FPA/S6/25/19/2

Finance and Public Administration Committee
19th Meeting, Session 6
Tuesday 3 June 2025

Inquiry into the cost-effectiveness of Scottish public inquiries

Purpose

1. The Committee is invited to take evidence from the following witnesses in relation to the Committee's inquiry into the cost-effectiveness of Scottish public inquiries—

    - Rebecca McKee, Senior Researcher, Institute for Government
    - Mary Morgan, Chief Executive, NHS National Services Scotland.

Inquiry remit and approach

2. The Committee agreed on 1 April 2025 to carry out an inquiry into the cost-effectiveness of Scottish public inquiries, with the following remit—

    - to foster greater understanding of the current position with public inquiries in Scotland, including their number, timescales, extensions to remit, costs, categories of spend and outstanding recommendations
    - to enhance clarity around the purpose, framework and decision-making process for establishing public inquiries and their terms of reference, and whether any improvements are required
    - to establish if public inquiries in Scotland deliver value for money, the extent to which spending controls are necessary, and how they might be implemented while maintaining the independence and effectiveness of inquiries
    - to identify examples of good practice (in Scotland or elsewhere) which ensure cost-effectiveness
    - to identify alternatives to the Scottish inquiry model, including how such alternatives may work, deliver outcomes and value for money.

3. The inquiry will not make recommendations on the merits or otherwise of individual Scottish Government decisions on whether to hold a specific public inquiry, or recommendations made by individual public inquiries.

4. The Committee ran a call for views from 4 April to 9 May 2025. Fifteen submissions have been received, as well as two written submissions from witnesses in support of their oral evidence, which are available under correspondence to the inquiry. Published responses are available on the Committee's webpage and a summary of those responses has also been published.

5. The Committee has also written to the Scottish Government and current public inquiries (Scottish Child Abuse Inquiry, Scottish Hospitals Inquiry, Scottish Covid-19 Inquiry, Eljamel Inquiry and Sheku Bayoh Inquiry) seeking additional information. Responses to these letters have been received from the Eljamel Inquiry, Scottish Covid Inquiry, Sheku Bayoh Inquiry, Scottish Child Abuse Inquiry and the Scottish Hospitals Inquiry.

6. A SPICe briefing providing background information on the area has also been published along with an updated cost table, to inform the evidence sessions for this inquiry.

Previous evidence session

7. On 20 May 2025 the Committee took evidence from Professor Sandy Cameron CBE.

8. The Committee took evidence from Rt. Hon. Lord Hardie, Former Chair, Edinburgh Tram Inquiry; Dr Emma Ireton, Nottingham Trent University; Law Society of Scotland; Faculty of Advocates; and Compass Chambers, at its evidence session for this inquiry on 27 May 2025. The following key issues were discussed—

Rt. Hon. Lord Hardie

- Regarding the process of setting up an inquiry Lord Hardie said that “each inquiry has to start from scratch” and that this was a waste of money and experience. With no experience of setting up an inquiry he was expected to find accommodation and install IT systems for the Edinburgh Tram Inquiry (ETI). He considered a government department should provide support for this aspect.
- On setting a timescale for an inquiry, Lord Hardie said it would have to be “an informed decision” and “at the outset nobody knows”. He gave an example from the ETI of the estimated relevant number of documents from interested parties, which rose from 2 to 500 million, which was whittled down to 3 million documents with 17,000 ultimately used. He wasn’t opposed to fixing a budget or timescale but said it risks an inquiry missing relevant information and could attract complaints from the media and public if their expectations could not be met.
- Lord Hardie explained time was needed to identify points of criticism in the report so warning letters (a process also known as Maxwellisation) could be sent out to people and for adequate time to be allowed for them to respond, as the report could impact on their reputation. Some responses to warning letters were several hundred pages long.
- In response to a question about amending Terms of Reference (ToR) mid-inquiry, Lord Hardie said it is “important to get the terms of reference right at the beginning” but that it is also important for the Chair to take a decision, where unforeseen evidence arises.

- Lord Hardie explained his experience of cost controls. An annual budget is set through discussion with the sponsor department and the inquiry secretariat. This includes timescales of what is to be achieved. This would be reviewed within the year, possibly monthly. An adjusted budget would then be set for the next year. Lord Hardie pointed out there is a risk of “cost creep” unless the government department is exerting significant control over the budget.
- On the question of incentivisation of legal involvement and ensuing costs, Lord Hardie said the Chair could take steps to avoid this by for example setting strict timetables or questions being asked by counsel to the inquiry only. He had asked core participants to give notice of questions for public hearings, from which he would select relevant questions for counsel to the inquiry to ask witnesses. It was also noted that not everyone had to be a core participant; he had refused two such applications. The Chair could decide to hear from one group where there were shared interests, but it would be for those participants to decide on their legal representation.

Dr Emma Ireton, Nottingham Trent University

- A lot of the institutional knowledge in the way inquiries are run is lost as there is not a central repository of best practice. She said Cabinet Office Inquiries Investigation Team do not have the resources or funding to capture lessons learned. There is also no induction for a Chair and no discussion about the differences of the process. There is 2012 Cabinet Office guidance for public inquiries to provide ‘lessons learned reports’. She suggested that, in the majority of cases this has not happened. Inquiry case studies have been submitted but these are not publicly available.
- Evaluation should be embedded throughout an inquiry for continuous learning and this approach would assist the Chair to take informed decisions.
- It is difficult to compare cost-effectiveness of inquiries as there is no consistency when inquiry costs are recorded.
- Other jurisdictions have a clearer purpose for their inquiries. The UK used to be like this but “we’ve had massive mission creep”. There are different types of inquiry e.g. forensic investigation of what went wrong, policy reform and correcting the public record. Ministers should be clear at the outset what the core purpose of an inquiry is. It could be a mixture of purposes though this could impact on time and cost.
- Dr Ireton stressed the core purpose of public inquiries is to address a matter of public concern and to inform government action. She also emphasised that victims/survivors are not a “homogenous group” and so want different outcomes in different timescales.
- With regard to timescales, Dr Ireton said there is precedent for inquiries completing in 24 months but that the task set for these inquiries had to be achievable within that timescale.

- Dr Ireton explained 'warning letters' could be made discretionary rather than mandatory to help reduce costs and timescales. Adverse evidence could still be put to witnesses in oral hearings with an opportunity to respond. Chairs who need to use warning letters could still choose to issue them.
- She described the role of core participants as "to assist the inquiry in doing its job – they are not parties to the process" although recognised that a lot of them will need legal assistance. Not everyone is entitled to be a core participant.
- On whether inquiries should be judge-led, Dr Ireton said it depends on the subject matter, e.g. a forensic inquiry might need these specific skills, whereas a policy expert might be better for an inquiry aimed at policy changes. Also, the decision could be dependent on the skills of the individual and wider team. The Scottish Government should give more thought to this when commissioning a public inquiry.
- It is important to have statutory powers to compel, although they are not always used. Public perception is that an inquiry having those powers is the 'gold standard'. Public trust in inquiries could be increased through more careful use of narrative/language around inquiries and education of all those involved in the process.

Law Society of Scotland

- The cost impact on public bodies involved with public inquiries is something Ministers should consider when taking a decision to hold an inquiry. The Public Inquiries Act 2005 contains powers to control costs, for example section 17(3) "In making any decision as to the procedure or conduct of an inquiry, the chairman must act with fairness and with regard also to the need to avoid any unnecessary cost (whether to public funds or to witnesses or others)."
- It was suggested that greater use of project planning tools, such as a Gantt chart with milestones would assist the chair with managing costs and allow scrutiny to take place.
- Ministers have a discretion to establish a public inquiry and therefore they should be taking costs into account at that point.
- Cost arrangements could be set up e.g. fixed costs for lawyers and other experts called to give evidence.
- There should be some form of Scottish inquiries unit to provide a bank of people skilled in running inquiries etc.
- Where a person is involved in lobbying a Minister about a public inquiry, they would need to declare that activity to the Lobbying Registrar. Solicitors also have a practice rule that prohibits them acting where there is a conflict of interests. The Scottish Legal Complaints Commission would deal with any complaints against a solicitor. In response to a question about conflict of interest, an example was given where a legal firm involved in a public inquiry has a pecuniary interest in an inquiry being extended and expressed this to the media, it was noted this was a difficult

question and perhaps for others to answer. It was noted, however, that it was not clear whether this was them exercising their freedom of speech. Also, it is not known whether this would result in the individual being paid more.
- There should be a requirement for Ministers to exercise their discretion to consider whether a statutory or non-statutory approach would be best and whether an inquiry should be judge-led or led by a panel etc. This would ensure these aspects have to be taken into account.

Faculty of Advocates

- The legislation states that warning letters would have to be sent to people that are the subject of significant or explicit criticism in the report. It is noted, however, that the criticism could be explicit but insignificant and a warning letter would need to be sent. Reflection on previous experience indicated that approximately 85% responded to these letters. This part of the legislation should be amended.
- When working on an inquiry you would be expected to submit an invoice (in this case to the solicitors' team) detailing what work is covered.
- As a legal professional, it was noted that being involved in a lengthy inquiry is very demanding with long working hours.
- People in general struggle with understanding what a conflict of interest might be, for example working for someone 10 years ago might be a conflict of interest. A process for this might be useful.
- Regarding the number of documents an inquiry considers, it was explained that multiple copies of a single document might be relevant as these can contain important manuscript notes.
- On the timescale for the government to respond to an inquiry report, it was suggested an initial response might be expected "within months at most".
- It was highlighted that Fatal Accident Inquiries could be a useful way of looking into certain issues of public concern and enjoy significant levels of public trust, notwithstanding backlogs and delays in commencing them.
- It was raised that in the Penrose Inquiry a lessons learned report was produced and published as an appendix to the inquiry report. There is therefore scope to clarify the title of these documents.

Compass Chambers

- Appointing a secretary from the civil service could assist the chair in helping the inquiry proceed efficiently as the Chair will often not have experience in setting up an inquiry and budgetary matters.
- The UK Covid inquiry is taking a modular approach to hearings. A different team has supported different modules. For example, the module into health care had 8 or 9 counsel supporting hearings

over 3 months, plus solicitors, but it could be less as it depends on the size of the topic and the volume of evidence.

- It was emphasised that as a legal professional, part of the role is to advise clients not to spend money where they do not need to.
- Where a legal representative to a core participant is being funded by the inquiry, oversight around payment would fall to the inquiry. For bodies not funded by the inquiry then it would be the body paying the legal fees.
- The Scottish Child Abuse Inquiry also takes a modular approach, publishing case studies. This allows ongoing consideration of what is being produced by the inquiry. It is understood the intention is to produce modular reports too. Though it was also noted that this approach is not suitable for all inquiries.
- For legal representatives a matter of "pure" conflict of interest would be a matter for the regulation of the legal profession – "we can't act in a situation of a conflict of interest" – it would be a professional obligation to deal with it at the time. It was suggested that a disclosure of interest is a separate issue. In response to a question about conflict of interest, where a legal firm involved in a public inquiry has a pecuniary interest and has gone to the media to ask for an extension to the inquiry, it was noted that it would not be a relevant conflict of interests if you were advancing your client's position.
- It was considered that the process of questioning witnesses is not adversarial: notice of points of clarification to be asked of witnesses have to be provided in advance. The Chair decides if these are accepted. There is no cross-examination of witnesses by other parties.
- Artificial intelligence is being used in public inquiries e.g. the UK Covid inquiry is using a package called "Relativity".

Written submissions of 3 June 2025 witnesses

9. Written submissions were received from one witness appearing at the Committee's meeting on 3 June. This is attached at Annexe A. Some key issues raised in this submission are summarised below.

NHS National Services Scotland (NHS NSS)

10. NHS NSS is a statutory body established to provide national strategic support services and expert advice to NHS Scotland. Central Legal Office (CLO) is a core service of NSS. CLO provide legal services to all NHS Scotland Boards including in relation to public inquires. NSS is a core participant in modules of the Scottish and UK Covid Inquiries having played a significant operational role in the response to the COVID-19 pandemic in Scotland. NSS was also a core participant in the UK Infected Blood Inquiry.

- **Duplication:** Public inquires do not determine criminal or civil liability. Inquiries are regularly held parallel to other court proceedings which may consider some/all of the same subject matter under different evidential rules. There can be duplication in the subject matter, such as between the Penrose Inquiry and the UK Infected Blood Inquiry, and the UK and Scottish Covid Inquiries.
- **Participation in public inquiries:** Inquiries are resource intensive for participants, both financially and in terms of the time and resource required to assemble and share documentation and in attending to give evidence. Different participants will resource and respond to inquiries in different ways.
- **Dedicated Public Inquiries Team:** NSS established a Public Inquiries Team to help the NHS respond to inquiries. It has supported three public inquiries since 2021. NSS states that the team reduces duplication of effort, provides a single point of contact, and support for the duration of the inquiry ensuring consistency of approach and providing confidence that the organisational response has been managed appropriately. The team has developed wraparound support for witnesses giving evidence in public inquiries, ensuring staff wellbeing is at the centre of the approach as there is a significant impact on staff wellbeing to participating in such work.
- **Cost of public inquiries:** NSS has spent £3.1 million since 2021/22 in responding to public inquiries. The cost to the NSS public Inquiries Team and the legal services provided by CLO to the NSS are detailed below.

  COVID-19 Public Inquiries (Legal costs and team costs)
  2021/22 - £nil
  2022/23 - £444,592
  2023/24 - £823,167
  2024/25 - £699,000
  2025/26 - £649,953 (forecast)

  Scottish Hospitals Public Inquiry (Legal costs only)
  2021/22 - £125,197
  2022/23 - £177,867
  2023/24 - £288,300
  2024/25 - £548,553

- CLO has provided around £9 million in legal services to NHS Scotland Boards for public inquiries since 2021. This cost includes the cost of Counsel.
- Core participants costs are not reimbursed consistently. It would be helpful for inquiries to set out what costs should be recorded by participants and arrange for those to be reported to the inquiry and shared publicly on a regular basis (e.g. quarterly) to ensure there is a consistent approach to providing information.

- Increased consistency in how inquiries are conducted would likely lead to better cost-effectiveness as participants would become familiar with inquiries' demands and what inquiries require from participants.
- **Timescales for inquiries:** Timescales can be lengthy. This means that support is required over long time periods for inquiry core participants. Issuing clear timetables for 'modules' for inquiries and detailed terms of references for each 'module' are effective in keeping public inquires to timetable and remit. This allows participants to prioritise resources and manage timescales appropriately.
- **Interim recommendations and implementation of recommendations:** The introduction of mandatory interim recommendations in all public inquiries, as happens with the UK Covid inquiry, would help to ensure learnings are captured and delivered ahead of inquiries' final reports.
- The Scottish Government set up an Oversight and Assurance Group after the UK Infected Blood Inquiry to consider the recommendations of that Inquiry. The Group consists of a variety of stakeholders. NSS suggests that such Groups could be considered to review recommendations' implementation.
- Section 28 of the Fatal Accidents and Sudden Death etc (Scotland) Act 2016 introduced a requirement that those to whom FAI recommendations are directed must provide a response to a FAI's Determination within 8 weeks. NSS suggest that a similar requirement could be introduced requiring participants in public inquiries to report to Parliament with their written response to inquiries' reports.
- **Independent advisory body:** A body could be established to support Parliament in deciding whether a public inquiry should be held. It could advise on the risks and opportunities of an inquiry, give advice on effectiveness and value for money, support the administration of a public inquiry, and highlight opportunities for lessons learned. It could also ensure consistency, hold inquiries to account for their conduct, and provide oversight over costs incurred.
- **Alternative models:** In New Zealand a Royal Commission was established to look at the country's response to Covid. It was chaired by an epidemiologist, with a former Government Minister and a Treasury Secretary as panel members, rather than a Judge.

Next steps

11. The Committee will continue taking evidence in relation to this inquiry at future meetings.

Committee Clerking Team
May 2025

ANNEXE A

NHS National Services Scotland (NHS NSS) Call for Views Response

Information about your organisation

NHS National Services Scotland (NSS) is a statutory body constituted under section 10 of the National Health Service (Scotland) Act 1978 (the "1978 Act"). NSS (previously named the Common Service Agency) has its functions conferred on it by the 1978 Act (which includes functions specified in the National Health Service (Functions of the Common Services Agency) (Scotland) Order 2008 ("2008 Order"), which is made under section 10 of the 1978 Act) and section 62 of the Public Bodies (Joint Working) (Scotland) Act 2014. The Common Services Agency for the Scottish Health Service was previously constituted under the National Health Service (Scotland) Act 1972. NSS was established to provide national strategic support services and expert advice to NHS Scotland.

Central Legal Office (CLO) is a core service of NSS. CLO provide legal services to all NHS Scotland Boards including in relation to public inquires.

Given its national support role to NHS Scotland and the diverse range of services it delivers, NSS is appropriately placed to respond to the Committee's call for views. NSS is a core participant in modules of the Scottish and UK Covid Inquiries having played a significant operational role in the response to the COVID-19 pandemic in Scotland. NSS was a core participant in the UK Infected Blood Inquiry.

CLO has a unique perspective, providing support to clients across a range of public inquiries and other court processes within the public sector.

1. How effective is the current model of public inquiries in Scotland, and to what extent does it deliver value for money?

The statutory framework governing public inquiries allows broad discretion in how inquiries are established and conducted once their terms of reference are established.

There are no prescribed time limits for events that public inquiries consider. This can present challenges in providing documentation and witness evidence, limiting the effectiveness of evidence considered.

There can be duplication in the subject matter, for example as between the Penrose Inquiry and the UK Infected Blood Inquiry, and the UK and Scotland Covid Inquiries.

Public inquires do not determine criminal or civil liability.

Inquiries are regularly held parallel to other court proceedings which may consider some/all of the same subject matter under different evidential rules.

A challenge presented by the current model is that different participants will resource and respond to inquiries in different ways.

Inquiries are resource intensive for participants, both financially and in terms the time and resource required to assemble and share documentation and in attending to give evidence.

NSS established a Public Inquiries Team to help NSS respond to inquiries. This team has supported NSS in three public inquiries since 2021. The team reduces duplication of effort, provides a single point of contact, and support for the duration of the inquiry ensuring consistency of approach and providing confidence that our organisational response has been managed appropriately. This system works well within NSS.

The NSS Public Inquiries Team has developed wraparound support for witnesses giving evidence in public inquiries, ensuring staff wellbeing is at the centre of the approach as there is a significant impact on staff wellbeing to participating in such work. Other time costs include the time and resource of staff assembling and sharing documentation and attending to give evidence. NSS has spent £3.1 million since 2021/22 in responding to public inquiries.

The direct cost to NSS of the Team and the legal services provided by CLO to NSS are detailed below.

COVID-19 Public Inquiries (Legal costs and team costs)

- 2021/22 - £nil
- 2022/23 - £444,592
- 2023/24 - £823,167
- 2024/25 - £699,000
- 2025/26 - £649,953 (forecast)

Scottish Hospitals Public Inquiry (Legal costs only)

- 2021/22 - £125,197
- 2022/23 - £177,867
- 2023/24 - £288,300
- 2024/25 - £548,553

CLO have provided around £9 million in legal services to NHS Scotland Boards for public inquiries since 2021. This cost includes the cost of Counsel.

Effectiveness of the current model – actual and perceived – can vary considerably between inquiries depending on their subject matter and outputs. Work to look at each concluded inquiry in Scotland against its terms of reference and examining what the inquiry has achieved from those terms of reference would allow effectiveness to be measured in more detail.

2. Is there sufficient transparency around the purpose, remits (including any extensions), timescales, costs and effectiveness of public inquiries and what, if any, improvements are required?

NSS's experience of public inquiries' terms of reference are that they are clear and helpful.

Timescales for inquiries vary significantly based on the scale of the harm being considered and the scope of the issues. Timescales can be lengthy. This means that support is required over long time periods for inquiry core participants.

Issuing clear timetables for modules for inquiries and detailed terms of references for each module are effective in keeping public inquires to timetable and remit. This allows participants to prioritise resources and manage timescales appropriately.

The introduction of mandatory interim recommendations in all public inquiries, as happens in the UK Covid inquiry, would help to ensure learnings are captured and delivered ahead of inquiries' final reports.

3. Are the current legislative framework and decision-making processes for establishing public inquiries adequate, and what, if any improvements are required?

NSS suggest that an independent advisory body could be established to support Parliament in deciding whether a public inquiry should be held. Such a body could advise on inter alia the risks and opportunities a public inquiry could offer in the circumstances involved, and opportunities for lessons learned. They could consider whether public inquiries would be effective and value for money in the circumstances, collate evidence from previous investigations to consider whether there would be benefits from a public inquiry being held, and advise Parliament accordingly.

Such a body could also support the administration of public inquiries to ensure consistency of approach and conduct in inquiries, holding inquiries to account for their conduct, and providing oversight over costs incurred.

4. Are the processes for setting and monitoring costs for public inquiries adequate? What measures should be put in place at the establishment of a public inquiry to ensure value for money and prevent time and cost overruns?

NSS suggests that current processes for monitoring public inquiry costs are inadequate. Costs are significant. NSS's costs incurred in preparing for and supporting three public inquiries since 2021 are as set out in response to question one.

Costs are incurred by each participant to an inquiry. Costs are not reimbursed or reported consistently. There is no oversight of costs incurred.

Public bodies involved in an inquiry incur costs to prepare for and participate in inquiries (including paying for staff time from the public body and legal representation).

It may be helpful for inquiries to set out what costs should be recorded by participants and arrange for those to be reported to the inquiry and shared publicly on a regular basis (e.g. quarterly) to ensure there is a consistent approach to providing information. NSS suggest that the independent advisory body suggested in answer three could have a role in assessing and monitoring costs.

Tight terms of reference are essential when a public inquiry is established to ensure value for money.

5. What is the best way to ensure cost effectiveness of public inquiries while maintaining their independence?

NSS's experience suggests that having clarity in the scope of inquiries' terms of reference and timelines at the outset is key to cost effectiveness. Increased consistency in how inquiries are conducted would likely support with this as participants would become familiar with inquiries' demands and what inquiries require from participants.

6. What, if any, measures should be put in place to ensure recommendations made by public inquiries are implemented in a timely way?

Arranging inquiries into modules or thematic areas and releasing interim reports with immediate considerations or recommendations can help to ensure learning is being applied more quickly.

The Scottish Government set up an Oversight and Assurance Group after the UK Infected Blood Inquiry to consider the recommendations of that Inquiry. The Group consists of a variety of stakeholders. NSS suggest that such Groups are one option that could be considered to review recommendations' implementation.

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. NSS suggests 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. NSS's assessment is that this was a positive step which occurred in the UK Infected Blood Inquiry.

7. What alternatives to the current model of public inquiries should be considered when particular events have, or could cause, public concern? Are there examples of good practice from other countries that Scotland could learn from?

Public inquiries are usually chaired by a legally qualified Chair. Other alternatives could be considered, such as in New Zealand where a Royal Commission was established to look at the country's response to Covid. It was chaired by an epidemiologist, with a former Government Minister and a Treasury Secretary as panel members, rather than a Judge.

NSS suggests that use of other Court processes could be used in some circumstances (likely those with more limited scope) as an alternative vehicle to consider lessons learned and how to minimise the risk of harm happening. This currently happens in Fatal Accident Inquiries. However, consistency and cascading out can be challenging. NSS suggest that the independent advisory body proposed in answer 3 could support consistency in cascading lessons learned to minimise risk of similar harm.

CLO's experience is that non-statutory inquiries can be effective, although they do not have power to compel witnesses to give evidence. In the case of public authorities, there is an expectation that they will co-operate with the inquiry even if there is no legal compulsion. This means that a non-statutory inquiry can be as effective, but lower cost than a statutory inquiry.