the counsel and charge the board for that. It also happens that my head of inquiries and scrutiny and some of our programme support will support NHS Tayside in setting up the administration and so on, and there will be additional costs associated with that.

Michael Marra: That is very useful. Do you have any understanding of the global figure for the impact of legal costs across all the territorial boards?

Mary Morgan: Absolutely none—sorry.

Michael Marra: That is fine. Thank you.

The Convener: Since 2007, there have been 10 public inquiries in Scotland, five of which are on-going. We have been given an update on the costs so far: up to £240 million at today's prices. The Scottish Parliament information centre produced a table of costs. As Rebecca McKee pointed out, 36 per cent of the costs go on legal fees, but more than 10 per cent go on consultancy fees. Who are these consultants? What do they do for public inquiries that has cost the Scottish taxpayer £25 million and the UK taxpayer no doubt considerably more?

Rebecca McKee: I am afraid that we have not looked at that area.

The Convener: I am just wondering what a consultant would do and where they would step in, given that there are already lawyers and this, that and the other.

Rebecca McKee: I have not looked at that area, but I imagine that some of the costs might be on IT consultants and that kind of thing.

The Convener: Those costs are included in other areas of funding.

Rebecca McKee: That is interesting. I am not sure.

The Convener: Mary Morgan, do you have any idea, given that you have been involved in inquiries?

Mary Morgan: No—not at that level. I do not know, but the costs might be to do with sourcing and fixing venues and those kinds of things. We would perhaps use property consultants, for example, if we were trying to find a building somewhere.

The Convener: I would have thought that £25 million would be a lot of money just to check out some venues.

Mary Morgan: Yes. Inquiries tend to have specialist fit-outs and so on, so the costs might relate to that. I do not know, but I can imagine lots of things.

The Convener: I am in the wrong business.

Among the on-going inquiries, we have not touched much on the Scottish child abuse inquiry, which began in December 2014 and, up to March this year, had cost £95.3 million. It is important that people have their say, but, when an inquiry looks at issues going back decades, many people who were involved will die during the course of the inquiry, so they will never see justice done at any level. Surely a balance needs to be struck. None of us is immortal, so, if an inquiry lasts years and years, a lot of people will simply not live to see the report coming out, never mind the recommendations being effectively implemented.

This follows on from what John Mason was saying. The Australian Covid inquiry cost £4 million and took 13 months. The UK inquiry has already cost £200 million, and the Scottish one has cost nearly £39 million. Is it likely that those inquiries will deliver more justice than the Australian one did? Where should the balance be struck?

Rebecca McKee: The balance depends on each inquiry and its purpose. Each inquiry will have a different set of interrelating purposes.

As I have said, it seems as though our Covid inquiries are trying to do everything, because the political situation was very different. Compared with Australia, we had quite a different experience with Covid, so we probably have quite a lot more lessons to learn about how things happened in order to help with future pandemic preparedness. In the UK Covid inquiry, that is all being tied up with a specific programme of public engagement and catharsis, and there is also the issue of addressing the historical record. As Mary Morgan said, by the end, there will be an incredible number of interrelated records of exactly what happened.

The Convener: Yes, but if a 10,000-page report or whatever is produced at the end, who will read it? Denmark and Sweden produced Covid reports years ago. Ultimately, we can get to the stage at which there are diseconomies of scale. We might end up with something so monumental that no one can grasp it. Are we in danger of doing that with the Covid inquiries and perhaps with the Scottish child abuse inquiry?

Rebecca McKee: There is definitely a danger of that. Again, it comes down to what we are trying to achieve. There are different models for doing different things, and there are different ways of learning lessons. Very long—and, by default, very expensive—inquiries do not immediately get to the lessons that should be learned. There are different approaches—for example, interim reports can be produced. The Dutch Safety Board, which carried out the Dutch Covid inquiry, ran three separate inquiries on very specific things in quite a short time. Addressing recommendations to specific bodies is another approach in order to get things going as soon as possible.

The Convener: Given how cumbersome inquiries are in Scotland and in the rest of the UK, relative to other areas, what can we do differently to ensure that the people who clamour for inquiries get the justice that they need and deserve but that that does not take five, 10 or 15 years or have an impact on public services? For example, some NHS services have to be forgone in order to fund aspects of inquiries.

11:45

Rebecca McKee: It will depend on the topic of the inquiry and whether there have been issues with, for example, the disclosure of records or the Government not having been truthful about things in the past, as happened in relation to Northern Ireland and the Chinook crash that we mentioned.

We need to be clear about what an inquiry is for. If we want to learn lessons because a new pandemic might be on the horizon, for example, we should chose a different model that is much faster, much sharper and much more focused on learning lessons. Some of the other things that inquiries try to do could be done through other methods, but that will depend on the topic.

We need to be clear up front on what the mechanism of an inquiry is for, and that political decision should be made early on, as other places have been able to do. The Covid topic varies from country to country, based on how the country was impacted and the number of lessons that need to be learned, but the approach that I have set out applies to other public inquiries. Having those difficult discussions and decision-making processes early on helps to set the boundaries much better.

The Convener: Mary Morgan, where should the balance be struck?

Mary Morgan: I do not know. Given that inquiries take a very long time, we recommend that there should be interim findings. We are there to respond to and answer questions as they are asked and to provide witness statements in accordance with what is required of us, so we do not have a view on that question, but it would be good to get interim findings.

We have spoken a lot about people who have been affected by issues that have led to public inquiries, and we have spoken about the finding of blame and failure. I do not think that public inquiries involve much appreciative inquiry; there are real negative connotations to them. A couple of better aspects could come out of inquiries, such as examples of good practice or good experiences that have been identified.

Inquiries also give people like me in our health service and other public services the opportunity to tell their stories, which might be important for their own learning. We derive a lot of learning from preparing and pulling together evidence. For example, we ask ourselves, “Why do we do that? Could we accelerate guidance or preparation?”

I do not know what the right balance is, but what we and Rebecca McKee have highlighted in relation to the choice of inquiry and setting out the terms of reference quickly is what will bring balance.

The Convener: It is important that people have an opportunity to say their piece, but, if that ends up getting lost in a 10,000-page report, how significant will that be in having an impact on what happens next?

I have a final question for Rebecca McKee. Two weeks ago, we asked Professor Cameron about the motivation for legal teams to deliver more timeously during inquiries—I will put it diplomatically—because inquiries can perhaps be seen as a dripping roast for lawyers. Where is the motivation for them to do their work more quickly and less expensively?

Rebecca McKee: I imagine that the motivation would differ across different legal teams. The people I have spoken to—who are particularly interested in this topic and have therefore made time for me to speak to them—are very motivated to find a way to cut down the time that inquiries take and to get to learning lessons earlier. Some of those people have worked on inquiries for 15 or 20 years and find it very frustrating that lessons are not learned and that things happen again. Those are individuals who work in those teams, so I cannot speak about the motivations of people at the higher level of legal firms, but plenty of people in the legal profession who have worked on inquiries over and over again are very frustrated by the issues that we have discussed.

The Convener: There is a concern about vested interests and that that situation could continue.

Mary Morgan, do you want to come in?

Mary Morgan: On the question of balance, we have yet to see what AI can do to shorten public inquiries. We know from the papers that the UK Covid inquiry has started to use AI through a system called Relativity. We tried to use AI to identify questions that were being asked of particular core participants in particular areas. That process was not perfect, but it gave us quite a lot of themes and saved quite a lot of time. Innovations and new ideas that are coming to the fore might help to reduce an inquiry's timelines and make its processes more efficient.

The Convener: When we put that question to the Faculty of Advocates, it said that, even though the same documents feature many times, some folk have annotated them, so people still have to look at them.

I thank both witnesses for their evidence, which is really appreciated. If there is anything that we have omitted or not touched on or something that you are desperate to say, now is your opportunity to put it on the record.

Mary Morgan: I have nothing to add. Thank you.

Rebecca McKee: There is nothing else from me, either.

The Convener: That is great. Thank you very much for your evidence. We will continue our inquiry, but that concludes our evidence session and, indeed, today's meeting.

Meeting closed at 11:50.

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