Sheku Bayoh Public Inquiry

Conduct and Procedure Hearing - 12 and 13 June 2025

Volume 4 [of 4]
Miscellaneous items

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on behalf of Retired Officer Alan Paton on the application for recusal on behalf of (1) The Scottish Police Federation; (2) PC Craig Walker and (3) Ms Nicole Short

1. Email chain dated 3 and 4 February 2022

From: Admin
To: Paul Kavanagh; Brian McConnachie; Laura Anne Radcliffe
Subject: FW: Alan Paton
Date: 22 May 2025 11:20:05
Attachments: image001.jpg

Good morning,
Please see attached emails below.
Kind regards,
[redacted]

From: Email address o legal inbox at Sheku Bayoh nquiry <[redacted]>
Sent: 04 February 2022 17:52
To: Paul Kavanagh <[redacted]>; Email address o legal inbox at Sheku Bayoh nquiry
Cc: Brian McConnachie email address; Laura Anne Radcliffe email address; [redacted]
Subject: RE: Alan Paton

Dear Paul,
The letter from the Chair to certain members of Mr Bayoh's family was issued following a meeting with those members of the family. The Inquiry will not be sharing the letter.
The submissions re the core participants have not been shared, and as I hadn't expressly advised core participants that they would be circulated, I was not intending to share them.
The Chair's ruling addresses the matter fully. Is there anything that causes you particular concern?
Kind regards
Sadif
Sadif Ashraf
Solicitor to the Sheku Bayoh Public Inquiry
[redacted]

From: Paul Kavanagh email address <[redacted]>
Sent: 03 February 2022 14:14
To: Sheku Bayoh Inquiry – legal enquiries <[redacted]>
Cc: 'Brian McConnachie' <[redacted]>; 'Laura Anne Radcliffe' <[redacted]>; [redacted]
Subject: Alan Paton

Dear Sirs,
I acknowledge receipt of the submissions for all core participants. I note in particular the terms of the email by Mr Anwar on behalf of the family. He makes particular reference to a personal letter suggesting it was written by the Chair to the Inquiry. Given this has been referred to and quoted please provide me with a copy of the full letter.
Further please provide me a copy of all core participants submissions regarding position statements. Please correct me if I am wrong but I do not appear to have them as yet.
Thank you for your assistance and I look forward to hearing from you.
Yours faithfully,

Paul [redacted] Kavanagh
Partner
KM Law
[redacted]

_____

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****
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****

From: Aamer Anwar
To: [redacted]
Subject: imran khan
Date: 22 May 2025 12:16:25
Attachments: image007.png

From: Imran Khan KC <[redacted]>
Sent: 20 May 2025 17:03
To: Aamer Anwar <[redacted]>
Subject: Public Inquiries

Dear Aamer,

This is to confirm that the Chair (and panel where there was one) met the families in almost every Inquiry I have been involved in:

1. Stephen Lawrence Inquiry chaired by Sir William Macpherson
2. Zahid Mubarek Inquiry chaired by Mr Justice Keith
3. Victoria Climbie Inquiry chaired by Lord Laming
4. Undercover Policing Inquiry chaired by Mr Justice Mitting

I am told that Sir Martin Moore-Bick met many victims of the Grenfell Tower Fire in that Inquiry but cannot confirm it myself.

I hope this helps.

Imran

Imran Khan KC
Partner
IMRAN KHAN AND PARTNERS
[redacted]
DX: [redacted]
Tel: [redacted], Fax: [redacted]
Email: [redacted]
Cjsm: [redacted]
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following an interaction with officers of Police Scotland.

The Chief Constable who is present here today has asked that I address my first remarks to you, his family. You are at the heart of this Inquiry. The Chief Constable wishes to express his support for this Inquiry to you in person and publicly. Today he offers his condolences to you for the loss of your loved one.

The Chief Constable was powerfully affected by Kadi's statement yesterday that she does not feel safe in Scotland, that she fears for her children and for her nieces and nephews. As Chief Constable, he leads a police service whose purpose is to improve safety and wellbeing of the people and communities of Scotland. That mission is and must be for the benefit of all citizens and, as Chief Constable, he is clear that Police Scotland has a major role in ensuring that Scotland is a safe, secure and welcoming place.

The Chief Constable has committed Police Scotland to support the Inquiry's aims and objectives with absolute candour. At his direction, extensive resources have been applied and continue to be applied to assist in the provision of material to the Inquiry and ensure the fullest possible engagement with the Inquiry.

He agrees that it is essential to understand all

(Short Break)

(11.19 am)

LORD BRACADALE: Now on behalf of the Chief Constable of the Police Service of Scotland, Ms Maguire.

Submissions by MS MAGUIRE

MS MAGUIRE: Thank you, Chair, for this opportunity to make interim closing submissions on behalf of Sir Iain Livingstone QPM, the Chief Constable of the Police Service of Scotland.

Written submissions on his behalf were submitted to the Inquiry on 23 June. These are adopted and they will be made available to the public by the Inquiry.

Today I will only address one part of those submissions. Because of its importance to policing in Scotland and public confidence in the police, I will focus on the chapter which deals with the issue of race.

Before doing so, the Chief Constable has asked that I once again address the families of Mr Bayoh.

The Chief Constable is aware that you have attended every hearing from May last year and that you have required to listen to difficult evidence about your loved one, Sheku. You are at the heart of this Inquiry and the Chief Constable wishes to acknowledge the courage, the strength and the dignity you have shown throughout.

The Chief Constable made a commitment to you in his opening statement. When he expressed his support for this Inquiry, he affirmed the mission of Police Scotland to improve the safety and wellbeing of the people and communities of Scotland, including your community, and to do so for the benefit of all citizens.

He wishes to reassure you of the positive steps that have been taken in honouring that commitment.

The Chief Constable has continued to support the Inquiry with absolute candour. He has engaged bespoke resources to provide extensive material and position statements to the Inquiry to assist the Inquiry in all its aims.

He has supported the Inquiry in its investigation to understand what happened in Kirkcaldy on 3 May 2015 and through operational organisation he has facilitated the attendance of officers of Police Scotland to ensure that they have been available as and when the Inquiry has needed them.

Like you, the Chief Constable is determined to support the Inquiry to ascertain and understand fully what happened that day. Organisational learning systems have been developed to respond to the evidence given to the Inquiry, lessons have been learned, continue to be learned, and there will be a constant striving for

DATE: 1 October 2021

Your Ref:

Our Ref: LSE19159M/EW

Sadif Ashraf,
Solicitor to the Public Inquiry

[redacted]

By email only

Legal Services Department
Police Scotland
[redacted]

E-mail:
[redacted]

Dear Sadif,

DISCLOSURE OF MATERIAL

I refer to your letter of 29 September 2021, which was sent in response to my own to you of 15 September 2021.

Preface

I am obliged to the Chair for the careful consideration which has been given to the matters set out in my said letter, and grateful for the opportunity to offer up further specification (and explanation) in development of our previously stated objections.

That further specification is provided to you – as requested – before close of business today (1st October). I note that our submission will be placed before Senior Counsel to the Inquiry for review, and further consideration.

I confirm that preparation and submission of this letter has followed on from a meeting and discussion yesterday afternoon with Senior Counsel, instructed for the Chief Constable, assisted by certain colleagues from Police Scotland's Public Inquiry Team. We have endeavoured – and mindful of what you say about the level of detail provided in support of our objection – to offer up as much in the way of specification as we have been able to draw together in the short period of time available to us.

For the sake of completeness, we continue to be guided by the overall statement of intention, set out in earlier correspondence and reiterated at meetings between us, of the Chief Constable and his commitment to supporting the Chair in fulfilling the Inquiry's Terms of Reference.

Position of COPFS on Vols 1 & 2, PIRC Report

I welcome the information in your letter (supported by what you were able to set out in the discussion we had before receipt of your correspondence) as to the change in the position of COPFS on disclosure. That was not previously known to us and, plainly, is not only of relevance but is of at least some assistance to us in addressing our own position in that regard.

Further to what you were able to reveal certain discussions then took place with COPFS about that change. I am given to understand that the significant redactions proposed by COPFS to the first two volumes of the PIRC Report have now largely been accepted by the Inquiry. I further understand that, consequently, COPFS indicated that it no longer withheld its agreement to disclosure (*of the redacted iteration*) of the said two volumes.

Position of Chief Constable on Vols 1 & 2, PIRC Report

It remains the case, nevertheless, that we have not seen the PIRC Report (in any iteration). Absent what is set out more particularly below (under the sub-heading which follows this paragraph) on the various identified 'Categories of Documents' (*per your letter to me*) the Chief Constable's basic position on **what remains** in the PIRC Report is unchanged. I surmise that 'what remains' must be synthesis or analysis of things said to arise from the various 'Categories of Documents' - which must be the source(s) for that synthesis or analysis. Although we are, with the benefit of your helpful exposition of those Categories, able to come to some sort of view on each of them we have no such ability on 'what remains' in the PIRC Report. We have not seen it, do not know what it comprises and do not feel able to offer up any proper submissions on same

Police Scotland position on Categories of Documents

With reference to the list of Categories of Documents helpfully articulated in your letter of 29 September 2021, it is our reasoned surmise that at least some of the material (e.g. "statements" from various persons) must include that provided to you by us in response to the first Notice under Section 21. That being so, then we must be "providers" of such material (per the Inquiry's published Protocol on its intended approach to Redaction). We have not been consulted about redaction. I only make that observation now for completeness: time and space do not permit full commentary from being set out and I respectfully suggest this may be an aspect better left to the meeting (the convention of which you kindly offer in the pre-penultimate paragraph of your letter to me) with Senior Counsel to the Inquiry and others.

Following receipt of your letter the Police Scotland Public Inquiry Team commenced a close and detailed search of our systems to retrieve the PSI numbers (from our already submitted Inventories) in an effort to try to assist you with the *"full specification"* you requested. Unfortunately, given the very tight time permitted and the need for the PIST to assist with other requests from the Inquiry, this has not been possible to complete and include in this letter; however, this information will be provided by the time the proposed meeting involving the Inquiry's Senior Counsel takes place.

As you know, Police Scotland has submitted Inventories to the Inquiry in five tranches of material. Due to the sensitive nature of some of the material held and disclosed, we requested the insertion of two additional columns on the PI Inventory at the stage we were working through our third tranche of material. We also requested a "not for further dissemination" column be added to the draft inventory to enable us to mark documents that contained police tactics, strategies etc.

As you are aware this material is in the process of being re-reviewed and restricted to now only contain relevant information. GDPR redaction of this material will still be required to be undertaken by the Inquiry, in line with your Redaction Policy issued on 12 August 2021.

Of the tranches that have been re-reviewed (Phases 1- 3) and re-submitted to the Public Inquiry, all Inventories now contain the two additional columns – for *"redaction"* and *"not for further dissemination"*. The items we have reviewed and assessed that require some form of redaction requires to be undertaken by the Inquiry have simply been marked in this column with either an 'x' or the word 'yes'. The column marked "not for further dissemination" has been marked with a brief description of why this document should not be disseminated further. Accordingly, if the document has been reviewed and deemed relevant but it contains police tactics, it has been marked as *"Policing tactics"*. If the document contains police strategies, it has been similarly marked as *"Strategic document."* The said descriptions (however brief) are respectfully presented as at least part of the further specification which is sought from us.

Referring to the list of documents contained in your letter, it is our further surmise that not all of them originated from Police Scotland. Indeed, some might have originated from other Core Participants. There are however, a number of documents which must have originated from us.

We also surmise that COPFS, (and/or) PIRC and Police Scotland may have supplied the Inquiry with a number of identical items of material.

I turn now to the Categories of Documents set out in your letter.

The following Categories ***do not*** cause us any difficulty:-

- **999 calls – recordings, transcripts and call logs** – these do not cause us concern as they do not contain police strategies, tactics or sensitive information. They may, however, require GDPR redaction.

- **Video footage/stills -** these do not cause us concern as they do not contain police strategies, tactics or sensitive information.

- **Training records, attending officers -** these do not cause us concern as they do not contain police strategies, tactics or sensitive information.

- **FME examination forms and reports, attending officers –** at first blush it is not entirely clear to us if this related to the Forensic Medical Examination of the late Mr Bayoh due to the appearance of the words "attending officers". If further clarification could be provided, I will be then be able to be more specific in my response to this item. Forensic analysis of material is conducted by Forensic Services which comes under the Scottish Police Authority ('SPA'). I have enclosed the relevant paragraph from [redacted] letter of 1 February 2021 for your information.

  'The Scottish Police Authority ("SPA"), was created following the Police and Fire Reform (Scotland) Act 2012, ("the Act"). Under the Act, the SPA (rather than the Chief Constable) is responsible for the management and delivery of Forensic Services in Scotland. It is presumed that SPA Forensic Services may hold some information that that may be relevant to the Inquiry.'

- **Photo of PC Short's face -** this does not cause us concern.

- **Forensic reports (tablets Arran Crescent, vest, knife) -** these do not cause us concern.

As you will be well aware by now, the Police Scotland investigation was taken over by PIRC at a very early stage, I fully expect that PIRC ordered that reports be prepared following the Forensic analysis of the documents you have mentioned. As with the 'FME 'point above, Forensic Services is likely to have undertaken this work at the behest of PIRC.

- **Medical Records PC Short -** these do not cause us concern.

- **Locus photos and video –** these do not cause us concern.

The following Categories ***do*** cause us difficulty and for the following reasons.

Statements

We surmise that some of the statements to which your letter refers must be statements taken or provided to or by Police Scotland.

Regarding the various Categories of statement listed below, we have no issue with these *per se*, but caveat our position with the general observation that Police Scotland considers that it has a duty of care to all those from whom witness statements are taken (or provided) in inquiries or investigations it is directing.

In order to expedite matters and to assist the Inquiry, notwithstanding that there are likely documents within this Category for which we should be regarded as a provider in terms of the redaction policy, we will assume that the Inquiry and the Lord Advocate are content that the rights of others have been protected by your agreed redactions.

Consequently, we assume that the Inquiry will have taken all required redaction steps prior to disclosure of information to all Core Participants.

- **Statements – family**
- **Statements – friends, evening 2nd/early morning 3rd May**
- **Statements – eyewitnesses, Arran Crescent, morning 3rd May**
- **Statements – eyewitnesses, SB's route from Arran Crescent to Hayfield Road**
- **Statements – eyewitnesses, Hayfield Road**
- **Statements – paramedics**
- **Statements – doctors and nurses, resuscitation, Victoria Hospital**
- **Statements – SPF reps**

In respect of the following categories of statements we consider that these require to be the subject of further discussion with Senior Counsel to the Inquiry at the meeting to be convened.

- **Statements – attending police officers –** these documents may contain police tactics or police strategies

- **Statements – PIM (PS, PIRC) 3.5.15 –** as the PIM process used to deal with this incident was the Firearms PIM process, these statements may contain firearms tactics.

Other material

- **Airwave** – we have previously explained to the Inquiry that we were unable to 'separate' these Airwave recorded communications with any ease. The Airwave recordings may therefore

contain material that is unrelated.to the Public Inquiry and may contain wholly unrelated personal and perhaps sensitive information.

- **Threat levels (briefings, statements FAQs)** – these cause us concern as they may contain police tactics and police strategy.

- **SOPs** – I am unclear as to which particular SOPs you are referring here. An example of a SOP that could yield damaging issues for Police Scotland ,if its contents were to be released entirely unredacted into the public domain, is the Firearms SOP. That SOP contains examples of actual firearms incidents (and of police tactics in response to same). This particular SOP will require significant redaction.

- **Multimedia** – again I would welcome the specific details of the content of this category of information as I suspect that the CCTV from Kirkcaldy Police Station may be included in this item. If that is the case then the release of this CCTV footage causes us concern because it is likely to show individuals who are unrelated to the issues for the Inquiry attending the Police Station for various reasons.

The suggestion you make in your letter of a 'personal briefing' to Senior Counsel to the Inquiry from a suitably senior police officer of Police Scotland – in development of this exchange - is hugely appreciated by me and my colleagues. We wish to avail ourselves of it, though I propose [redacted] in the place of your suggestion of Deputy Chief Constable Taylor. [redacted] not only leads the Public Inquiry Team but is herself a very experienced and knowledgeable police officer who I am entirely confident will be an excellent resource. In addition to you and me attending that briefing I am pleased to say that our Senior Counsel too has kindly agreed to be present. I am sure that that will prove to be an expeditious means of progressing this key aspect to the Inquiry's wholly understandable wish to ensure the fullest, and fairest, disclosure of relevant material in early course.

I respectfully submit same for consideration and determination by the Chair. I await hearing from you at your convenience, once the Chair – as advised by Senior Counsel to the Inquiry - has had an opportunity to consider matters.

Yours sincerely,

[redacted]

[redacted]

Solicitor,

Head of Legal Services (Police Scotland)

DATE: 15 September 2021

Your Ref:

Our Ref: LSE19159M/EW

Sadif Ashraf,
Solicitor to the Public Inquiry

[redacted]

By email only

POLICE SCOTLAND
Keeping people safe
POILEAS ALBA

Legal Services Department
[redacted]

E-mail:
[redacted]

Dear Sadif,

**FOR THE URGENT ATTENTION OF THE CHAIR, THE Rt. HON LORD BRACADALE
INQUIRY INTO THE DEATH OF MR SHEKU BAYOH - POLICE SCOTLAND
DISCLOSURE OF SENSITIVE MATERIAL**

I shall be obliged if you would place this letter before the Chair, and confirm when that has taken place.

THE ISSUE

I was informed – via the Inquiry team - on Thursday 9th September that it was your Lordship's intention to disclose Volumes 1 and 2 of the Police Investigation and Review Commissioner's (PIRC) report (to the Lord Advocate, further to its investigation into the circumstances of Mr. Bayoh's death) to Core Participants this week. I therefore write in anticipation of that proposed disclosure taking place.

The most urgent issue is the proposed disclosure of those parts of the PIRC report but this submission is apt to cover all documents originating from Police Service of Scotland ('PSoS') produced to the Inquiry by other Core Participants.

On 9 July 2021, the respective legal teams of PSoS and the Public Inquiry had their monthly meeting. It was during that meeting that the PSoS legal team was informed of the intention to disclose the first two Volumes of the PIRC report to Core Participants this week. I am told that this report contains a number of documents originating from PSoS and sensitive material relating to the officers involved in

the incident with Mr Bayoh. I have not had sight of any of the Volumes of the report and rely on general, descriptive, information provided by PIRC, COPFS and the Inquiry team as to its content.

There is significant concern about the proposed disclosure of the type of material held by PSoS – and provided by it to PIRC in the course of its investigation. The Chief Constable has a duty to protect the serving police officers and members of police staff of PSoS and those who have retired from the service. He has a duty of care to protect the public and complainers or informants who have provided (possibly highly sensitive) information to PSoS; and, generally to preserve the security of general policing practices, policies, strategies and tactics employed by the PSoS. It is our view that the release of such information into the public domain could cause a great risk to policing in Scotland. There is a potential risk to individuals if sensitive personal information is produced.

PROGRESS TO DATE

Since July 2020, the PSoS Public Inquiry team ('PSoS PI') has met regularly with both the Inquiry Evidence team and the Inquiry legal team. At each of these meetings PSoS PI team has raised the issue of the nature of the material held by PSoS (and provided to PIRC), the potential sensitivity surrounding it (or some of it) and the consequent possible need for redaction.

As no redaction policy was in place, we suggested a number of things to identify the issues contained in the documents to which we had referred. For example, we raised the possibility of there being an Information Sharing Agreement ('ISA') in place - as had been the case with other inquiries under the 2005 Act. An ISA was drafted and sent to the Inquiry legal team for consideration. However, I was informed that no such agreement would be entered into by the Inquiry.

As the PSoS PI team worked through the material retrieved in response to the first Notice served on PSoS under section 21 of the Act it was produced to the Inquiry in Phases, along with detailed inventories. We requested that the PI Inventory had two columns added – one marked for 'redaction' and the other 'not for further dissemination'. At the time PSoS PI team requested the addition of these two columns it was explained that PSoS was producing a significant amount of material to the Inquiry that contained sensitive material that could harm police investigations, information about individuals and documents which were mixed in terms of relevance. The very clear direction given by the Public Inquiry team was that no documents were to be redacted before submission to the Inquiry. PSoS adhered strictly to that direction and – of course – to the requirements of the Notice under section 21 of the 2005 Act.

The issue of material which may have required redaction has been raised at each meeting with either the PI Legal team or the PI Evidence team, both of whom PSoS PI team meet with on a monthly basis.

The majority of the material was required by the Inquiry to be produced by PSoS in the absence of any redaction policy. The Inquiry Redaction Policy was only published on 12 August 2021. Examination of its terms reveals that it does not cover material produced to the Inquiry originating from one Core Participant (in this instance, PSoS) that may be in the hands of other Core Participants (again in this instance, PIRC and COPFS). This was raised with the PI Legal Team in early July 2021. It was then re-raised and discussed further at the joint legal meeting on 8 July 2021. At that meeting, it was suggested by the Inquiry Team that PSoS liaise directly with PIRC and the Crown to discuss a way to deal with PSoS material they may hold.

Whilst we appreciate and understand the desire the Inquiry have for treating all Core Participants equally, we explained the need to treat PSoS *material* differently. The Chief Constable remains committed to cooperating with the Inquiry in an open and transparent manner, as we have done throughout. However, that must be balanced – where appropriate - with the protections of the public, the officers and staff of PSoS and the occasionally sensitive material which informs and guides police investigations.

As suggested, PSoS met with PIRC and COPFS in an attempt to establish a way forward. All parties agreed informally that PSoS would be consulted by both PIRC and the Crown prior to agreeing to the disclosure by the Inquiry of any document(s) or information comprising possibly sensitive material they hold which had originated from PSoS. It was hoped that PSoS held a list of the documents produced by it to PIRC for the latter's investigation, or that PIRC held a list of these items. Unfortunately this has not proven to be the case. In addition, contact was made with the representatives of all other relevant Core Participants (in case any of them might be in a position to assist). It transpired that not all had been served with a section 21 Notice.

As far as I understand it, no Core Participant is aware of the Inventories or material produced by another Core Participant nor are any Core Participants aware of the material produced by each other to the Inquiry. Only the Inquiry hold all of this information.

Discussions among COPFS, PIRC and PSoS have continued. I was recently provided with the version numbers and some paragraphs of PSoS documents referred to within the first two Volumes of the PIRC report. Although that is of some assistance I have not seen the report and do not know if there is other material contained therein that might be classed as so sensitive as to require redaction.

I was told at the joint legal meeting on 9 September 2021 that COPFS was content to accept responsibility for advising on the disclosure of the information originating from PSoS within the PIRC report. I have since been advised that COPFS does not consider that it can offer an informed view about the impact the disclosure of Volumes 1 and 2 of the PIRC report to the Lord Advocate may have on policing matters and cannot therefore accept the responsibility of agreeing to its disclosure. This is understandable. The issue will become more acute once the disclosure of other Volumes is being considered. I understand that COPFS has been asked for its views on redaction of the remaining Volumes.

PSoS has simply been informed by the Inquiry Team that there, "appears to be no concern about Volumes 1 and 2". Apart from the identification of some SOPs, PSoS has been given no opportunity to offer any meaningful view regarding possible redaction requirements.

It is clear from previous history that documents produced by PIRC, under strict conditions of non-disclosure or dissemination, have been provided to the media. This is evidenced by the BBC 1 Documentary broadcast on 17 December 2018 in which statements taken by PIRC were aired. Once material is in the public domain, in a case of this nature, the damage will have been done. Section 36 of the Inquires Act 2005 procedure is unlikely to be a fully effective remedy for all individuals affected by any such 'leak' should there be a recurrence. It is unlikely that an action for breach of any restriction order, attendant on a regulated disclosure by the Inquiry, would be feasible for individuals. In any event, once disclosed to Core Participants on the basis of relevance it seems likely that such materials or information would not be withheld from full public disclosure at a later stage. It is therefore respectfully submitted that it is vital that the issue is addressed thoroughly at this stage.

PSoS has provided information about redaction and possible disclosure of the material it has provided directly to the Inquiry. The PSoS PI team has spent considerable time revisiting the very many items in the Phases already produced at the request of the Inquiry to now redact sensitive personal material. If any of that material (or material like it) has been produced via another Core Participant and disclosed in an unredacted format, this gives us cause for significant unease. It is extremely important to avoid triangulation issues where something is (quite properly) redacted in one document but revealed through examination of a combination of the production of material in other documents. This can also arise where documents, when read in conjunction with others, reveal the identity or personal information of individuals.

SOLUTIONS

The PSoS respectfully proposes that a further protocol be drafted with the input from all Core Participants to consider the appropriate method for consultation about the protection of the material originating from PSoS. Alternatively, an Appendix might be considered to the recently published Redaction Protocol on the Inquiry's website. The Crown could not be expected to take responsibility for identifying potentially sensitive PSoS material within the PIRC report or other documents. It may also be helpful in any event to consider a specific redaction protocol for sensitive material with an agreed category of redactions.

An alternative way of proceeding would be to allow interim limited access to the documents at issue to allow PSoS to comment on possible redaction of same before wider disclosure.

The possible adverse consequences of release of this type of material – unredacted or not fully redacted - into the public domain should not be underestimated.

I fully understand that your Lordship wishes the Inquiry to make progress and be seen to be making progress. That aim is shared by the Chief Constable, who has allocated significant resources to assist all aspects of the Inquiry. As the Inquiry Team could not assist with this issue, considerable effort has been put into resolving it by liaison with those concerned as soon as possible. If another Core Participant holding possibly sensitive material which has originated with PSoS does not consider itself qualified to provide the necessary view or submission about its proposed disclosure by the Inquiry then there is somewhat of an *impasse*.

I respectfully suggest that a clear and agreed protocol for the handling of such documents and material would be an efficient manner of proceeding. Limited access granted to PSoS to the documents in the proposed redacted format prior to final disclosure would, it is respectfully suggested, be a fair way to achieve the desired outcome of maximum disclosure whilst protecting the legitimate interests of the public and individuals consistent with the respective obligations of the Chief Constable and the Inquiry. It would avoid delays in the future. Issues are undoubtedly going to arise with the remaining Volumes of the PIRC report.

INTERIM POSITION

In the absence of any opportunity to consider the material proposed to be disclosed I am clearly not in a position to make any application, on behalf of the Chief Constable in terms of paragraph 10 of the Protocol for Disclosure. All I could responsibly do at this stage would be to object officially on behalf of the Chief Constable to the disclosure of sensitive material originating from PSoS upon which it has not been consulted. That would include any relevant part of Volumes 1 and 2 of the PIRC report.

The Chief Constable has acted in a manner consistent with his obligations under the Data Protection Act ('DPA') 2018 and produced material as required to do so under the Inquiries Act 2005 Section 21 notices. Of course, production of such material being in accordance with DPA obligations is not necessarily the same thing as further disclosure of such material to third parties also being in accordance. Doubtless the Inquiry is seized of this question too. Production of such material by PSoS to the Inquiry was on the basis that a recognised procedure of consultation about possible redaction would be followed. Material from PSoS in the hands of PIRC and COPFS is only there as a result of statutory procedures which protect against further dissemination. Clearly, there is a *lacuna* regarding the ability of PSoS to comment on redaction of documents originating from them if the material is provided to the Inquiry by PIRC and COPFS or others.

I respectfully submit that consideration of disclosure of **all** sensitive PSoS material (regardless of how and from whom it came to be in the hands of the Inquiry) requires a more flexible approach to

consultation about possible redaction of such material. I submit that that is required to protect the public interest and the rights of those individuals who may be adversely affected by disclosure of personal and sensitive personal information.

I shall be pleased to clarify or develop any part of this submission as may be thought fit. I confirm that this letter has been drafted with the assistance and advice of Senior Counsel instructed to assist the Chief Constable at the Inquiry. Otherwise, I respectfully submit same for consideration and determination by the Chair. I await hearing from you at your convenience, once the Chair has had an opportunity to consider matters.

Yours sincerely,

[redacted]

[redacted]

Solicitor,

Head of Legal Services (Police Scotland)

Solicitor to the Inquiry
Sadif Ashraf

E: [redacted]
T: [redacted]

SHEKU BAYOH INQUIRY

[redacted]
Police Scotland

By email only – [redacted]

18 November 2021

Dear [redacted],

REDACTION OF DOCUMENT RETRIEVED FROM MORE THAN ONE PROVIDER

Thank you for taking the time to attend our offices on Monday 15 November.

As advised at our meeting, Police Scotland are objecting to any changes to paragraph 20 of the Protocol on for receipt and handling of documents to clarify what should happen where an item has been retrieved from more than one provider. The Inquiry position is that we should only revert to one provider – that is the provider whose document we intend to disclose. Each document provided has a separate Doc ID. For example, a statement provided by Police Scotland will have a PS Doc ID. The same statement provided by PIRC will have a PIRC Doc ID.

There are two concerns. First, the robustness of the redaction process. Second, the responsibilities or liability of Police Scotland to the individuals whose personal data is contained within a document to be disclosed.

On the first, I have explained that the purpose of sharing redacted documents with the provider is to allow the provider the opportunity to consider whether the redactions are appropriate. It has the benefit of ensuring the scope for unintentional release of personal data is greatly reduced because there are two teams that have had the opportunity to review the redactions. Further, even after the provider has commented and agreed a document, the document is reviewed by the Inquiry Team before being released to Core Participants. I would

stress it is only released to Core Participants and not the public and is subject to a Restriction Order. While the Police Scotland team have identified documents where personal data has not been redacted during the redaction process, there have been no cases identified of documents disclosed to Core Participants with personal data *unintentionally* left unredacted.

While not infallible, the Inquiry is taking every measure possible to protect personal data. The Inquiry, for example, alerted Police Scotland when we realised that unrelated personal data was being shared with us in response to our section 21 Notice. We have a shared goal in protecting personal data.

On the second, I would like to invite you to share out your GDPR/data protection concerns in more detail. If the same document has been provided by Police Scotland and the Lord Advocate and the Inquiry discloses the Lord Advocate's copy after sharing the redactions with the Crown Office, do Police Scotland consider they will have breached their data protection obligations in respect of the individuals referred to in that document even though the copy being shared is that provided by the Lord Advocate?

In order to progress this matter, I've asked my team to prepare a list of items that have not yet been disclosed, that need to be ahead of Hearing 1 and which have been retrieved from more than one provider. I'll share this along with an indication of which provider we would propose to revert to in order to give an example of how the Inquiry are intending to resolve the one document/multiple provider issue.

I'll update the Chair of the objections of Police Scotland and the actions being taken to resolve the matter. I'll let you know if he has any concerns.

While this is a priority for the Inquiry in order to release documents to Core Participants, we do also need to make progress on the matter of complaint files/disciplinary records which would also form part of disclosure for Hearing 1.

I look forward to hearing from you soon.

Yours sincerely,

Sadif Ashraf
Solicitor to the Inquiry

SUBMISSIONS TO THE DEPUTY FIRST MINISTER, KATE FORBES MSP

on behalf of the Chief Constable, Police Scotland

in relation to

THE CONSIDERATION OF THE EXTENSION OF THE TERMS OF REFERENCE OF THE SHEKU BAYOH PUBLIC INQUIRY

PREFACE

- The Deputy First Minister is respectfully invited, for the reasons more fully set out below, to adhere to the existing Terms of Reference for the Sheku Bayoh Public Inquiry.

- Properly understood, the test applicable to any decision to amend the terms of reference for an inquiry (per section 5(3) of the Inquiries Act 2005) is not made out in this instance. Indeed, it would be contrary to the public interest to extend them in this Inquiry – as the Deputy First Minister is now invited to do.

- Furthermore, and in any event, it would be constitutionally incompetent for the Deputy First Minister to extend the Terms of Reference as she is invited to do.

- Also properly understood, the seeming concerns expressed about the matter of police training (as it was in 2015) proceed upon an entirely flawed premise and therefore offer no sound basis for the current request to extend the Terms of Reference.

- Wholly disproportionate, and very significant additional, cost to the public purse would be occasioned were the Deputy First Minister to accede to the current request to extend the Terms of Reference. For the Chief Constable, such costs are entirely unfunded as regards the budget for policing; bearing them would have a materially

damaging impact upon the Chief Constable's ability to discharge her statutory duties and to meet her responsibilities for the policing of Scotland.

INTRODUCTION

1. The families of Mr. Bayoh have made a request to the Deputy First Minister, Kate Forbes, MSP, ('the Deputy First Minister') to change the Terms of Reference ('ToR') of the Sheku Bayoh Inquiry ('the Inquiry'). The exact terms of that request are understood to be set out in correspondence (more fully described below) sent to the Deputy First Minister from Mr. Anwar, the solicitor instructed on behalf of Mr. Bayoh's families. However, the proposed terms of any such changed ToR have not been intimated to other Core Participants. It appears to be 'to include the prosecutorial decision of the Crown Office and Procurator Fiscal Service ('COPFS') and, latterly, the Victims' Right of Review ('VRR') decision that followed thereon.

2. The Chief Constable, Jo Farrell ('the Chief Constable') is a Core Participant in the Inquiry.

3. The Inquiry was announced in 2019. The ToR were announced on 21 May 2020 and the Inquiry began in November 2020. It has been ongoing since that date chaired by the Right Honourable Lord Bracadale ('the Chair'). The hearing of evidence is concluded. A timetable for submissions has been provided.

4. The matter was brought to the attention of the Deputy First Minister by the families in June 2024. It was not until her letter dated 14 October 2024, that the Deputy First Minister first invited the legal representatives of the Chief Constable to provide written representations on behalf of the Chief Constable on the Inquiry's ToR and whether they should be amended.

5. At that point, the Chief Constable was unaware of the full terms and the date of the request from the families to extend the ToR. The Chief Constable provided such submissions as were possible on the limited information available on 30 October 2024. Further letters were sent on 20th November 2024. In response to an invitation by the Deputy First Minister to make further submissions by 9 December 2024, further

correspondence, to be read together with the previous submissions of 30 October 2024, was sent on behalf of the Chief Constable on 9 December 2024.

6. At one point the Chair of the Inquiry invited submissions to him regarding the extension of the ToR, a process with which the Chief Constable considered she should not engage give that it is the Deputy First Minister who is the decision maker and not the Chair.[1]

7. Whilst certain representations have been made previously, that procedure has been protracted because the Core Participants to the Inquiry were not provided with the documents said to comprise the application for the extension to the ToR. Without those documents, it was not possible for the Chief Constable – or any of the other Core Participants – properly to comment on it. Not having been able to acquire those documents voluntarily from the Deputy First Minister, the Chief Constable reluctantly was left with no option but to commence judicial review proceedings in the Court of Session in January 2025 in order to review the lawfulness of the procedure adopted by the Deputy First Minister.

8. Those proceedings resulted in further documentation being made available by the Deputy First Minister. On 30 January 2025, the Deputy First Minister made available the correspondence received from Mr Bayoh's families regarding the request to extend the ToR. Furthermore, the Deputy First Minister made available on 31 January 2025 two notes addressed to her from the Solicitor General. The Deputy First Minister has stated that she will not be making available any further documentation to the Core Participants.

9. Having made available that material, the Deputy First Minister has requested final representations by 7 February 2025 at 4pm. These are the representations on behalf of the Chief Constable.

[1] Letter dated 1 November to the Solicitor to the Inquiry and Letter dated 9 December 2024 to the Deputy First Minister

10. For convenience, these submissions have been prepared incorporating most of the previous representations that have been made on this matter. The previous representations that have been provided on behalf of the Chief Constable are not departed from save in relation to those paragraphs identified in the letter dated 21 January 2025 and should be read alongside these submissions.[2] They are attached for ease of reference.

GUIDING PRINCIPLES

11. Before turning to the submissions in relation to the proposed extension of the ToR, the Chief Constable wishes to make clear that she shares, entirely, the families' understandable desire to get to the truth of what happened to their loved one, Sheku Bayoh, on 3 May 2015 in Kirkcaldy. This was specifically addressed on 11 May 2022 in the opening statement on behalf of the then Chief Constable, Sir Iain Livingstone QPM at the start of the oral hearings of the Inquiry. The Chief Constable continues to honour the commitments made to the families of Mr Bayoh and to the Chair in that regard. The families are at the heart of the Inquiry and that has been recognised from the outset. The Chief Constable acknowledges that the families have shown complete commitment in their quest for the truth which has undoubtedly been a long and hard process for them.

12. The Chief Constable is aware of the depth of feeling on the part of the families for the extension of the ToR. It is a matter of profound disappointment that the families' perception of any approach in the making of these representations could be based on racial discrimination against the families because Mr Bayoh or they are black.[3] The unwavering commitment of the Chief Constable and what she expects of Police Scotland is to combat racism in all its forms and to take action to prevent it.

13. The Chief Constable's very firm commitment to engage fully and positively with the Inquiry, and to assist the Chair to discharge the ToR, remains undiminished.

[2] Paragraphs 52 and 53 of the submissions dated 30 October 2025
[3] As reported in the media

Considerable resources have been expended by Police Scotland in fulfilling that commitment not only to the Inquiry but to the families; a truly vast amount of documentary material (both contemporaneous as well as a large number of lengthy and extremely detailed Position Statements) has been made available to the Inquiry. Witnesses from Police Scotland have spent significant amounts of time providing statements to the Inquiry and/or giving evidence, which has removed them from other duties. Throughout the engagement, the overarching imperatives have remained candour and transparency.

14. However, as head of a key part of the Scottish Justice system, the Chief Constable is obliged to make responsible submissions based on the law and to address all issues including the competency of what is proposed. The request comes at the very end of the Inquiry's proceedings, after all the evidence has been heard and on the eve of submissions. Indeed, as a result of the application, the date of the final submissions has been delayed twice.

15. The Chief Constable is concerned that the proposed extension will not further the Article 2 aims of the Inquiry and instead will simply cause further delay. There are also very significant matters – including a constitutional point – which indicate that not only should the extension not be granted, but that it would be incompetent to grant it as a matter of law. Each of those points is dealt with consecutively below in the interests of clarity.

16. The Chief Constable requires to address matters in line with the obligations of her office including those she has to all communities served by Police Scotland. Police Scotland has been open to rigorous and thorough examination by the Inquiry. The organisation has also examined and reflected on all the processes and procedures in 2015.

17. The intention, in presenting these submissions, is to support the Deputy First Minister in the careful and thoughtful consideration required to be given to the questions placed before her. These are supportive of the declared intention that the processes to be

engaged in this connection be fair and robust. The importance and significance of those questions – in the context they come to be raised – demands this of the Chief Constable.

18. These submissions will address matters in the following order:

1. The legal context in which the Inquiry takes place.
2. History and process to date.
3. The application(s) to extend the ToR.
4. Amending the ToR.
5. Actions in furtherance of the existing ToR.
6. Chilling effect of late-stage amendment of ToR.
7. Welfare of the officers.
8. Police Scotland training in 2015.
9. Costs, delay, impact, and efficiency.
10. Consequences of extending the ToR.
11. The decision maker.
12. Conclusion.

THE LEGAL CONTEXT IN WHICH THE INQUIRY TAKES PLACE

19. When a death has taken place in police custody or following police contact, the State has a procedural obligation under Article 2 of the European Convention on Human Rights to have an independent investigation into the circumstances, correct mistakes,

identify good practices and learn lessons for the future so as to prevent recurrence of similar incidents. It must be reasonably prompt, provide a sufficient element of public scrutiny, and involve the next of kin to the appropriate extent.

20. In this case there has been a PIRC investigation, a Crown investigation, and a review process of the Crown investigation. The Chief Constable is now aware that the families had various meetings with the then Lord Advocate, the then Solicitor General and Crown Counsel who made the original decision and the VRR. The families also received detailed correspondence from the Crown in respect of the decision not to prosecute – the seventeen-page letter referred to in the Note from the Solicitor -General to the Deputy First Minister.[4] The contents of the seventeen-page letter are unknown to the Chief Constable. The Chief Constable is, similarly, unaware whether the contents of the seventeen-page letter were known to the Inquiry (perhaps having been disclosed under and in terms of a section 21 notice served on another Core Participant, or another person or organisation).

21. The next stage would usually be a Fatal Accident Inquiry to review processes not covered by the criminal investigation. Each of those stages plays a role in the fulfilment by the State of its Article 2 procedural obligation.

22. In order to review the wider issues in this case, the then Lord Advocate, James Wolffe KC, considered that a Public Inquiry was the proper way forward. The power to set up a Public Inquiry derives from section 1 of the Inquiries Act 2005 ('the 2005 Act') as follows:

> "(1) A Minister may cause an inquiry to be held under this Act in relation to a case where it appears to him that—
>
> (a) particular events have caused, or are capable of causing, public concern, or
>
> (b) there is public concern that particular events may have occurred.
>
> (2) In this Act "Minister" means—
>
> (a) a United Kingdom Minister;

[4] Note for the Deputy First Minister 131224, paragraphs 34 - 37.

(b) the Scottish Ministers…"

23. The purpose of this Inquiry is to fulfil the Scottish Government's procedural obligation in accordance with Article 2 to investigate the circumstances, correct mistakes, identify good practices and learn lessons. The power to set up a Public Inquiry derives from section 1 of the Inquiries Act 2005

24. The purpose of the Inquiry is not – and could not be – the determination of accountability and/ or punishment. Firstly, the determination of civil or criminal liability is expressly excluded from the powers of an Inquiry established under the 2005 Act by section 2 of the 2005 Act. Secondly, the constitutional arrangements in Scotland provide that the power and authority to determine whether to prosecute any person in the criminal courts is a matter reserved to the Lord Advocate to the exclusion of all others, including the courts. This constitutional issue is explored in more detail below.

25. There is no right to obtain a prosecution or conviction or indeed a particular sentence. The fact that an investigation ends without such outcomes, or with only limited outcomes, is not indicative of any failings as such. The requirement is to review whether or not there has been careful scrutiny such that the deterrent effect of the judicial system in place and the significance of the role it is required to play in preventing violations of the right to life are not undermined.[5]

26. Compliance with Article 2 will require the Chair to establish facts and review the processes as articulated within the ToR. It is not for the Chair to substitute his own views as to the outcome of such processes.

HISTORY AND PROCESS TO DATE

27. In November 2019, following the conclusion of the Crown investigations, the then Lord Advocate, James Wolffe KC, confirmed a decision not to bring charges against Police

[5] *Giuliani and Gaggio v. Italy* (2012) 54 EHRR 10 at [298] – [306]

Scotland or any of the five officers involved in the restraint of Mr Bayoh in relation to criminal, corporate or Health & Safety offences.

28. On 12 November 2019, Mr Bayoh's families had a meeting with the then Cabinet Secretary for Justice, Humza Yousaf MSP, following which the intention to hold a Public Inquiry was announced. The ToR for the Inquiry were set in 2020 and announced by him on 21 May 2020. Mr Yousaf was, at that time, the Minister responsible for setting up the Inquiry under the 2005 Act.

29. The ToR expressly excluded from consideration at the Inquiry: "… *the making by the Lord Advocate of the prosecutorial decision communicated to the family of Sheku Bayoh on 3 October 2018 (and the Victim's Right to Review process that was undertaken by the Crown Counsel in 2019)*…". That exclusion is clear and unambiguous in its terms.

30. The ToR were agreed following consultation with the Chair and the families. Other interested parties were the legal representatives of Mr Bayoh's families, the Lord Advocate, Police Scotland, and the Scottish Police Federation, amongst others. Mr Yousaf wrote to the then Chief Constable on 21 May 2020, providing a copy of the ToR which he had announced to the Scottish Parliament the same day. Mr Yousaf also stated to the Chief Constable (noting an earlier meeting between the two, on 29 January 2020, to discuss the ToR) that:

> *"As I outlined when we met, my intention was to keep the Terms of Reference focused on the incident but sufficiently broad to allow Lord Bracadale to look at wider issues he considers to be pertinent to the Inquiry. While the final Terms of Reference that I published today do not feature all of the issues raised with me during my discussions, I am confident the scope is broad enough to include consideration of the operational and procedural aspects suggested by different stakeholders".*
>
> and
>
> *"I recognise that there will be a range of different perspectives on the Terms of*

Reference, but I believe the Terms of Reference published today are suitably broad to strike a balance and retain the confidence of all parties involved."

31. In subsequent engagement with the Inquiry, and throughout its progress to date, the Chief Constable has proceeded upon the reasonable expectation that that remained the basis upon which the matter was being conducted. Although the Chief Constable does not, and cannot, know whether (broadly) similar letters were sent by Mr Yousaf to those other different "stakeholders" to whom he refers – including the Chair – it seems reasonable to surmise that he did. That being so, they, too, would have been left with the same understanding from the very outset of the Inquiry as to the basis upon which it was being conducted and the quite deliberate limit set on its ToR. The Chief Constable is, similarly, unaware of any reservations having been expressed or challenges raised to the setting of said ToR – beyond, plainly, those submitted to the Deputy First Minister from and after June 2024 on behalf of the families.

32. The Chair was recorded as having said, on publication of the ToR, as follows:

"I believe that [the Terms] will enable my inquiry to conduct a thorough examination of the circumstances surrounding the death of Mr. Bayoh and the wider issues arising."

33. As a result of that express exclusion, ahead of the evidence given to the Inquiry by the then Lord Advocate, James Wolffe KC, there was express engagement to ensure that, during his evidence, there was no transgression into the areas excluded by the ToR.

34. In light of the above, it is important that it be recognised that what is being proposed by way of the extension is not a clarification or an ancillary matter. What is being proposed is the reversal of the clear and express exclusion of a matter in relation to which all Participants in the Inquiry have relied.

THE APPLICATION(S) TO EXTEND THE ToR

35. As set out above, the Chief Constable was reluctantly left with no option but to bring judicial review proceedings in order to access the application made on behalf of Mr Bayoh's families. As a result of those proceedings, the Deputy First Minister provided under cover of a letter of 30 January 2025 "the correspondence I have received from Mr Anwar".

36. The correspondence consists of letters dated 4 September 2024, 16 September 2024, 3 October 2024, 22 November 2024, and 14 January 2025. In essence, Mr Anwar's application recognises the constitutional difficulty presented by the application, which is discussed in more detail below, but seeks to have that constitutional issue disregarded without explaining how that ought to be done in order for the decision to be lawful. He says in his letter of 4 September 2024:

> "*For too long Crown Office and its decision -making process has remained shrouded in secrecy, it is an archaic practice in breach of their claim to adhere to supporting the human rights of families such as the Bayohs.*"

37. Initially, the VRR decision did not form part of the application. Latterly, and certainly by the time of the letter of 22 November 2024, it appears to have been brought within the application for an extension. There is, of course, an inherent conflict in relation to the VRR decision on the part of the Crown Office, perhaps more so than the general conflict which has caused the Lord Advocate to have to delegate her functions in the Inquiry to the Solicitor General. That conflict is referred to by Mr Anwar in his letter of 3 October 2024:

> "*We note you will wish to ask the Lord Advocate for advice on this natter – but as you will be aware the present Lord Advocate Dorothy Bain KC helped prepare the Victims Right to Review (as our Counsel) and was of the strong opinion that there should have been a prosecution. She will have to pass responsibility to the Solicitor General, because of the Lord Advocate's previous role as counsel for the Bayoh family, however I am sure you will be aware of the public*

perception if the Crown were to oppose extension or even to be asked by you for advice in their ministerial role, on whether they should be investigated."

38. The Solicitor General has been placed in an impossible position. It will be appreciated immediately that in consequence of this request, whether it is granted or refused, that perceptions may be such that the decision is viewed publicly as being tainted as a result of the involvement of the current Lord Advocate prior to taking up that position.

39. The language of the correspondence sent on behalf of Mr Bayoh's families is understandably emotive in its tone. Whilst the Chief Constable does not underestimate the emotional impact of these matters on the families, it is essential that the application for the extension is approached in a manner that results in a lawful decision and one that is required in the public interest. For the reasons set out in these representations, there are significant legal barriers to acceding to the request of the families.

AMENDING THE ToR

40. For the avoidance of doubt, the Chief Constable has no quarrel with the general proposition that the ToR of an Inquiry can be amended. There is express provision to permit such amendment in section 5 of the 2005 Act. Subsection 5(3) makes it clear that the Minister may amend <u>if</u> the public interest <u>requires</u> the amendment.

41. The Chief Constable agrees with the Deputy First Minister that '*any request to amend the Terms of Reference ('ToR') for a Public Inquiry requires careful and thoughtful consideration, and it is essential that this is done through a fair and robust process*'. The Deputy First Minister is the decision maker in this process and will require to come to her own independent view as to the merits of the request based on consideration of all the relevant factors and the submissions before her.

42. In relation to the proposed extension to the terms of reference, the Chair expressed an initial view that (i) a change to the terms of reference would cause delay and increase cost, and (ii) if the extension was limited to a consideration of the reasons for the decision, and did not extend to the VRR, the Chair felt that it would be manageable,

although it would still require a substantial amount of work. The Chair has since offered various different views.

43. The exercise of the power to extend the ToR – as with any power exercised by the Scottish Ministers – must be carried out lawfully.

44. There is a long-standing constitutional rule in relation to the functions of the Lord Advocate which prevents the proposed extension, making it legally incompetent for it to be granted as sought. Because it appears from the judicial review proceedings that this matter remains contentious, the position is set out here in detail.

45. In *Hester v MacDonald* 1961 SC 370 at [377], the Inner House found as follows:

> *"This question raises a matter of quite fundamental importance in our unique Scottish system relating to indictable offences.*
>
> *To appreciate its significance, it is necessary, first of all, to consider the position of the Lord Advocate in this system. Under our constitution, the Lord Advocate has a universal and exclusive title to prosecute on indictment (Macdonald, Criminal Law, p. 212). As Baron Hume says (Crimes, vol. ii, p. 155): "By custom, the process by indictment is the exclusive privilege of the Lord Advocate, or public prosecutor, who alone is possessed of that notorious and public character, which entitles him summarily, and of his own authority, to state himself to the Court as accuser, and call on the Judges for trial of his charge, without any previous licence obtained." In our system, the Lord Advocate alone possesses the function, in indictable offences, of deciding whether he will prosecute or whether he will withdraw a prosecution, and there is no appeal to any Court against his decision on these matters. No Court or magistrate can compel or direct or recommend to him what he should do. These are matters exclusively for him and exclusively within his province—Alison's Criminal Law, vol. ii, p. 87."*

46. It was suggested on behalf of the Deputy First Minister in her answers to the judicial review proceedings that that statement no longer represented the law. The High Court of Justiciary Appeal Court, however, determined otherwise in *HM Advocate v Cooney* 2022 JC 108, noting expressly that *Hester:*

> *"has since been overturned on the central question of whether the Lord Advocate enjoyed immunity from suit for malicious prosecution, but the statement of the law regarding the role of the Lord Advocate in our system remains valid."*

47. The Appeal Court indeed went further in *Cooney* at paragraph19, citing *McBain v Crichton* 1961 JC 25 with approval in the following manner:

> *"In McBain v Crichton (p 29), Lord Clyde noted, in relation to the role of the Lord Advocate:*
>
> *'In this country he is the recognised prosecutor in the public interest. It is for him, in the exercise of his responsible office, to decide whether he will prosecute in the public interest and at the public expense, and under our constitutional practice this decision is a matter for him, and for him alone. No one can compel him to give his reasons, nor order him to concur in a private prosecution. The basic principle of our system of criminal administration in Scotland is to submit the question of whether there is to be a public prosecution to the impartial and skilled investigation of the Lord Advocate and his department, and the decision whether or not to prosecute is exclusively within his discretion … It is utterly inconsistent with such a system that the Courts should examine, as it was suggested it would be proper or competent for us to do, the reasons which have affected the Lord Advocate in deciding how to exercise his discretion, and it would be still more absurd for this Court to proceed to review their soundness. Any dicta indicating that such a course is open to any Court are, in my view, quite unsound.'*

48. If it is impermissible for a court to *consider* such decisions and to make such recommendations, that rule must apply a fortiori to non-judicial bodies. There is no judicial authority whatsoever for the proposition that it is legally competent for the prosecutorial decisions of the Lord Advocate to be subjected to the scrutiny sought by way of the proposed extension of the ToR.

49. During the course of the judicial review proceedings, parties appearing in opposition to the petition sought to suggest two possible responses to the otherwise unanswerable constitutional point above. Respectfully, neither is a proper answer.

50. Firstly, it was suggested that the provisions of section 28 of the 2005 Act would permit the proposed extension to be granted. Section 28 is a limitation on competence not an empowering provision. Section 28 of the 2005 Act is clearly a provision aimed at ensuring that inquiries for which the Scottish Government is responsible do not stray beyond the competence of the Scottish Ministers and into matters reserved to the UK Government. It is not a provision with any broader purpose than that. In particular, it does not make it competent for the Scottish Ministers to determine something to be reviewable which is constitutionally non-reviewable. Any suggestion that section 28 of the 2005 Act circumvents the non-justiciable nature of the Lord Advocate's prosecutorial discretion is, respectfully, incorrect.

51. Secondly, it was suggested that the prosecutorial discretion had been considered in the Chhokar Inquiry. That is not a judicial precedent. That an unlawful decision was taken in those circumstances and was not subject to challenge does not make that decision lawful. It does not override the judicial authorities referred to above.

52. Finally, it was suggested in correspondence from the Deputy First Minister to the Core Participants on 14 January 2025 and in advance of the judicial review proceedings that the Crown Office had undertaken not to "*stand in the way"* if the extension were to be granted. The implication given was that the Solicitor General had provided consent to the proposed extension. Having now seen the correspondence from the Solicitor General as part of the disclosure made during the judicial review procedure, it is clear

that the Solicitor General did not purport to grant any such consent and regarded there to be an ongoing discussion in relation to the proposed extension.

53. In any event, even had she purported to have acted as suggested by the Deputy First Minister, it is not for the Solicitor General (or indeed the Lord Advocate) to consent to something being justiciable which is constitutionally non-justiciable.

54. It is not lawfully competent for the extension to be granted as sought. It is not open to the Deputy First Minister to extend the ToR in the manner in which she is being invited to do. Nor is such an extension required in the public interest. [6] If the Deputy First Minister, having taken legal advice, accepts the validity of the argument set out above, that is an end to the matter: the application to extend the ToR should be refused.

55. Even if the argument set out above in relation to competency is incorrect (which is not accepted) the facts and circumstances of the application in the context of the Inquiry make it clear that the application to extend the ToR should be refused. Those points are developed below.

ACTIONS IN FURTHERANCE OF THE EXISTING ToR

56. The Chief Constable's approach to, and full engagement with, the Inquiry to date has been in accordance with the ToR as they were set nearly five years ago.

57. The Chief Constable has proceeded with absolute candour in the absence of information about the consideration process as regards any potential criminal prosecution of the office of Chief Constable. This was the proper approach having regard to the ToR. Information about those considerations by the Crown has only been disclosed in relatively recent material from the Inquiry.

58. Since early 2021, the Inquiry has been provided with documentation from Police Scotland, the PIRC and COPFS. Core Participants were not aware of what section 21

[6] Note for the Deputy First Minister 131224, paragraph 33.

notices were served on other organisations or their responses until disclosure much later by the Inquiry. It is now clear that the Inquiry was in possession of very detailed material about the Crown position in terms of their investigation from the outset.

59. There have been 122 days of evidence and hearings and 105 witnesses who gave oral evidence (several more than once). The volume of documentation is vast. In terms of disclosure to the Inquiry from Police Scotland alone these are in excess of 19,000 documents. Disclosures from the Inquiry number over 3,000 which includes documentation of over 42,500 pages.

60. It is highly concerning in this context that, it now appears that as early as June 2024, there was consideration being given to extending the ToR and, furthermore, that the Inquiry and the Core Participants have been left in limbo in relation to the proposed extension into February 2025.

61. It is now tolerably clear from the correspondence disclosed that there was a deliberate decision not to put in a formal application to extend the ToR until after much of the critical evidence had been heard.[7] It is not entirely clear who was party to this decision. In any event, if there were considered to be issues with the ToR the following questions arise:

    1. Why was this not raised when the Inquiry ingathered all the information from the section 21 notices dating back to November 2020 and before the leading of evidence in May 2022?

    2. Why was it not raised from the very earliest stages when the Inquiry had issues with the Crown regarding the understanding and scope of the ToR in relation to disclosure and before evidence was led?

[7] Letter to the Deputy First Minister from Mr Anwar dated 4 September 2024

3. Given that the families have had direct access to the Chair and a number of meetings with him, why was this not raised from the outset and, if it was, why was the Inquiry not suspended to address this issue?

62. Police Scotland has conducted its engagement with the Inquiry to date on the basis of the existing ToR.

63. The Chief Constable is aware that Mrs Taylor, QPM, the then Deputy Chief Constable designate under the Police Service of Scotland (Conduct) 2014 Regulations, responded to the request for undertakings from Police Scotland regarding not taking misconduct proceedings in a manner which made clear her expectations of officers in engaging with the Inquiry. In her letter of 25 March 2022, Mrs. Taylor stated that Police Officers should give full and frank testimony to the Inquiry in accordance with her expectations of them as police constables. These statements were made, properly, but in the context of the existing ToR. Each officer responded by being wholly co-operative with the Inquiry in providing their evidence. Whilst their engagement would no doubt have been subject to legal advice, and is a matter for others, the Chief Constable does not underestimate the significance that would have been placed on that letter from Mrs. Taylor. Had the ToR not been in the terms which it was, that letter would have been expressed differently.

CHILLING EFFECT OF LATE-STAGE AMENDMENT OF ToR

64. In the public interest, it is vital that consideration is given to the effect and the consequences of acceding to the proposed extension not just for the Inquiry but for all public inquiries from hereon. If, as is being proposed, the ToR can be moved at the last minute in a Scottish inquiry and matters which were expressly excluded are brought into the scope of the ToR – particularly matters relating to criminal prosecution - who would advise any person to participate openly and freely with such an inquiry? There will be an inevitable chilling effect on the willingness of witnesses and participants to proffer information to an inquiry, and therefore an inevitable hindrance on the ability

of the inquiry to fulfil its central role, which is to examine the facts and make recommendations.

65. Participants in any inquiry will be faced with difficult – perhaps irreconcilable – conflicts in relation to wanting to assist with the inquiry's core purpose but not leaving themselves open to criticism or worse if and when the ToR in that inquiry are latterly amended to undermine earlier-provided assurances. That is exactly the chilling effect which gives the Chief Constable cause for considerable concern.

66. Every person has the guaranteed right to remain silent and not to contribute to incriminating himself. It is enshrined in our justice system and protected by way of the criminal limb of Article 6 ECHR[8]. The right not to incriminate oneself presupposes that the prosecution in a criminal case seek to prove their case against the accused without recourse to evidence obtained through methods of coercion or oppression in defiance of the will of the accused.[9] It is, respectfully, no less a breach of that guaranteed right that it be circumvented by encouraging participants in an inquiry to be frank and candid (which is in the public interest being furthered by the inquiry) by telling them that the consideration of prosecutorial decisions is expressly excluded by the ToR only for that to be amended after the evidence has been provided. It is the height of unfairness for the basis of the Inquiry to be amended after the evidence has been given in reliance on the agreed ToR.

67. Given the uncertainty which would be created by a change at this stage, how will there be any trust that the amended ToR would not be amended again? If the ToR were to be extended, the Inquiry would need further evidence in order for the ToR to be dealt with fairly and for the Inquiry to fulfil its function. This would entail evidence being re-examined, witnesses being recalled, and new witnesses being added. The very significant question arises as to whether and how those witnesses will in fact engage with the Inquiry and how they will be advised having regard to their rights. There is a

[8] *Saunders v United Kingdom* (1997) 23 EHRR 313 at [60]
[9] *Saunders* at [68]

real risk that the conduct of the Inquiry and the late-stage extension of the ToR will result in an unwillingness to provide evidence.

68. As set out above, the Chief Constable recognises and respects that there are Article 2 considerations to be borne in mind, but those Article 2 considerations do not exist in a vacuum. The individual officers who have taken part in the Inquiry, and indeed every party who has taken part in the Inquiry, have fundamental rights that are no less worthy of protection. The Deputy First Minister will, of course, be aware that section 57(1) of the Scotland Act 1998 makes it unlawful for her – and any of the Scottish Ministers – to do any act which is incompatible with the ECHR Convention rights.

WELFARE OF THE OFFICERS

69. The Chief Constable has a clear welfare duty towards all the Core Participants who are members of Police Scotland. In this Inquiry, those officers are separately represented, and no doubt submissions will be made on their behalf. However, it is appropriate that this aspect is addressed by her in her role as Chief Constable.

70. In making these submissions, there is no intention to equate what the officers and their families have suffered with the death of a loved one or the impact of the processes on the families of Mr Bayoh.

71. However, this process has been ongoing for nearly ten years. For police officers involved, this has been held over them for that period. It has resulted in the diagnosis of mental health conditions for some and has been career ending for others. This is a grave concern for the Chief Constable. Consideration of certain matters arising in consequence of the death of Mr Bayoh remain in limbo. That includes complaints against the Police raised on behalf of the families (the full progress of which, and dependent on outcome, might yet engage the PIRC once more). It also includes decisions under the Conduct Regulations as bearing upon the actions of any of the officers involved in the incident of 3 May 2015, and its aftermath, who continue to serve with Police Scotland. This will be particularly acute for the officers if they are to be

subject to protracted proceedings after use of force in the course of their duties. Given the rate of progress at the Inquiry to date, when one begins to consider the consequences of an extension to the ToR in the terms now under consideration (and leaving aside any additional delay that may be occasioned in the event of judicial review challenges being raised) it is not unreasonable to contemplate the extended timescales for completion of the Inquiry being measured in the many months, and perhaps even longer than that.

72. These delays in resolution are unacceptable for all involved. It is reasonable to infer that interference with the ToR at this late stage will remove the certainty and understanding of the process in which they were all engaged.

73. This will likely cause further issues for those members, but it also has a wider effect on policing. It means reassurance cannot be given that other response officers are not exposing themselves to similar protracted processes in the exercise of their duty. It is not in the public interest for there to be a disincentive to enter policing as a career or take up the essential first responder roles. Further delay and uncertainty are to be avoided.

POLICE SCOTLAND TRAINING IN 2015

74. The Chief Constable is particularly concerned about how the Inquiry has approached this crucial chapter. It is central to understanding the response of officers on the day.

75. After two years, the Inquiry produced a report on the adequacy of the Police Scotland training at the material time, on 5 September 2024 but dated 19 August 2024, from the original Crown expert Martin Graves. The Inquiry was notified on behalf of the Chief Constable of the serious issues and procedural unfairness arising on 11 September 2024 and again on 18 September 2024. No substantive response was received.

76. The Inquiry decided to lead Mr Graves on 2, 3 and 4 October 2024 and encouraged him to develop matters further without notice and to apply an undefined or unclear legal

test to an incomplete selection of materials. The absence of fair notice meant that the Chief Constable was unable to respond properly at that time.

77. Had the ToR been expressed differently, as is now being requested, the Chief Constable would have taken the necessary steps to prevent the calling of Martin Graves at that time and, ultimately, if necessary, have sought Judicial Review of the procedural unfairness in calling him without regard to the fairness of doing so. The Inquiry legal team has repeatedly advised the Chief Constable that issues regarding the adequacy of training should be dealt with in submissions and, having regard to the existing ToR (and the Inquiry timetable for oral hearings), the Chief Constable complied with the Inquiry's direction and adopted that approach.

78. However, if the ToR were to be extended, that approach will clearly require reconsideration. The decision of the Inquiry to proceed to hear the evidence on training in October 2024, when it would appear that the ToR review was under consideration, has to be considered in the light of the unfairness of such an extension.

79. It is also important to note the following in relation to the Chair's letter shared among Core Participants' legal teams on Monday, 18th November 2024. The reference to the further evidence heard since *"September this year"*, referred to in the unnumbered third page under the bold section '*Public interest in examining a flawed prosecutorial decision*' undoubtedly refers to the evidence of Martin Graves.

80. It is the position of the Chief Constable that the evidence elicited from Mr Graves, which is now said to reinforce concerns regarding the prosecutorial decision, was based on an incomplete provision of relevant material to the expert, a flawed interpretation of the proper test and standard of proof, a failure to examine the factual evidence of the relevant witnesses (both those who provided the training and those who had undergone the training), taking the expert beyond what was proper for him to provide opinion upon, and without due notice or opportunity for testing of the evidence. This will all be the subject of Final Closing Submissions on behalf of the Chief Constable within the current timetable and under the current ToR.

81. The position, in short, is that the Crown investigation could only be said to be flawed on this critical issue of the training of the officers on the basis of the flawed approach taken by the Inquiry in its examination of the issue. The Crown would have required to proceed in like flawed manner to obtain the same evidence from Mr Graves. Such evidence obtained on this basis would not stand scrutiny in any prosecution.

82. The Inquiry appears to the Chief Constable to have proceeded unfairly to obtain evidence upon which to form the basis for perpetuating and furthering that unfairness by using is as a factor in support of an extension of the ToR.

83. It is not in the public interest for this flawed approach to form the basis of the incurrence of further unnecessary expenditure in an extended Inquiry.

COSTS, DELAY, IMPACT AND EFFICIENCY

84. The Chief Constable has statutory obligations under the Police and Fire Reform (Scotland) Act 2012 ('the 2012 Act') including responsibility for the allocation of deployment of resources received from the Scottish Police Authority.[10] It is the duty of the Chief Constable to secure best value in terms of section 37 as follows:

> "(2) It is the duty of the chief constable to make arrangements which secure best value for the Police Service (that is, a continuous improvement in the carrying out of police functions).
> (3) In securing best value, the Authority and the chief constable must maintain an appropriate balance among—
> (a) the quality of the carrying out of functions,
> (b) the cost of carrying out functions,
> (c) the cost to persons of any service provided for them on a wholly or partly rechargeable basis by the Authority or, as the case may be, under arrangements made by the chief constable.

[10] section 17(b)

(4) In maintaining that balance, the Authority and the chief constable must have regard to—

(a) efficiency,

(b) effectiveness,

(c) economy, and

(d) the need to meet the equal opportunity requirements.

(5) The Authority and the chief constable must carry out their duties under this section in a way which contributes to the achievement of sustainable development…"

85. The Auditor General is appointed by the Crown, on the recommendation of the Scottish Parliament. The independent post was created under the Scotland Act 1998 to help ensure that public money is spent properly, efficiently, and effectively.

86. The Scottish Ministers are subject to the scrutiny of Audit Scotland. The Chief Constable is also subject to that scrutiny and would not be fulfilling her obligations to the public in terms of use of public money if she did not draw this factor to the attention of the Scottish Ministers.

87. There are very considerable concerns about the use of time to date and the costs to the Police Scotland Budget. All resourcing for public services is under pressure and there are proposed cuts to public services. Police Scotland's budget is not infinite. In that context, the assessed total financial cost to Police Scotland in consequence of its engagement with the Inquiry to date is £22.2 million with the costs currently estimated to exceed £25million by the end of the financial year. That places a significant additional pressure upon an already heavily strained budget and compromises the ability of Police Scotland to meet the expectations of the Scottish Government and the public, particularly as regards sections 32 and 33 of the 2012 Act. This is not in the public interest.

88. In his correspondence, the Chair predicts a process which, whilst uncertain in terms of length, will clearly be of at least a year from the date of the extension, if granted. That

date, if the grant is made, may be a considerable time from the date of your decision if there is judicial review procedure in the meantime and appeal processes.

89. This brings to focus the point the Chair makes regarding the profound effect on the Inquiry regarding the retention of skilled and knowledgeable teams. This point is also acutely relevant to the position of the Chief Constable. Police Scotland has invested considerable time and resource in the teams both within Police Scotland and external to Police Scotland. To my own knowledge as an in-house solicitor first for Strathclyde Police and then for Police Scotland of more than 30 years' experience, it is quite unparalleled. Police Scotland finances the legal teams of all the other 'police' Core Participants. It is unreasonable to expect that these teams will remain intact for a further lengthy period. The Operation Tarn team for the learning from the Inquiry has already been reconfigured in line with the previous end of the Inquiry date and the Superintendent in charge of the team will retire in March this year. It takes time and financial resources to have individuals build up the depth of knowledge required to engage responsibly with an inquiry of this nature. Due to the length of the Inquiry to date, this process has already taken place in respect of key members of teams at various times. The process is very likely to be required for more personnel going forward if the ToR extension is granted.

90. Questions of proportionality inevitably arise. There is currently no budgetary provision for any further extension of the Inquiry. Police Scotland is expected to function with a budget approved by the Scottish Government which is already stretched in terms of providing a policing service to all communities.

91. There is a strong public interest in the maintenance of policing in Scotland in compliance with the policing principles in section 32 of the Police and Fire Reform (Scotland) Act 2012. The Chief Constable is subject to an ongoing obligation (per section 17(2)(e) of that Act) to secure continuous improvement in the policing of Scotland.

92. That factor is something that must, respectfully, be given considerable weight when determining whether to accede to the request for an extension of the ToR.

CONSEQUENCES OF EXTENDING THE ToR

93. The extension would be unlawful. In addition, interference with the constitutional position will have consequences for policing.

94. It will be a matter for other Core Participants to address matters specific to them. It is the position of the Chief Constable that the extension of the ToR will also have the following consequences for this Inquiry, none of which are in the public interest:

1. There will be a chilling effect for engagement in this Inquiry going forward.
2. There will be inevitable (and possibly very lengthy) delay.
3. There will be further legal processes before the Inquiry can proceed with any extended ToR given the various issues and procedural unfairness.
4. The extent of any such (expanded) evidence from the Crown – or, perhaps, reading of the evidence from the Crown to date – would impact materially on all or most of the other evidence which has been laid before the Inquiry.
5. There are very considerable, **potentially incurable**, issues of procedural fairness engaged which would call into question the continuation of the Inquiry in its current form.
6. Any plan or intention to materially expand the Inquiry's ToR as is now surfaced ought to have been raised at the outset, once the Inquiry had ingathered all of the documentary evidence. The matter might then have been more fully explored by all concerned and – critically, in the event that the ToR were changed into those now being suggested – would have enabled evidence to be elicited from relevant witnesses.
7. The examination of the VRR will be a whole chapter with new evidence from those who were involved in the review; one which would only commence after a delay of 5 years from that review

with the attendant evidential difficulties that arise.

8. Further evidence will be required, further witness statements taken, witnesses recalled, existing evidence reviewed again, and submissions redrafted, all at considerable cost.
9. In respect of submissions, Core Participants have been compelled to adhere to the Inquiry's current deadline for closing submissions to date. Those costs will inevitably be wasted costs.

THE DECISION MAKER

95. The Deputy First Minister will no doubt be careful to bear in mind that it is she who is the decision maker. It is of note that she intends to consult the Chair before making her decision. Whilst there is a statutory provision to consult the Chair (see section 5(4) of the Inquiries Act 2005) the process has now afforded all Core Participants status as consultees. The judicial review process has exposed the very real concerns about transparency. The Chair has been involved in meetings with the families regarding the extension but not with any other Core Participant. The concerns in this regard have now been articulated in a letter written on behalf of the Scottish Police Federation and representatives of most of the Core Participant officers.[11]

96. Justice must be seen to be done in an open and transparent matter. The Chair must not be elevated to the position of co-decision maker.

CONCLUSION

97. It is constitutionally incompetent to extend the ToR in the manner proposed.

98. If it is necessary to go further, then the Deputy First Minister must have regard to the provisions of section 5(3) and be satisfied that the public interest requires the extension.

[11] Letter dated 6 February 2025 from Professor Peter Watson, Solicitor Advocate, addressed to the Chair.

99. The effects of the extension of the ToR which are contrary to the public interest have been articulated in these submissions. These adverse effects mean that rather than the public interest requiring such an extension, it would be against the public interest to make the extension. A fair, balanced, and reasoned conclusion is that the requirements of section 5(3) have not been met.

100. If, contrary to the submission above, the Deputy First Minister considers that she requires to consider matters further as regards the competing interests at stake, she must weigh all matters carefully in order to reach a sound conclusion. Having regard to all of the factors above, it is submitted that the balance weighs heavily in favour of rejecting the extension to the ToR.

101. It is submitted that the factors in this submission are strong factors in favour of the ToR remaining as they were drafted and published in 2020 and acted upon throughout by all concerned. A decision to do otherwise than leave the ToR on the basis upon which the Inquiry has been conducted in its entirety would be regarded in law as an irrational decision.

102. The Chief Constable accordingly invites the Deputy First Minister to reject the application.

103. In making this submission, the Chief Constable has thought carefully about the rights and interests of the families. The Chief Constable is considerably reassured by the fact that in terms of Article 2, the rights of the families are already being met by the Inquiry fulfilling its current ToR within its existing remit as properly understood.

104. The Solicitor General has provided reassurance that matters not within the remit of the Inquiry will more appropriately be addressed by the Crown. [12]

[12] Note for the Deputy First Minister 131224, paragraph 33.

105. The core purpose of the Inquiry should be fulfilled by enabling the Chair to finalise the timetable for submissions and permitting him to consider and publish his decision.

106. In the public interests of certainty and finality, the Inquiry must be permitted to end. That is what the Chief Constable invites the Deputy First Minister to do.

[redacted]
Chief Legal Officer
Police Scotland
7th February 2025

INVENTORY OF ITEMS

Referred to in

SUBMISSIONS TO THE DEPUTY FIRST MINISTER, KATE FORBES MSP

on behalf of the Chief Constable, Police Scotland

in relation to

THE CONSIDERATION OF THE EXTENSION OF THE TERMS OF REFERENCE OF THE SHEKU BAYOH PUBLIC INQUIRY

1. Letter, from Senior Solicitor, Police Scotland, dated 1st November 2024 to Solicitor to the Inquiry.
2. Letter, from Chief Legal Officer, Police Scotland, dated 9th December 2024 to the Deputy First Minister.
3. Submissions (on behalf of the Chief Constable) dated 30th October 2024 to the Deputy First Minister.
4. Note dated 13th December, from the Solicitor General for the Deputy First Minister.
5. Letter from Mr. Anwar, Solicitor, dated 4th September 2024, to the Deputy First Minister.
6. Letter, from Professor Peter Watson, Solicitor Advocate, to the Chair.

Date: 01 November 2024

Your Ref:

Our Ref: LSE19159M/AN/BFM

Sadif Ashraf
Solicitor to Sheku Bayoh Public Inquiry

By email only:
[redacted]

POLICE SCOTLAND
Keeping people safe
POILEAS ALBA

Legal Services Department
Police Scotland
[redacted]

E-mail:
[redacted]

Dear Ms Ashraf

TERMS OF REFERENCE
INVITATION BY THE CHAIR FOR SUBMISSIONS

With reference to the Note by the Chair dated 25 October 2024 requesting submissions by 01 November 2024, I am instructed to respond on behalf of the Chief Constable.

The Deputy First Minister had already instituted a formal consultation process with Core Participants to inform her decision as to whether or not to extend the terms of reference ('TOR') at this late stage. In terms of the Inquiries Act 2005 ('the 2005 Act'), she is the decision maker.

The Chief Constable, through her legal representatives, has presented her submissions within that process in response to the Deputy First Minister's invitation to the Chief Constable dated 15 October 2024.

The Chair has been consulted by the Deputy First Minister, as is required in accordance with the 2005 Act. This was notified to the Chief Constable in your letter dated 06 September 2024. It is noted that the Chair expressed his views to the Deputy First Minister at a meeting on 05 September 2024 prior to any consultation with the Core Participants.

In response, Deputy Chief Constable Alan Speirs required to write to the Deputy First Minister to explain about the lack of consultation.

In his Note, the Chair, who is a consultee in this process, now invites the views of the Core Participants to assist with him expressing his own further views which he intends to make the Deputy First Minister, on the request to extend the TOR.

The Chief Constable has concerns about this process. It may be perceived as blurring the lines as to with whom the decision-making power under the 2005 Act lies, namely, the Deputy First Minister as opposed to the Chair.

The Chair will no doubt receive differing views and perspectives. The extent to which he proposes to allow these to inform his response to the Deputy First Minister is unclear. Any distillation or analysis of the submissions by him, will inevitably traverse the line to become a determination of the merits or otherwise of those submissions. This process introduces another level of decision making and any distillation or analysis of the submissions made by him may be perceived as a delegation of some part of the decision-making process to the Chair.

The Chief Constable cannot engage with and support such a process which could be open to challenge by Judicial Review. She has made full submissions to the Deputy First Minister in the Scottish Government consultation process.

We note that the Solicitor General, yesterday, advised the Chair that she will be unable to respond to the invitation made in his Note until the 15 November 2024. She intends to address the very significant points in relation to both the factual and legal basis for the Chair's provisional view regarding the extension of the TOR. This includes the important constitutional issues relating to the independence of the Lord Advocate as head of the systems of prosecution and investigation of deaths in Scotland.

The Chair is already in possession of applications from Core Participants, including the Chief Constable, in respect of the suspension of the Timetable for closing submissions.

The Chief Constable's application does not contain reference to the Solicitor General's position in relation to the date for her response regarding the TOR which is after the draft submissions and proposed exchange dates, namely 07 and 11 November 2024, respectively. The Chair is requested to take this into account when considering the Chief Constable's application for suspension of the Timetable.

Yours sincerely

[redacted]

[redacted]
Senior Solicitor
Legal Services Department

DATE: 9th December 2024

Your Ref:

Our Ref:

Kate Forbes MSP
Deputy First Minister, and Cabinet Secretary for Economy and Gaelic
Scottish Government

By email only

Legal Services Department
Police Scotland, [redacted]

Tel: [redacted]
Fax: [redacted]

E-mail: [redacted]

Dear Deputy First Minister

SHEKU BAYOH PUBLIC INQUIRY – TERMS OF REFERENCE ('ToR')

I refer to the above and to previous correspondence. I refer, particularly, to my Submissions to you of 30th October 2024, my email to your Office of 4th November (enclosing copy letter, dated the 1st, addressed to the Solicitor to the Inquiry), the letter to you from the Chair of the Inquiry in the same connection (which was shared among Core Participants' legal teams on Monday, 18th November 2024), my letter to you of 20th November 2024 and your letter to me dated 29th November 2024.

You invite any further submissions on this matter by, today, 9th December 2024. I note that the families have declined to share their (originating) application to you and rationale for the extension with other Core Participants. I also note that it appears they have not been shared with the Chair of the Inquiry.

In the meantime, there has been publicity of the fact that the Chair met with the families of Mr Bayoh on 5th December 2024 on this matter. It appears, from media reporting and the media release forthcoming from their solicitor, that at least part of the meeting said to have taken place on the 5th included discussion (to whatever extent) bearing upon the question currently before you of the ToR being extended or not. At the time of writing, I am not aware of whether there is to be a report of this meeting shared with you or indeed the Core Participants. Respectfully, I am bound to observe that that does not strike me as entirely satisfactory – and certainly not in the context of an Inquiry whose fundamental purpose is intended to be the rigorous and public exploration of matters.

The context of any further submissions I can make is therefore in the absence of any of the Core Participants having had sight of the representations made to you on behalf of the families. It is difficult to respond fully. For example, it is not clear whether they still seek only an extension to include review of the prosecutorial decision and not the VRR and, if so, the rationale for that approach.

I appreciate that the inability to share the application and grounds with all of the other Core Participants also places you, as decision maker, in a somewhat invidious position. That is to say, it seems to me really rather difficult for you to place a lot of weight upon what might be set out in the detail of those representations, because the consultation exercise which you have been able to conduct is now necessarily limited and compromised (and in consequence of actions beyond your control).

Response to the Chair's current view in the undated letter

In addition to the points made in my letter to you of 20th November 2024 regarding the Chair's reference to the further evidence from Mr Graves, I make the following additional submissions.

Cost, delay, and impact

In providing his views to you, the Chair, did not receive submissions on behalf of the Chief Constable because these were directed to you as the decision maker. In that regard, please note what was set out in our letter to the Solicitor to the Inquiry, dated 1st November 2024, explaining why the Chief Constable did not engage with the Chair's process. Therefore, there should be no inference drawn from the fact that the Chair omits any reference to the cost and impact of delay on Police Scotland. His points are restricted to the impact on the Inquiry.

I have already articulated in some detail in paragraphs [48] to [51] of my Submissions dated 30th October 2024, the costs impact on Police Scotland and the fact that Police Scotland is bearing the cost for the majority of Core Participants. The Chair predicts a process which, whilst uncertain in terms of length, will clearly be of at least a year from the date of the extension, if granted. That date, if the grant is made, may be a considerable time from the date of your decision if there is judicial review procedure in the meantime and appeal processes.

This brings to focus the point the Chair makes regarding the profound effect on the Inquiry regarding the retention of skilled and knowledgeable teams. This point is also acutely relevant to the position of the Chief Constable. Police Scotland has invested considerable time and resource in the teams both within Police Scotland and external to Police Scotland. To my own knowledge as an in-house solicitor first for Strathclyde Police and then for Police Scotland of very nearly 30 years' experience, it is quite unparalleled. Police Scotland finances the legal teams of all the other 'police' Core Participants. It is unreasonable to expect that these teams will remain intact for a further lengthy period. The Operation Tarn team for the learning from the Inquiry has already been reconfigured in line with the previous end of the Inquiry date and the Chief Superintendent in charge of the team will retire in February next year. It takes time and financial resources to have individuals build up the depth of knowledge required to engage responsibly with an inquiry of this nature. Due to the length of the Inquiry to date, this process has already taken place in respect of key members of teams at various

times. The process is very likely to be required for more personnel going forward if the ToR extension is granted.

Public Interest

In his conclusion, the Chair identifies only three competing public interests. He omits the public interest in the maintenance of policing in Scotland in compliance with the policing principles in section 32 of the Police and Fire Reform (Scotland) Act 2012. The Chief Constable is subject to an ongoing obligation (per section 17(2)(e) of that Act) to secure continuous improvement in the policing of Scotland. The grant of the extension of the ToR would impact on the Chief Constable's ability to fulfil her obligations for the reasons articulated in my letters and Submissions.

I would be grateful if this letter could be read together with my previous correspondence and Submissions.

I shall be pleased to clarify or otherwise develop any aspect of the foregoing as you may see fit. Otherwise, I await hearing from you at your earliest convenience.

Yours sincerely,

[redacted]

[redacted]
Solicitor,
Chief Legal Officer

THE SCOTTISH GOVERNMENT

SUBMISSIONS TO THE DEPUTY FIRST MINISTER, KATE FORBES MSP

on behalf of the Chief Constable, Police Scotland

RE:

THE CONSIDERATION OF THE EXTENSION OF THE TERMS OF REFERENCE OF THE SHEKU BAYOH PUBLIC INQUIRY

Introduction

1. The families of Mr. Bayoh have made a formal request to the Deputy First Minister, Kate Forbes, MSP, ('the Deputy First Minister') to change the Terms of Reference ('TOR') of the Sheku Bayoh Inquiry ('the Inquiry') to include the prosecutorial decision of the Crown Office and Procurator Fiscal Service ('COPFS').

2. The Chief Constable, Jo Farrell ('the Chief Constable') is a Core Participant in the Inquiry.

3. The Inquiry was announced in 2019. The TOR were announced on 21 May 2020 and the Inquiry began in November 2020. It has been ongoing since that date chaired by the Right Honourable Lord Bracadale ('the Chair'). The hearing of evidence is concluded with the exception of any further evidence to be led (witnesses) or otherwise considered (documents) in the event that the TOR are extended in the terms now under consideration.

4. By letter dated 14 October 2024, the Deputy First Minister, invited the legal representatives of the Chief Constable to provide written representations on behalf of the Chief Constable on the Inquiry's TOR and whether they should be amended.

5. The Chief Constable is unaware of the date of the request from the families to extend the TOR but understands that it was made earlier this year. The Chief Constable first received notice of the request by letter of 6 September 2024 from the Solicitor to the Inquiry, Ms. Sadif Ashraf. The letter informed the Core Participants of the occurrence of a meeting between the Deputy First Minister and the Chair, which had taken place on 5 September 2024 to discuss the request.

6. At that point there had been no consultation with those representing the Chief Constable or, as it appears from that communication, with any other legal representatives other than those of the families.

7. Whilst not yet having sight of request, it is understood that that the families of Mr. Bayoh requested the Deputy First Minister to extend the TOR to include consideration of the decision by the Lord Advocate not to prosecute.

8. On 1 October 2024, Deputy Chief Constable Alan Speirs, the Police Scotland Strategic lead for matters relating to the Inquiry wrote to the Deputy First Minister on behalf of the Chief Constable expressing some concerns. These submissions confirm and expand upon those. (A copy of the said letter is produced as an Appendix to these submissions.)

9. The Chief Constable shares, entirely, the families' wholly understandable desire to get to the truth of what happened to their loved one, Sheku Bayoh, on 3 May 2015 in Kirkcaldy. This was specifically addressed on 11 May 2022 in the opening statement on behalf of the then Chief Constable at the start of the oral hearings of the Inquiry. The families are at the heart of the Inquiry and that has been recognised from the outset.

10. The Chief Constable's very firm commitment to engage fully and positively with the Inquiry, and in assistance to the Chair to discharge the TOR, remains undiminished. Very considerable resources have been applied by Police Scotland in fulfilling that commitment; a truly vast amount of documentary

material (both contemporaneous as well as a large number of lengthy and extremely detailed Position Statements) have been made available to the Inquiry. Witnesses from Police Scotland have spent significant amounts of time providing statements to the Inquiry and/or giving evidence, which has abstracted them from other duties. Throughout the engagement, the overarching imperatives have remained candour and transparency.

11. The Chief Constable is aware of the depth of feeling on the part of the families for the extension of the TOR. However, the Chief Constable requires to address matters given that what seems to be being proposed by the Chair now, as set out in the letter from Ms. Ashraf. This comes almost at the very end of the Inquiry's proceedings, after all the evidence has been heard and on the eve of submissions. The Chief Constable is concerned that such a course of action will not further the Article 2 aims of the Inquiry and instead will simply cause yet further delay. There are also very significant matters of procedural fairness given the conduct of the Inquiry to date.

12. These submissions will address matters in the following order:

    1. The legal context
    2. History and Process to date
    3. Conduct of the Core Participants in furtherance of the existing TOR

       Undertakings letter

       Police Scotland and Training 2015
    4. Review of the TOR
    5. Restriction of any extension of the tor to the prosecutorial decision
    6. Welfare of officers
    7. Costs and efficiency
    8. Competency of the extension of TOR
    9. Consequences of the extension of the TOR
    10. Conclusion

1. THE LEGAL CONTEXT

13. When a death has taken place in police custody or following police contact, the State has what is known as the Article 2[1] procedural obligation to have an independent investigation into the circumstances, correct mistakes, identify good practices and learn lessons for the future so as to prevent recurrence of similar incidents. It must be reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to the appropriate extent.

14. In this case there has been a PIRC investigation, a Crown investigation, and a review process of the Crown investigation. The next stage would usually be a Fatal Accident Inquiry to review processes not covered by the criminal investigation.

15. In order to review the wider issues in this case, the then Lord Advocate, James Wolffe, K.C. considered that a Public Inquiry was the proper way forward.[2]

16. The purpose of this Inquiry is to fulfil the Scottish Government's procedural obligation following from Article 2 of the European Convention on Human Rights ('Article 2').

17. The power to set up a Public Inquiry derives from section 1 of the Inquiries Act 2005 ('the 2005 Act') as follows:

> "(1) A Minister may cause an inquiry to be held under this Act in relation to a case where it appears to him that—
> (a)particular events have caused, or are capable of causing, public concern, or
> (b)there is public concern that particular events may have occurred.
> (2) In this Act "Minister" means—

[1] European Convention on Human Rights
[2] Inquiry Statement SBPI-00529 [24] available on the Inquiry website https://www.shekubayohinquiry.scot

(a)a United Kingdom Minister;

(b)the Scottish Ministers…"

18. There are specific provisions for the setting up of the Inquiry and the TOR. The 2005 Act provides:

"5. Setting-up date and terms of reference

(1) In the instrument under section 4 appointing the chairman, or by a notice given to him within a reasonable time afterwards, the Minister must—

(a)specify the date that is to be the setting-up date for the purposes of this Act; and(b)before that date—

(i)set out the terms of reference of the inquiry;"

19. The aim of the Inquiry is to help to restore public confidence in systems or services by investigating the facts and making recommendations to prevent recurrence. It is no part of the Inquiry's function to conduct a prosecution or to establish any person's civil or criminal liability. This is very clear from section 2 of the 2005 Act and the accompanying explanatory notes. The Inquiry is not to be inhibited by the likelihood of liability being inferred from the facts it determines or the recommendations it makes:

"(1) An inquiry panel is not to rule on, and has no power to determine, any person's civil or criminal liability.

(2) But an inquiry panel is not to be inhibited in the discharge of its functions by any likelihood of liability being inferred from facts that it determines or recommendations that it makes".

20. Compliance with Article 2 will require the Chair to establish facts and review the processes as articulated within the TOR. It is not for the Chair to substitute his own views as to the outcome of such processes.

21. There is no right to obtain a prosecution or conviction or indeed a particular sentence and the fact that an investigation ends without such outcomes, or with

only limited outcomes, is not indicative of any failings as such. The requirement is to review whether or not there has been careful scrutiny such that the deterrent effect of the judicial system in place and the significance of the role it is required to play in preventing violations of the right to life are not undermined. [3]

2. HISTORY AND PROCESS TO DATE

22. In November 2019 following the conclusion of the Crown investigations, the then Lord Advocate, James Wolffe, K.C confirmed a decision not to charge Police Scotland or the five officers involved in the restraint of Mr. Bayoh with criminal, corporate or Health & Safety offences.

23. On 12 November 2019, the families had a meeting with the then Cabinet Secretary for Justice, Humza Yousaf, MSP, following which the intention to hold a Public Inquiry was announced. The TOR for the Inquiry were set in 2020 and announced by him on 21 May 2020. Mr. Yousaf was, at that time, the Minister responsible for setting up the Inquiry under the 2005 Act.

24. The TOR bear repeating:

> "The aim of this Inquiry is twofold: firstly, the Inquiry will establish the circumstances surrounding the death of Sheku Bayoh in police custody on 3 May 2015 and make recommendations to prevent deaths in similar circumstances, as would have been required under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. Secondly, the Inquiry will assess and establish aspects of the case that could not be captured, or fully captured through the FAI process, namely (a) the post incident management process and subsequent investigation and make any recommendations for the future in relation to these; and (b) the extent (if any) to which the events leading up to and following Mr. Bayoh's death, in particular the actions of the

[3] *Giuliani and Gaggio v. Italy* [2011] ECHR 513, [2011] ECHR 24358/02, (2012) 54 EHRR 10 paragraphs 298-306

officers involved, were affected by his actual or perceived race and to make recommendations to address any findings in that regard.

The remit of the Inquiry is accordingly:

- to establish the circumstances of the death of Sheku Bayoh, including the cause or causes of the death, any precautions which could reasonably have been taken and, had they been taken might realistically have resulted in the death being avoided, any defects in any operating models, procedures and training or other system of working which contributed to the death and any other factors which are relevant to the circumstances of the death;
- to make recommendations, if any, covering the taking of reasonable precautions, improvements to or introduction of any operating models, procedures and training, or other system of working, and the taking of any other steps which might realistically prevent other deaths in similar circumstances;
- to examine the post-incident management process and the investigation up to, but not including, the making by the Lord Advocate of the prosecutorial decision communicated to the family of Sheku Bayoh on 3 October 2018 (and the Victims' Right to Review process that was undertaken by the Crown Counsel in 2019), including: (i) the effectiveness of procedures for gathering and analysing information, (ii) the securing and preserving of evidence, (iii) the roles and responsibilities of those involved, (iv) liaison with the family of the deceased and (v) compliance with any relevant Convention rights; and make recommendations, if any, for the future in respect of these matters;
- to establish the extent (if any) to which the events leading up to and following Mr. Bayoh's death, in particular the actions of the officers involved, were affected by his actual or perceived race and to make recommendations to address any findings in that regard; and

- to report to the Scottish Ministers on the above matters and to make recommendations, as soon as reasonably practicable. "

25. The TOR explicitly excluded from consideration at the Inquiry: "*… the making by the Lord Advocate of the prosecutorial decision communicated to the family of Sheku Bayoh on 3 October 2018 (and the Victim's Right to Review process that was undertaken by the Crown Counsel in 2019)…*".

26. The TOR were agreed following consultation with the Chair and the families. Other interested parties were the legal representatives of Mr. Bayoh's families, the Lord Advocate, Police Scotland, and the Scottish Police Federation, amongst others. Mr. Yousaf wrote to the then Chief Constable on 21 May 2020, providing a copy of the TOR which he had announced to the Scottish Parliament the same day. Mr. Yousaf also stated to the Chief Constable (*noting an earlier meeting between the two, on 29 January 2020, to discuss the TOR*) that:

> *"As I outlined when we met, my intention was to keep the Terms of Reference focused on the incident but sufficiently broad to allow Lord Bracadale to look at wider issues he considers to be pertinent to the Inquiry. While the final Terms of Reference that I published today do not feature all of the issues raised with me during my discussions, I am confident the scope is broad enough to include consideration of the operational and procedural aspects suggested by different stakeholders"* and *"I recognise that there will be a range of different perspectives on the Terms of Reference, but I believe the Terms of Reference published today are suitably broad to strike a balance and retain the confidence of all parties involved."*

27. In subsequent engagement with the Inquiry, and throughout its progress to date, the Chief Constable has proceeded upon the reasonable expectation that that remained the basis upon which the matter was being conducted. Although the Chief Constable does not, and cannot, know whether (broadly) similar letters were sent by Mr. Yousaf to those other different "stakeholders" to whom he refers – including the Chair – it seems reasonable to surmise that he did. That being so,

they, too, would have been left with the same understanding from the very outset of the Inquiry as to the basis upon which it was being conducted and the quite deliberate limit set on its TOR. The Chief Constable is, similarly, unaware of any reservations having been expressed or challenges raised to the setting of said TOR – beyond, plainly, those submitted to the Deputy First Minister at some earlier point this year on behalf of the families.

28. The engagement with the Lord Advocate is particularly important given that the TOR, as agreed, is consistent with the Crown's well-established position that decisions to prosecute (or not) were not matters upon which it could be required to be subjected to scrutiny.

29. The Chair was recorded as having said, on publication of the TOR, as follows:

> "*I believe that [the Terms] will enable my inquiry to conduct a thorough examination of the circumstances surrounding the death of Mr. Bayoh and the wider issues arising.*".

3. CONDUCT OF THE CORE PARTICIPANTS IN FURTHERANCE OF THE EXISTING TOR

30. The Chief Constable's approach to, and full engagement with, the Inquiry to date has been in accordance with the TOR as they were set four years ago.

31. The Chief Constable has proceeded with absolute candour in the absence of information about the consideration process as regards any potential criminal prosecution of the office of Chief Constable. This was the proper approach **having regard to the TOR**. Information about those considerations by the Crown has only been disclosed in the more recent material from the Inquiry.

32. Since early 2021, the Inquiry has been provided with documentation from Police Scotland, the PIRC and COPFS. Core Participants were not aware of what section 21 notices were served on other organisations or their responses until disclosure much later by the Inquiry. It is clear from what is now being disclosed back in

recent days that the Inquiry has been in possession of very detailed material about the Crown position in terms of their investigation from the outset.

33. There have been 122 days of evidence and hearings and 105 witnesses who gave oral evidence (several more than once). The volume of documentation is unprecedented. In terms of disclosure to the Inquiry from Police Scotland alone these are in excess of 19,000 documents. Disclosures from the Inquiry to date, which is ongoing, number over 3,000 which includes documentation of over 42,500 pages.

34. It is highly concerning in this context that it is not until September 2024 that there is consideration being given to extending the TOR. Police Scotland has conducted its engagement with the Inquiry to date on the basis of the existing TOR.

UNDERTAKINGS LETTER

35. The Chief Constable is aware that Mrs. Taylor, QPM, the then Deputy Chief Constable designate under the Police Service of Scotland (Conduct) 2014 Regulations responded to the request for undertakings from Police Scotland regarding not taking misconduct proceedings in a manner which made clear her expectations of officers in engaging with the Inquiry. In her letter of 25 March 2022, Mrs. Taylor stated that Police Officers should give full and frank testimony to the Inquiry in accordance with her expectations of them as police constables. These statements were made, properly, but in the context of the TOR. Each officer responded by being wholly co-operative with the Inquiry in providing their evidence. Whilst their engagement would no doubt have been subject to legal advice, and is a matter for others, the Chief Constable does not underestimate the significance that would have been placed on that letter from Mrs. Taylor. Had the TOR not been in the terms which it was, that letter would have been expressed differently.

POLICE SCOTLAND TRAINING IN 2015

36. The Chief Constable is particularly concerned about how the Inquiry has approached this crucial chapter. It is central to understanding the response of officers on the day. After two years, the Inquiry produced a report on the adequacy of the Police Scotland training at the material time, on 5 September 2024 but dated 19 August 2024, from the original Crown expert Martin Graves. The Inquiry was notified on behalf of the Chief Constable of the serious issues and procedural unfairness arising on 11 September 2024 as per the attached letter and again on 18 September 2024. No substantive response was received. The Inquiry decided to lead him on the 2nd 3rd and 4th of October 2024 and encouraged him to develop matters further without notice and to apply an undefined or unclear legal test to an incomplete selection of materials. The absence of fair notice meant that the Chief Constable was unable to respond properly at that time. Had the TOR been expressed differently, as is now being requested, the Chief Constable would have taken the necessary steps to prevent the calling of Martin Graves at that time and, ultimately, if necessary, have sought Judicial Review of the procedural unfairness in calling him without regard to the fairness of doing so. From the outset, the Inquiry legal team has advised the Chief Constable that such issues regarding training should all be dealt with in submissions and, having regard to the existing TOR, the Chief Constable was content to proceed in that way. That will not be sufficient, if the TOR are expanded and review of that approach will be necessary.

4. REVIEW OF THE TOR

37. There is a power to amend the TOR in a Public Inquiry:

> "5 (3) The Minister may at any time after setting out the terms of reference under this section amend them if he considers that the public interest so requires.
>
> (4) Before setting out or amending the terms of reference the Minister must consult the person he proposes to appoint, or has appointed, as chairman.

6(3) (3) Where the terms of reference of an inquiry are amended under section 5(3), the Minister must, as soon as is reasonably practicable, make a statement to the relevant Parliament or Assembly setting out the amended terms of reference."

38. The Chief Constable agrees with the Deputy First Minister that '*any request to amend the Terms of Reference (ToR) for a Public Inquiry requires careful and thoughtful consideration, and it is essential that this is done through a fair and robust process.*

39. The Deputy First Minister is the decision maker in this process and will require to come to her own independent view as to the merits of the request based on consideration of all the relevant factors and the submissions before her.

5. RESTRICTION OF ANY EXTENSION OF THE TOR TO THE PROSECUTORIAL DECISION

40. Since 1 July 2015 in Scotland there has been a procedure instituted whereby a victim [4] of a crime has the right to review a prosecutorial decision taken by COPFS.[5] This is called the Victims 'Right of Review ('VRR'). The VRR process gives victims the opportunity to ask how the COPFS came to the decision and to submit an application for review of that decision. The Reviewer of the decision is a lawyer who was not involved in the original decision making. If a review is unsuccessful, the applicant can submit a complaint about the handling of the review. The Chief Constable, whilst aware that the families lodged a VRR, is unaware of whether or not there was also any complaint about the handling of the VRR.

[4] Term used as per the legislation.
[5] Victims and Witnesses (Scotland) Act 2014 in furtherance of DIRECTIVE 2012/29/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 25 October 2012 establishing minimum standards on the rights, support, and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA

41. At the time of drafting these submissions, the request from the family has not been disclosed. However, it is inferred from the summary account of the Chair's meeting with the Deputy First Minister set out in Ms. Ashraf's letter of 6 September 2024 that it is to extend the TOR to include only the consideration of the decision by the Lord Advocate not to prosecute and does not appear to include the VRR.

42. It is simply inconceivable that there could be a review of any decision without reviewing subsequent procedure which is designed to review that decision and by which any perceived defects could be rectified. The very fact of the existence of the VRR means that there has been a mechanism whereby the rights of the families have been protected in terms of their ability to review the prosecutorial decision.

43. If there is any proposal that the TOR might be extended to permit only consideration of the first decision and not the review, as appears to be in the Chair's contemplation in the report of the meeting of 5 September 2024 from Miss Ashraf, this lacks rationality. No reasonable decision maker could examine a decision but not the subsequent review of that decision. Each decision would warrant examination and consideration.

6. WELFARE OF OFFICERS

44. The Chief Constable has a clear welfare duty towards all the Core Participants who are members of Police Scotland. In this Inquiry those officers are separately represented, and submissions will be no doubt made on their behalf. However, it is appropriate that this aspect is addressed by her in her role as Chief Constable.

45. In making these submissions there is no intention to equate what the officers and their families have suffered with the death of a loved one or the impact of the processes on the families of Mr. Bayoh.

46. However, this process has been ongoing for nearly ten years. For police officers involved this has been held over them for that period. It has resulted in the

diagnosis of mental health conditions for some and has been career ending for others. This is a grave concern for the Chief Constable. Consideration of certain matters arising in consequence of the death of Mr. Bayoh and – more pertinently – because of the institution of the Inquiry remain in limbo. That includes Complaints Against the Police raised on behalf of the families (the full progress of which, and dependent on outcome, might yet engage the PIRC once more). It also includes decisions under the aforementioned Conduct Regulations as bearing upon the actions of any of the officers involved in the incident of 3 May 2015, and its aftermath, who continue to serve with Police Scotland. This will be particularly acute for the officers if they are to be subject to protracted proceedings after use of force in the course of their duties. Given the rate of progress at the Inquiry to date, when one begins to consider the consequences of an extension to the TOR in the terms now under consideration (and leaving aside any additional delay that may be occasioned in the event of judicial review challenges being raised – which now should be considered as a more than lively possibility) it is not unreasonable to contemplate the extended timescales for completion of the Inquiry being measured in the many months, and perhaps even longer than that.

47. These delays in resolution are unacceptable for all involved. It is reasonable to infer that interference with the TOR at this late stage will remove the certainty and understanding of the process in which they were all engaged. This will likely cause further issues for those members. It means that reassurance that other response officers are not exposing themselves to similar protracted processes in the exercise of their duty cannot be given.

7. COSTS AND EFFICIENCY

48. The Auditor General is appointed by the Crown, on the recommendation of the Scottish Parliament. The independent post was created under the Scotland Act 1998 to help ensure that public money is spent properly, efficiently, and effectively.

49. The Chief Constable has statutory obligations under the Police and Fire Reform (Scotland) Act 2012 ('the 2012 Act') including responsibility for the allocation of deployment of resources received from the Scottish Police Authority.[6] It is the duty of the Chief Constable to secure best value in terms of section 37 as follows :

> "(2) It is the duty of the chief constable to make arrangements which secure best value for the Police Service (that is, a continuous improvement in the carrying out of police functions).
>
> (3) In securing best value, the Authority and the chief constable must maintain an appropriate balance among—
>
> (a) the quality of the carrying out of functions,
>
> (b) the cost of carrying out functions,
>
> (c) the cost to persons of any service provided for them on a wholly or partly rechargeable basis by the Authority or, as the case may be, under arrangements made by the chief constable.
>
> (4) In maintaining that balance, the Authority and the chief constable must have regard to—
>
> (a) efficiency,
>
> (b) effectiveness,
>
> (c) economy, and
>
> (d) the need to meet the equal opportunity requirements.
>
> (5) The Authority and the chief constable must carry out their duties under this section in a way which contributes to the achievement of sustainable development…"

50. The Scottish Ministers are subject to the scrutiny of Audit Scotland. The Chief Constable is also subject to that scrutiny and would not be fulfilling her obligations to the public in terms of use of public money, if she did not draw this factor to the attention of the Scottish Ministers.

[6] section 17(b)

51. There are very considerable concerns about the use of time to date and the costs to the Police Scotland Budget. All resourcing for public services is under pressure and there are proposed cuts to public services. In that context, the assessed total financial cost to Police Scotland in consequence of its engagement with the Inquiry is £22.2 million with the costs currently to exceed £25million by the end of the financial year. That places a significant additional pressure upon an already heavily strained budget and compromises the ability of Police Scotland to meet the expectations of the Scottish Government and the public, particularly as regards sections 32 and 33 of the 2012 Act. There is currently no budgetary provision for any further extension of the Inquiry.

8. COMPETENCY OF THE EXTENSION SOUGHT

52. The constitutional position of the Lord Advocate in respect of decisions to prosecute (or not) is acutely engaged in this decision-making process regarding the extension of the TOR. The review of the TOR will now go behind the rationale and agreement reached in the original framing of the TOR based on that longstanding constitutional position. However, the Chief Constable considers that this is clearly a matter for the Lord Advocate to address and it would not be appropriate for her to encroach upon the remit of the Law Officers.

53. In so far as the remit of the Chief Constable is concerned, this would include consideration of any compromise on the ability of police constables to fulfil their duties in respect of the investigation of crime and reporting to the Lord Advocate. The strong public policy arguments in favour of the police being able to investigate and report matters to the Crown with absolute candour and freedom, and to be protected absolutely against subsequent disclosure, are not in doubt.[7] Transgression of such longstanding and well understood legal principles would undoubtedly occasion harm to the efficient and effective conduct of such policing

[7] See *McKie -v- Western SMT Co. Ltd.* 1952 SC 206 (per L-P Cooper at paragraph[216]), and *Wm. Beggs -v- OSIC and Chief Constable* [2014] CSIH 10 (per Lord Menzies at paragraph [17]).

activity, and be to the general detriment of the justice system and the public whom it serves (and protects).

9. CONSEQUENCES OF ANY EXTENSION OF THE TOR

54. The position about any impact on the administration of justice will be dealt with by the Lord Advocate but the Chief Constable is clear that interference with the constitutional position will have consequences for policing.

55. It will be a matter for other Core Participants to address matters specific to them. It is the position of the Chief Constable that the extension of the TOR will also have the following consequences:

    1. There will be inevitable (and possibly very lengthy) delay.
    2. Any expansion would have to include the VRR which the Chair already seemingly accepts will be an issue in terms of manageability.
    3. There will be further legal processes before the Inquiry can proceed with any extended TOR given the various issues and procedural unfairness.
    4. The extent any such (expanded) evidence from the Crown – or, perhaps, reading of the evidence from the Crown to date – would impact materially on all or most of the other evidence which has been laid before the Inquiry.
    5. There are very considerable, potentially incurable, issues of procedural fairness engaged which would call in to question the continuation of the Inquiry in its current form.
    6. Any plan or intention to materially expand the Inquiry's TOR as is now surfaced ought to have been raised at least a year ago. The matter might then have been more fully explored by all concerned and – critically, in the event that the TOR were changed into those now being suggested – would have enabled evidence to be elicited from the Crown's witnesses, including the former Lord Advocates, who were all yet to be called. There have been various days upon which the Inquiry was intended to hear evidence but which - for a variety of reasons and with various levels

of advance notice being given - were simply cancelled and that there would have been more than enough time in which to achieve that.

7. The examination of the VRR will be a whole chapter with new evidence from those who were involved in the review; one which would only commence after a delay of 5 years from that review with the attendant evidential difficulties that will arise.
8. Further evidence will be required, further witness statements taken, witnesses recalled, existing evidence reviewed again and submissions redrafted, all at considerable cost. In respect of submissions, core participants have been compelled to adhere to the Inquiry's current deadline for closing submissions to date.

10. CONCLUSION

56. The Deputy First Minister has stated her intention to weigh all matters carefully in order to reach a sound conclusion. It is submitted that the factors in this submission are strong factors in favour of the TOR remaining as they were drafted and published in 2020 and acted upon subsequently by all concerned.

57. The rights of the families in terms of Article 2 are being met by the Inquiry fulfilling its current TOR within its remit as properly understood.

[redacted]**, Solicitor**
Chief Legal Officer
Police Scotland .

30 October 2024

APPENDIX

1. Letter of 21 May 2020, from Mr. Yousaf, MSP to the then Chief Constable, Sir Iain Livingstone, QPM
2. Letter of 25 March 2022 from Mrs. Taylor QPM, to the Chair of the Inquiry, the Rt Hon. Lord Bracadale
3. Letter of 11 September 2024 from [redacted], Solicitor Chief Legal Officer, Police Scotland to Ms. Sadif Ashraf, Solicitor to the Inquiry
4. Letter of 1 October 2024, from Deputy Chief Constable, Alan Speirs to Deputy First Minister, Kate Forbes, MSP

Cabinet Secretary for Justice
Humza Yousaf MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: [redacted]
E: [redacted]

Chief Constable Iain Livingstone
Police Scotland
[redacted]

21 May 2020

Chief Constable,

PUBLIC INQUIRY INTO THE DEATH OF SHEKU BAYOH – TERMS OF REFERENCE

Thank you for meeting with me on 29 January 2020 to discuss the Terms of Reference for the Public Inquiry into the circumstances surrounding the death of Sheku Bayoh. Please find enclosed a copy of the final Terms of Reference, which, in line with the Inquiries Act 2005, I announced to the Scottish Parliament today.

As I outlined when we met, my intention was to keep the Terms of Reference focused on the incident but sufficiently broad to allow Lord Bracadale to look at wider issues he considers to be pertinent to the Inquiry. While the final Terms of Reference that I published today do not feature all of the issues raised with me during my discussions, I am confident the scope is broad enough to include consideration of the operational and procedural aspects suggested by different stakeholders.

In line with the phased approach I have taken so far to establish the Public Inquiry - first announcing my intention to hold an Inquiry and then latterly announcing that Lord Bracadale will be Chair - today I am publishing the Terms of Reference and will later announce the formal setting up date. The setting up date is the starting point for the course of the Inquiry and marks the point at which the Chair takes over responsibility for the Inquiry and can start considering evidence.

As I am sure you will appreciate, the current Coronavirus health pandemic has had an impact on our ability to take forward work on the Public Inquiry, while resources are refocused on essential Covid-19 priorities. Progress in certain areas, such as work to identify premises, will be affected by the current restrictions, but I will continue to discuss these matters with Lord Bracadale and will be providing further updates in due course. This will include developments on the appointment of Assessors and confirmation of the setting up date.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

I recognise that there will be a range of different perspectives on the Terms of Reference, but I believe the Terms of Reference published today are suitably broad to strike a balance and retain the confidence of all parties involved.

HUMZA YOUSAF

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

PUBLIC INQUIRY INTO THE DEATH OF SHEKU BAYOH - FINAL TERMS OF REFERENCE

The aim of this Inquiry is twofold: Firstly, the Inquiry will establish the circumstances surrounding the death of Sheku Bayoh in police custody on 3 May 2015 and make recommendations to prevent deaths in similar circumstances, as would have been required under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. Secondly, the Inquiry will assess and establish aspects of the case that could not be captured, or fully captured through the FAI process, namely (a) the post incident management process and subsequent investigation and make any recommendations for the future in relation to these; and (b) the extent (if any) to which the events leading up to and following Mr Bayoh's death, in particular the actions of the officers involved, were affected by his actual or perceived race and to make recommendations to address any findings in that regard. The remit of the Inquiry is accordingly:-

- to establish the circumstances of the death of Sheku Bayoh, including the cause or causes of the death, any precautions which could reasonably have been taken and, had they been taken might realistically have resulted in the death being avoided, any defects in any operating models, procedures and training or other system of working which contributed to the death and any other factors which are relevant to the circumstances of the death;

- to make recommendations, if any, covering the taking of reasonable precautions, improvements to or introduction of any operating models, procedures and training, or other system of working, and the taking of any other steps which might realistically prevent other deaths in similar circumstances;

- to examine the post-incident management process and the investigation up to, but not including, the making by the Lord Advocate of the prosecutorial decision communicated to the family of Sheku Bayoh on 3 October 2018 (and the Victims' Right to Review process that was undertaken by the Crown Counsel in 2019), including: (i) the effectiveness of procedures for gathering and analysing information, (ii) the securing and preserving of evidence, (iii) the roles and responsibilities of those involved, (iv) liaison with the family of the deceased and (v) compliance with any relevant Convention rights; and make recommendations, if any, for the future in respect of these matters;

- to establish the extent (if any) to which the events leading up to and following Mr Bayoh's death, in particular the actions of the officers involved, were affected by his actual or perceived race and to make recommendations to address any findings in that regard; and

- to report to the Scottish Ministers on the above matters and to make recommendations, as soon as reasonably practicable.

Date: 25th March 2022

Our Ref:

POLICE
SCOTLAND
Keeping people safe

POILEAS ALBA
Fiona Taylor QPM
Deputy Chief Constable
Professionalism, Digital and Transformation

Police Scotland Headquarters
Tulliallan Castle
Kincardine
Fife
FK10 4BE

Tel: [redacted]

[redacted]

The Right Hon.
Lord Bracadale
Chair,
The Sheku Bayoh Inquiry

By e-mail only

Dear Sir,

UNDERTAKING FROM THE DEPUTY CHIEF CONSTABLE

I refer to your Ruling, sent under cover of the letter of 1st March 2022 from the Solicitor to the Inquiry (on your behalf), directed to me in my capacity as the Deputy Chief Constable Designate in terms of the Police Service of Scotland (Conduct) Regulations 2014 ('the 2014 Conduct Regulations'), to give an undertaking, that, in any future disciplinary proceedings against an individual serving officer arising out of the events at Hayfield Road on 3 May 2015 and the post-incident management, I will not seek to rely on evidence given to the Inquiry by that officer. I also refer to your Supplementary Ruling, of 21st March, intimated under cover of an email from the Solicitor to the Inquiry, dated the same day.

Your Rulings follow applications made by Sergeant Scott Maxwell, PC Daniel Gibson and PC James McDonough that you request such an undertaking. In response to a request from Senior Counsel to the Inquiry in your initial Ruling you extended the request to include other officers, namely, PC Kayleigh Good, PC Alan Smith, PC Ashley Tomlinson and Chief Superintendent Conrad Trickett. You also included Temporary Assistant Chief Constable Patrick Campbell (but it should be noted that his correct rank is Detective Chief Superintendent). Your Supplementary Ruling followed upon a written application – dated 18th March 2022 – to you made by the solicitors acting for Constable Craig Walker. In that application you were invited to make the same request of me (for an undertaking) as you had made in

your initial Ruling. You have acceded to that application and extended that original request. All these officers are serving officers, albeit Detective Chief Superintendent Patrick Campbell is currently suspended.

The request made of me is contemporaneous with a request made of the Solicitor-General as regards future prosecution, which is, of course, made in the context of the privilege against self-incrimination which exists in respect of potential criminal offences. However, it is a matter of consensus that the privilege against self-incrimination does not apply in disciplinary proceedings. As the Inquiry Chair, you retain the power to compel the officers to provide evidence under the provisions of sections 21(1) and (2) and 35 of the Inquiries Act 2005 and officers of the Police Service of Scotland have a duty of candour to the Inquiry.

The stated reason for the request is that without both these undertakings (i.e. from the Solicitor-General and me) the Inquiry is likely to be seriously impeded in fulfilling its function in relation to the terms of reference in the context of the likelihood of the officers and former officers exercising their right against self-incrimination and not giving full, frank and uninhibited evidence to the Inquiry. As the former only applies in relation to criminal matters, the request from me is in the context of the latter.

I note that it is accepted that the decision as to whether to grant any undertaking, and the terms thereof, is a matter solely within my discretion as Deputy Chief Constable Designate and that I require to weigh the competing public interests. A clear and significant public interest is the maintenance of public confidence in the police. One of the primary purposes of an effective disciplinary regime with accountability is to ensure that public confidence. The Chief Constable and I have a duty in the public interest to maintain discipline to ensure public confidence in policing.

The rights of the bereaved family of Sheku Bayoh are at the centre of the Inquiry. As stated in the submission on behalf of the Chief Constable, their Art.2 rights encompass not only the carrying out of thorough, diligent and comprehensive inquiry, but the duty also requires there to be appropriate provision for disciplinary action. The views of the family require to be considered by me. The family have opposed the seeking of undertakings. The submissions made on their behalf by Miss Mitchell Q.C., founded on the duties of police officers, the declaration made by each officer in terms of the Police and Fire Reform (Scotland) Act 2012, the code of ethics of Police Scotland and the statutory standards of professional behaviour (per the 2014 Conduct Regulations). As I understand your Ruling, these submissions were not persuasive because of the right against self-incrimination, but this only applies as regards the Crown.

In my role as Deputy Chief Constable, I have oversight of the operation within Police Scotland which responds to and supports the Inquiry. I am committed to supporting the Inquiry's aims and objectives with absolute candour. Extensive resources have been applied and continue to be applied to assist in the provision of material to the Inquiry and ensure the fullest possible sharing of evidence and support to the Inquiry. I recognise the importance to the Inquiry of ascertaining the truth as to what happened to Mr Bayoh on 3 May 2015.

As the Chief Constable has stated publicly, policing in Scotland is done with and by the consent of the public. The main purpose of policing is to improve the safety and well-being of persons, localities and communities in Scotland (per the policing principles at Section 32 of the Police and Fire Reform (Scotland) Act 2012). Effective policing is enabled and enhanced by the trust and confidence of the public.

Your aim in seeking the undertaking from me is to '*remove any barrier to the giving of full, frank and uninhibited evidence*' by witnesses who are serving police officers. Police officers should not and do not need to seek comfort from me, nor any of their colleagues, to give full and frank testimony – either to this Inquiry or to any inquiry. Giving such full and frank testimony is the basic expectation we have of one another as police officers and the very least the public demands of us as their servants. It is not 'transactional' and it should never be conditional.

The Chief Constable has made it clear that racism or discrimination of any kind is deplorable and completely unacceptable; it should have no place in society and it has no place in policing. Any perceived failure to further the policy of zero tolerance within Police Scotland of racist views or discriminatory attitudes would seriously undermine the confidence of every community in Police Scotland. It would be highly damaging to the integrity of the Service and the rigour with which that policy of zero tolerance is discharged between and among police officers and members of police staff. It would be antithetical to Police Scotland's values of integrity, fairness and respect and contrary to our commitment – reflected in the police officer's declaration - to upholding human rights and a shared mission to keep people safe.

The Coalition for Racial Equality and Rights ('CRER') made an important point in their submissions to you regarding the potential impact on communities and relationships within the Police Service of Scotland should an undertaking (*from me*) cover evidence that an officer had evinced malice and ill will towards Mr Bayoh based on his membership or presumed membership of a racial group.

The rulings in the *Rosemary Nelson Inquiry* and the *Hutton Inquiry* were cited to you in support of the request for the undertakings. I have considered those carefully. It is notable that in the *Rosemary Nelson Inquiry*, the position taken by the Chief Constable of the Police Service of Northern Ireland – with the concurrence of the Police Ombudsman – was considerably more restricted than the undertaking sought in the application made to you. In that Inquiry, although an undertaking was granted, this was under specific exception of evidence which might have pointed to alleged behaviour on the part of police officers of such severity that they may have been liable to the most serious disciplinary sanction. The equivalent, in terms of the 2014 Conduct Regulations, would be an exception for alleged behaviour amounting to gross misconduct. In the *Hutton Inquiry,* the Cabinet Secretary also excluded serious misconduct from the undertaking.

I am aware that in the *Baha Musa Inquiry*, Sir Michael Gage stated that there should not be an unreasonable restriction on the ability of the authorities to hold accountable, by disciplinary or administrative proceedings, those who had been guilty of misconduct.

I am being required to approach my decision, further to your Ruling, in this matter in a somewhat unusual position. In the first place, I do not yet have all the relevant material upon which a decision (whether or not to institute a misconduct investigation and/or proceedings) under the 2014 Conduct Regulations might be made in the normal course of things. That material is still being disclosed to Core Participants by the Inquiry Team and the greater part which might have been presumed by me to be of interest in this connection would have been held by the Crown and/or PIRC. It is not material hitherto known to me. Additionally, I am asked to come to a view (on an undertaking) *'in anticipation'* of what the evidence to the Inquiry may be from the various officers who would potentially benefit from its terms.

I also recognise that, were any undertaking (in whatever terms) to be given by me, its actual effects (or 'benefits' if they might be seen in such terms by officers seeking to avail themselves of such effects) may not become manifest for some period – possibly even after the Inquiry itself has concluded. The competing public interests which it is fairly recognised I must weigh in the balance in coming to my decision will, likewise, obtain after the Inquiry has concluded.

I have been provided with a copy of the letter, to you, dated 22nd March 2022 from the Solicitor-General. I have had very careful regard to its terms. In particular, I note the Solicitor-General's decision not to provide the undertaking requested of her in your Ruling, and her reasons for so doing. Having had due regard to my own responsibilities under the said 2014 Conduct Regulations, and especially the provisions which mandate the referral of any matter which may reasonably be said to infer criminality on the part of a police officer to the Crown (per Regulation 9), I cannot do other than decline to give an undertaking.

I respectfully submit the foregoing for your consideration.

Yours sincerely

[redacted]

Fiona Taylor QPM
Deputy Chief Constable

DATE: 11th September 2024

Your Ref:

Our Ref: LS19159M/DC

Ms. Sadif Ashraf
Solicitor to the Inquiry
[redacted]

By email only

Legal Services Department
Police Scotland, [redacted]

Tel: [redacted]
Fax: [redacted]

E-mail: [redacted]

Dear Sadif,

SHEKU BAYOH PUBLIC INQUIRY
MARTIN GRAVES REPORT

I write regarding the report of Martin Graves dated 19 August 2024 disclosed on the afternoon of 5 September 2024. [SBPI -00667].

This is an incredibly disappointing report given that he has had over a year to prepare it. I note that he had meetings with the Inquiry team on 20 November 2023, 26 March 2024 and on 2 August 2024.

Our preliminary view is that the report fails the standard to be expected of an expert report. In particular, it fails to do the following:

1. Apply the correct, or even a consistent, standard of proof.
2. Carry out proper benchmarking.
3. Address any of the witness evidence of OSTIs or of Inspector Bradley.
4. Address Police Scotland Position Statements 8, 9 or 11.
5. Address all of the relevant documentation including lesson notes and plans as well as other documents such as those relating to the UoFMGs .

To the extent that he did benchmark we are concerned that the comparison with the material may not have been as thorough as required given the material which appears to have been omitted from his consideration and the actual Police Scotland training at the material time.

We also note that he has not been provided with Police Scotland Position Statements 1,2,3,5 and 7 which are particularly relevant to the points he was asked to consider. The Police Scotland team is reviewing the extent to which other relevant documentation has not been provided to him.

There is a significant issue of Procedural Fairness given the timing of disclosure of this report so close to the next hearing having regard to the date when he was instructed and the timing of the first hearing on training in 2022. There appears to be no opportunity now for further oral evidence from Inspector Young, the OSTIs who carried out the actual training, Inspector Bradley or Chief Superintendent Alan Gibson, Head of LTD to respond to this report.

A key document which informs his report is a Position Statement from the College of Policing which was requested on 21 December 2023. This was also only disclosed on 5 September 2024.

In order to engage properly and professionally with the report of Martin Graves we would require to spend a great deal of the time and effort which was applied to Position Statement 8. This was a very time consuming and expensive exercise for Police Scotland. It cannot now be done in accordance with the timetable for Rule 9s or even when this witness is due to give evidence. To draft a Rule 9, will, in any event, result in a document of inordinate length and necessitate a detailed review and comparison with the documents and evidence already before the Inquiry.

In relation to current training, I refer to our letter of 30 August 2024. We observe that Mr Graves comments on 2017 training. Our clear understanding is that we were told, specifically, that the Inquiry were not interested in reviewing interim training.

At the time of drafting this letter, we have just received you letter of 11 September today which we will require to discuss with our client. In the meantime, I note that Inquiry counsel do not intend to put any current training documents to Mr Graves and that our invitation to Mr Graves to attend training is not to be taken up. What is not clear is what is to be taken from him regarding the position post 2015.

To be clear, Police Scotland regard the current training material as not only relevant for submissions, but, in fact, key to them, even if it is not to be considered by your expert.

In light of the above, the Chief Constable will likely confine her engagement with the report of Mr Graves and his evidence to the making of detailed submissions on the evidence before the Inquiry in terms of documents, witness statements and oral evidence.

The Chief Constable does not adopt this position out of concern about criticism - which the organisation has always been candid about facing. Whilst the report is positive about some aspects of training there is no intention to be selective about the approach. Lessons will always be learned as long as they are based on a fair analysis of the material and evidence.

For the avoidance of doubt, Police Scotland regards the College of Policing as a body with whom to consult and collaborate in furtherance of the mutual interest in setting standards for police training nationally and internationally. College of Policing training

and learning is incorporated into Police Scotland training, where appropriate. Police Scotland continues to develop training packages independently of the College of Policing; Police Scotland training development may in some business areas be at a more advanced stage, but the collegiate working means that learning is shared for the benefit of all.

Yours sincerely,

[redacted]

[redacted]
Solicitor,
Chief Legal Officer

Date: 01 October 2024

Our Ref:

Kate Forbes, MSP
Deputy First Minister
Scottish Government
St. Andrew's House
Regent Road
Edinburgh
EH1 3DG

POLICE SCOTLAND
Keeping people safe
POILEAS ALBA

Alan Speirs
Deputy Chief Constable
People and Professionalism

Police Scotland Headquarters
Tulliallan Castle
Kincardine
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FK10 4BE

[redacted]

Dear Deputy First Minister,

Sheku Bayoh Public Inquiry – Terms of Reference

With reference to the foregoing and to recent correspondence received from Ms. Sadif Ashraf dated 6 September 2024 informing us of a meeting between you and Lord Bracadale, the Chair to the Inquiry where I am informed an extension to the current Terms of Reference was sought.

As Deputy Chief Constable for People and Professionalism and the Strategic lead for matters relating to Public Inquiries I am responding on behalf of the Chief Constable.

As you may be aware the Terms of Reference for the Inquiry was published more than four years ago and were set by the then Cabinet Secretary for Justice, Humza Yousaf, MSP.

The then Chief Constable gave a very firm commitment to engage fully and positively with the Inquiry, and in assistance to the Chair to discharge the Terms of Reference remains undiminished, the commitment to date has been fulfilled and continues through our current Chief Constable Jo Farrell, who also shares the families' wholly understandable desire to get to the truth of what happened to Sheku Bayoh on 3rd May 2015 in Kirkcaldy. That has been the Police Scotland position since then.

Police Scotland wish to convey some concerns surrounding what seems to be being proposed by the Chair now, and at almost the very end of the Inquiry's proceedings

before considering his determination. It is our position within Police Scotland that this has the potential not only fail to achieve the desire to get to the truth, but in all probability will obscure things further and introduce more delay and cost.

It is worthy of note that legal costs incurred by Police Scotland associated with our commitments have now exceeded £15m which does not include costs associated with building a Public Inquiry team, there remains no budgetary provision for any further extension of the Inquiry.

It is my understanding that there was engagement with those acting for the Lord Advocate at the Inquiry, dating back to last year, ahead of evidence led from then Lord Advocate, James Wolffe, KC, to ensure there was no transgression into areas agreed to have been excluded from the Inquiry's scrutiny.

A change to the Terms at this time raises concern at this very late stage as Crown witnesses have already given evidence and the extent and impact on that evidence materially and on all the other evidence which has been laid before the Inquiry cannot be assessed. There seem to me to be very considerable, and some might say insurmountable, issues of procedural fairness engaged.

Furthermore, I am concerned at the proposal that the Terms might be adjusted to permit consideration of the reasons not to prosecute but not (also) to the VRR, given this decision preceded the subsequent review decision. In my respectful view, the two decisions must warrant equal examination and consideration.

Whilst the Chief Constable fully supports the aims of the Inquiry, I am compelled to write to you on behalf of Police Scotland out of a real and significant concern that you are being invited to take a course of action that I think will yield material and disadvantageous consequences for all concerned.

Yours sincerely,

Alan Speirs
Deputy Chief Constable

SHEKU BAYOH INQUIRY – TERMS OF REFERENCE

1. You are currently considering a request by the family of Sheku Bayoh to extend the Terms of Reference ("TOR") relative to the statutory Inquiry set up to examine the events surrounding the death of Sheku Bayoh, the subsequent investigation and whether race was a factor. The family have requested that the TOR be expanded to allow consideration by the Inquiry of the decision communicated to the family in October 2018 not to prosecute any individual or organisation in relation to the death of Mr Bayoh. In addition to the views of the family, you have been provided with the views of the Chair of the Inquiry, Lord Bracadale, together with submissions from Core Participants.

2. The examination of prosecutorial decision-making by an inquiry has significant implications for the independence of the Lord Advocate in her capacity as head of the system of criminal prosecution in Scotland. There is some doubt as to the legal competency and constitutional propriety of such a step and whether the consent of the Lord Advocate is a prerequisite. That is all the more so where, as here, an inquiry is ongoing, and a commitment has been made to keep the decision not to prosecute under review.

3. I have sought below to summarise the relevant factual and legal context and explain my position as to the issues highlighted by the Chair as relevant to consideration of the request of the family. I have also set out some additional factors from the Crown's perspective which you may wish to consider when approaching your evaluation of the public interest in extending the TOR.

Prosecutorial background

4. Sheku Bayoh died following contact with police officers in Kirkcaldy on 3 May 2015. On that date the Police Investigations and Review Commissioner ("PIRC") was instructed by the then Lord Advocate in terms of section 33A of the Police Public Order and Criminal Justice (Scotland) Act 2006 to investigate the matter. The PIRC subsequently reported its findings to the Crown. Following further enquiries, a report was submitted to Crown Counsel, who concluded that there should be no criminal proceedings. The decision not to prosecute any individual or organisation in relation to the death of Mr Bayoh was communicated to the family at a meeting on 3 October 2018.

5. The family exercised their right to request a review of this decision. A review of the decision not to prosecute was carried out and concluded that there was insufficient evidence to bring criminal proceedings against the police officers or Police Scotland and that the original decision not to prosecute was reasonable. The family were advised of this decision on 11 November 2019.

6. On 11 November 2019, following the conclusion of the VRR process, the Crown wrote to the officers involved in the restraint of Sheku Bayoh, reminding them that there was an obligation on the prosecutor to keep cases under review and advising that the Crown reserved the right to prosecute at a future date.

7. I have been exercising the Lord Advocate's functions in relation to this matter as the Lord Advocate has recused herself in consequence of earlier involvement in the case. In March 2022 the Chair requested that I provide an undertaking that in any future prosecution of a police officer or former officer, arising out of the events on 3 May 2015 and the post-incident management, the Crown would not use against that officer evidence which that officer has provided to the Inquiry. I declined to provide the undertaking sought. In my response to the Chair, I explained:

> *"In carrying out my assessment of this request for undertakings I must act fairly and in the public interest. I must ensure that the security and confidence of the people of Scotland is maintained by providing just and effective means by which crimes may be investigated, prosecuted and offenders brought to justice. Accordingly, any decision which has a direct impact upon the ability of prosecutors to carry out their obligations must be made independently after careful consideration of the individual facts and circumstances."*

8. My consistent position before the Inquiry has been that I will keep all the evidence emerging from the Inquiry's work and the Chair's findings under review and will consider their impact upon the original decision not to prosecute. This includes not only direct evidence as to what happened on 3 May 2015 but also any evidence relating to concerns about the way in which the Crown originally approached the investigation.

The inquiry and its terms of reference

9. Prior to the conclusion of the criminal investigation the then Lord Advocate made it clear that in his view the issues arising from Mr Bayoh's death should be fully aired in an appropriate forum and that a public inquiry would be the most appropriate mechanism for investigating the circumstances of Mr Bayoh's death. He considered however that it did not seem to him to be desirable or appropriate for the remit of any public inquiry to cover the criminal investigation beyond the examination of structural and systemic issues which arose in relation to the immediate post-incident management.

10. On 12 November 2019 the then Cabinet Secretary for Justice, Mr Humza Yousaf, confirmed that he was establishing a statutory public inquiry under the Inquiries Act 2005. Following this announcement a consultation took place in relation to the Terms of Reference, involving the Cabinet Secretary for Justice, Lord Bracadale, the Bayoh family, the Lord Advocate, the Chief Constable and the PIRC.

11. In March 2020 Lord Bracadale prepared a note on the draft TOR. He stated that,

> *"In light of the constitutional position outlined above [in relation to the independence of the Lord Advocate as head of the prosecution system in Scotland] I am of the view that the terms of reference should not extend to the prosecutorial decision of the Lord Advocate not to prosecute in this case. But that does not mean that the public inquiry should not examine how the Crown*

conducted the investigation, both at the stage of directing PIRC and thereafter. In my view the public inquiry ought to be able to carry out that examination and any more restricted approach would prevent the inquiry from properly fulfilling its function…

As I indicated to the Cabinet Secretary for Justice, I consider that it would be possible to carry out a full and searching examination of the investigation by the PIRC and the Crown without expressing a view on the ultimate prosecutorial decision not to prosecute."

12. On 21 May 2020 the Cabinet Secretary for Justice formally announced the Inquiry's TOR. These specifically state that they do not include "the making by the Lord Advocate of the prosecutorial decision communicated to the family of Sheku Bayoh on 3 October 2018 (and the Victims' Right to Review process that was undertaken by the Crown Counsel in 2019…").

13. Throughout the course of the Inquiry the breadth of this exclusion has been the subject of some debate and a hearing on this issue took place on 12 April 2024. The Chair issued a written decision dated 15 April 2024 in which he clarified the scope of the exclusion, specifically adopting an approach which would enable the Inquiry to (paragraph 11):

    (i) meaningfully examine the investigations carried out by the Crown in order to ascertain whether it complied with articles 2 and 14 ECHR;
    (ii) identify deficiencies that might render the process incapable of leading to the establishment of the facts;
    (iii) examine the steps taken by the Crown to explore the cause of death and the issue of causation;
    (iv) explore whether there had been a failure to follow particular lines of inquiry;
    (v) properly examine the extent to which the Crown took steps to establish whether or not racial prejudice may have played a role in the events.

14. The Chair indicated that his approach to the scope of the TOR was influenced by the process which brought them to fruition. He noted (paragraph10):

    "It was clear to me that what the cabinet secretary required was a full and frank examination of the events after the death of Mr Bayoh, of which the investigation conducted by the Crown should be part. I think that it is reasonable to conclude from the way in which the terms of reference developed that the cabinet secretary wanted a wide-ranging public inquiry, able to follow the evidence, with wide discretion to the chair, limited by the exclusion of the prosecutorial decision".

15. The Chair went on to make clear that it was open to the Inquiry to examine the procurator fiscal's analysis of the evidence as to what happened on 3 May 2015, including issues of credibility and reliability; that would also include identification of available sources of evidence. It would be open to the Inquiry to examine the analysis of the evidence as to the actings of individual officers; cause of death and causation; and the analysis of the use of force and whether that was justified. It

would be open to the Inquiry to examine the extent of the investigation by the Crown of the issue of race. In short, the Chair concluded that the examination of the procurator fiscal's analysis of the evidence was "the key to a meaningful examination of the investigation by the Crown" (paragraph 15).

16. Therefore, as of 15 April 2024, the Chair believed that the Inquiry was able to carry out all the investigations referred to above and expressed no concerns that the current TOR would prevent 'a full and frank examination of the events after the death of Mr Bayoh' as desired by the Cabinet Secretary.

Proposal to change the current TOR

17. The family of Sheku Bayoh have requested that the TOR of the Inquiry be expanded to allow consideration by the Inquiry of the decision communicated to the family in October 2018 not to prosecute any individual or organisation in relation to the death of Mr Bayoh.

18. In a note dated 24 October 2024 the Chair set out certain provisional views and indicated that he was minded to support the request of the family on the basis that any extension should also include the VRR process. After inviting submissions from the other Core Participants, the Chair wrote to the Deputy First Minister in November 2024 setting out his views. He identified, from the point of view of the Inquiry, three competing public interests to be taken into account in considering the request of the family. These were; (i) the public interest that a potentially flawed prosecutorial decision is a matter for public concern such that an inquiry set up to examine the investigation by the Crown should be permitted to take the additional steps to examine the decision; (ii) the public interest in maintaining, under the current state of the law, the independence of the Lord Advocate; and, (iii) the public interest in bringing the Inquiry to an end without additional delay, cost and impact on all those involved.

19. The Chair also confirmed his view that any extension of the TOR should include the VRR process.

The independence of the Lord Advocate

20. The Chair rightly recognised the public interest in the maintenance of the independence of the Lord Advocate in the exercise of the prosecutorial function, a principle which he recognised has "since time immemorial been enshrined in common law". In his note dated 25 October 2024, the Chair queried whether the consent of the Lord Advocate was necessary before the Inquiry could consider the October 2018 decision and the VRR.

21. The maintenance of the independence of the Lord Advocate is clearly a matter of considerable concern to me and this concern is particularly acute given that I have committed to keeping the evidence at the Inquiry under review and reserved the right to bring future proceedings.

22. It is unnecessary for me to set out the common law position in any detail. Suffice to say that the Lord Advocate is the "master of the instance" and no court or individual can "control or superintend" the Lord Advocate in the exercise of her functions as independent head of the system of criminal prosecution in Scotland. The decision whether to prosecute is exclusively within her jurisdiction and no one can compel her to give her reasons. Far from being a historic relic, recent Appeal Court decisions continue to emphasise the unique role of the Lord Advocate and her power to act independently as master of the instance.

23. It is nevertheless open to the Lord Advocate herself to consent to the examination of prosecutorial decision-making by an inquiry. This has been done in previous inquiries, for example the Chhokar Inquiry. The requirement for the consent of the Lord Advocate serves as an important protection against the politicisation of prosecutorial decision-making and is a significant reassurance to prosecutors.

24. While the position at common law is clear, what is more difficult is its interplay with the terms of the Inquiries Act 2005. Regardless of the effect of the 2005 Act, I remain sceptical as to the constitutional propriety of reviewing the decisions of independent prosecutors without the consent of the Lord Advocate. However, for the reasons explained in the following section, it is unnecessary for current purposes to resolve this issue.

The nature of the allegation

25. When providing his views in November the Chair focussed on the allegation of the family that the prosecutorial decision was taken on an incomplete and erroneous understanding of the evidence and failed to take into account important issues of race. The Chair stated that, although he had not formed a concluded view, some of the evidence heard by the Inquiry raised a question as to whether the October 2018 decision was flawed on the basis that it proceeded on a misunderstanding of the factual evidence; the instructions given to expert witnesses were misconceived; and there was a failure properly to examine the issue of race. He concluded that it may be in the public interest for the Inquiry to examine the October 2018 decision and the ensuing VRR.

26. The Chair does not detail his concerns or explain how he considers that they might impinge upon the October 2018 decision or the VRR. Moreover, his letter does not explain why he believes that he cannot adequately address those concerns in his final report without the Terms of Reference being extended.

27. Notwithstanding, I take the views of the Chair extremely seriously. I consider that his concern that there was a failure on the part of the Crown to properly examine the issue of race is particularly grave. Without making any concession as to the validity of the Chair's concerns as to the potentially flawed nature of the prosecutorial decision, I consider that it would not be in the public interest for me to stand in the way of an examination of the prosecutorial decision-making. I am therefore content to agree that it is open to you to assess the competing factors identified by the Chair and the Core Participants and, if you consider that it is in the public interest to do so, to decide to extend the TOR to cover both the October

2018 decision not to prosecute and the VRR. I consider that it is imperative that any extension should not only examine the October 2018 decision but also the VRR, since any other approach would fail to examine or understand the prosecution decision-making process as a whole.

28. Given my particular interest in safeguarding the prosecutorial independence of the Lord Advocate, should you decide to extend the TOR, it would be essential for me to be consulted in relation to the terms of any proposed extension and how consideration of the prosecutorial decision-making, including the VRR, will be approached. There may also be additional practical safeguards in relation to statement taking, sharing documents and the involvement of counsel for the Crown at the Inquiry which might usefully be discussed and agreed with the Chair.

Other considerations

29. I consider that the Chair's concern that proper consideration was not given by the Crown to the issue of race is a weighty factor in your assessment of the public interest. However, I have also set out below certain additional considerations from the Crown perspective which you will wish to weigh in the balance when making your decision.

(i) The timing of the request

30. As noted above, at the outset the Chair believed that he could carry out a full and searching examination of the investigation by the Crown without expressing a view on the ultimate prosecutorial decision not to prosecute. This remained his position in April 2024. In the weeks that followed, during the Crown hearing, witnesses were repeatedly reminded of the scope of the TOR and warned that there were certain matters that could not be discussed during their evidence.

31. The Inquiry has now effectively concluded its investigations. From the Crown's perspective, had the TOR originally included the prosecutorial decision, a different approach may have been taken in relation to the examination of witnesses led at the Inquiry. Challenges may have been made to rulings from the Inquiry regarding the prohibition in taking statements from witnesses, or with sharing material with them in advance of them providing statements to the Inquiry. Questions currently prohibited by the current TOR may have been asked of a number of Crown witnesses. The Crown may have asked for additional witnesses to be called.

32. If the TOR are now extended, it is a realistic possibility that the evidence from previous hearings may require to be examined again by the Crown. It is assumed that this will also be the case for other Core Participants. A potential consequence is that several witnesses – not just those from the Crown – may require to be recalled. The impact that this may have on their wellbeing should not be underestimated. It is also likely that some key Crown witnesses will apply for Core Participant status.

(ii) Potential for future proceedings

33. As explained above, I have committed to keeping the evidence at the Inquiry under review and the right to prosecute has been expressly reserved. This commitment includes any direct evidence relating to what happened on 3 May 2015 but also includes any evidence relating to concerns about the way in which the Crown originally approached the investigation. In this way, questions in relation to the integrity of the decision not to prosecute will be examined. The Chair does not indicate why he considers that the aspect of the public interest identified under (i) in paragraph 18 above would appropriately be addressed by the Inquiry when the prosecution process, which is the generally recognised means of resolving such matters, is not yet complete.

(iii) Liaison with the family

34. Following the original decision not to prosecute, a meeting took place with the Bayoh family, along with the family's solicitor. This meeting was attended by the then Lord Advocate and the Crown Counsel who had issued the instructions in the case. Minutes from this meeting show that the family were advised that there was insufficient admissible evidence to take criminal proceedings against individual police officers and there was insufficient evidence for criminal proceedings against the Chief Constable of Police Service of Scotland. A letter was issued to the family at the same time, setting out the basis of the prosecutorial decision.

35. Thereafter an extensive VRR process took place by the Crown. The fact this review was conducted by the Crown is in line with the constitutional position in Scotland and with the underlying European Directive on Victims' Rights. The Bayoh family were legally represented in the VRR process and made extensive submissions about the correctness of the original decision.

36. On 11 November 2019, at the conclusion of the VRR process, a further meeting was held with the family and the family's solicitor. Both the then Lord Advocate and the then Solicitor General were present at this meeting, as was the Crown Counsel who had undertaken the review of the decision not to prosecute. The family were informed that there was insufficient evidence to establish that the actions of the police, individually or collectively, amounted to criminality and that the original decision not to prosecute any of the police officers or Police Scotland in relation to events of 3 May 2015 was reasonable and was upheld.

37. A 17-page letter was then sent to the family, detailing the reasons for the decision and fully explaining the responses to issues raised by the family during the VRR process.

(iv) Views on a "flawed" decision

38. Although other inquiries have looked at prosecutorial decisions, these examinations were not carried out in situations where a decision not to prosecute had been reached and an undertaking to keep that decision under review had

been given. It is imperative that the integrity of any future prosecutorial decision-making, as well as of any future proceedings, is protected.

39. In his November letter the Chair makes reference to the possibility of a "flawed" decision in October 2018. It is not clear in what way the decision might be flawed. If the Chair means that the decision not to prosecute was the wrong decision, and therefore that there should have been a prosecution of an individual or an organisation, then any determination in those terms may be regarded as a ruling on or a determination of criminal liability, contrary to section 2(1) of the Inquiries Act 2005.

40. It is of course open to the Chair, in terms of section 2(2) of the 2005 Act, to make a determination even though this might lead to an inference of criminal liability. In the present circumstances, however, this carries an obvious risk that the Inquiry's assessment of the prosecutorial decision-making, and any conclusions it forms, will condition and influence the approach of those considering the case in the future. This calls into question the fundamental principle that decisions of the Crown in individual cases should be taken independently and be immune from political influence or other pressure.

41. Moreover, should the Inquiry examine the prosecutorial decision and reach conclusions as to whether or not the decision was flawed, there is a risk that it will do so in the light of evidence which it has heard at the Inquiry which was not available to Crown decision-makers at the time. Aside from issues of fairness to the original decision-makers, it is precisely this evidence which I have committed to review and will fully consider its impact upon the decision not to prosecute.

Conclusion

42. There is no doubt that the consequences of any extension to the TOR will be significant and far reaching. The assessment of the public interest involves complex issues which will doubtless receive your careful consideration. I trust that the above information will be helpful.

Solicitor General
13 December 2024

For the urgent attention of:

Kate Forbes MSP
Deputy First Minister

By email only: [redacted]

4th September 2024

Dear Kate,

Sheku Bayoh Inquiry – Terms of Reference

We refer to the above and thank you for your meeting with the Bayoh family earlier this year. The family were extremely grateful as they felt that their concerns were carefully listened to. Last Friday the Bayoh family met with the Chair of the Inquiry, Lord Bracadale and his legal team, at which a number of concerns as outlined below were raised, we now understand he is due to meet with you this week.

As we briefly explained at our meeting with you an Inquiry excluding a consideration of prosecutorial decision makes for an incomplete Inquiry into the death of their loved one. The family of Sheku Bayoh ask that the terms of the Inquiry are expanded to explore the prosecutorial decision and to allow consideration of the decision taken by the Lord Advocate in discussion with Ashley Edwards KC, Crown Counsel by the Inquiry. We note we raised this

issue with you previously and we were to write in detail to you but thought it best until the last chapter of evidence was completed so we had a fuller picture.

Reference is made to s5(3) of the Inquiries Act:

> *(3) The Minister may at any time after setting out the terms of reference under this section amend them if he considers that the public interest so requires.*

While doubtless Chair of the Inquiry, Lord Bracadale, has all the relevant information to inform him what information the Lord Advocate had when he made his final decision, the family have now had the opportunity to consider the decision making of the police, the PIRC, and the Crown in extensive detail up to, but excluding the decision taken on whether to prosecute.

Kadi, on behalf of the family has stated, "*We want the public to know the whole truth. The way the police were scrutinised, yet we believe the Crown has not been scrutinised in that manner. They should be held to account as much as the police…"*

It is not known why the prosecutorial decision was removed from the scope of the Inquiry, albeit that I was led to believe at the time in discussions with ministers at the Scottish Government, there was strong resistance from the Lord Advocate James Wolfe KC in including the decision-making process in the terms of reference.

Crown Office has a history of being closely guarded with its decisions and excluding families from understanding the process and decision making in relation to prosecutions. This 20th Century approach does not sit well with the duties on the Crown in the 21st century as a public body that ought to be transparent about and accountable for, its decisions.

The Terms of Reference in this case was set out in 2019 and since that time scrutiny of Crown Office decision-making has been the subject of high-profile cases and found wanting. The landscape has changed for the better and the Crown Office' anachronistic views on the "sanctity" of the decision-making process is not in step with the need for public bodies to be accountable to the people they serve.

The most high-profile case was that involving Rangers Football Club, but in that instance the individuals had access to significant financial resources to take on the authorities and show that the Crown Office did indeed act maliciously. You will be aware that in August 2020 the Scottish Government wrote to those connected to the acquisition and administration of Rangers Football Club, admitting that the prosecution was malicious and advising that damages would be paid, and apology issued. In 2023 it was reported that the wrongful arrests could cost up to £72 million.

In the case of the Sheku Bayoh, his family had no access to significant financial resources as those in the Rangers case did, but that is the case for many other families and victims, for example the families of Katie Allan, William Lindsay, Allan Marshall, Emma Caldwell.

In all these cases the Crown Office have been accused of arrogance and acting behind a veil of secrecy to avoid any accountability whilst paying lip service to the article 2 rights of families.

The Sheku Bayoh Public Inquiry has been robust in its investigation of all other parts of the process and there seems no good reason not to complete this investigation with this final investigation into the prosecutorial decision- after all it cannot be right that the Lord Advocate and his team should be allowed to escape robust scrutiny into their decision making whilst those in Police Scotland and the PIRC are required to account for theirs.

Whilst it is clear from the evidence already elicited that the article 2 rights of Sheku Bayoh have not been properly considered and breached by the Crown, the inclusion of the prosecutorial decision would allow for access to the "whole truth" that the family not only need but deserve.

In essence an extension of the TOR to include this decision would require the recall of two witnesses – the then Lord Advocate James Wolffe KC and Ashley Edwards KC, to be asked questions specifically focused on the decision not to prosecute. Given the time and care already taken in this inquiry to remain on schedule, this would be a very minor additional part of the inquiry process.

Any suggestion that consideration of the detail of the prosecutorial decision could prejudice any further prosecution should be given the utmost scrutiny and not accepted at face value, apart from the bitter irony of such a submission, it does not bear consideration. - it is the excuse used time and time again to avoid accountability.

This Bayoh decision that is sought to be examined was taken on an incomplete and erroneous understanding of the evidence and failed to consider important issues such as race. How consideration of this decision could prejudice any further, proper consideration of the evidence and properly instructed, appropriate expert witnesses is not known.

It is submitted that, whatever the view taken in 2019, viewed in 2024 it is in the public interest to complete this Inquiry by finding out exactly what decisions were taken in respect of the prosecution and why they were taken.

For too long Crown Office and its decision -making process has remained shrouded in secrecy, it is an archaic practice in breach of their claim to adhere to supporting the human rights of families such as the Bayohs. You should be aware that we have spoken to those in the Scottish

Parliament from the leader of Scottish Labour Anas Sarwar MSP and Russell Findlay MSP of the Conservative Party, they have offered their full support and believe their party will also for our request for an extension to the terms of reference to include the prosecutorial decision making process. I will also be speaking to Alex-Cole Hamilton leader of the Scottish Liberal Democrats and very much expect for the family to have his support also, later today. We will also seek the support of the Scottish Greens.

Evidence has been given by the Crown that it did not do any further investigations / work in relation to race and the death of Sheku Bayoh as they knew there would be an Inquiry. The Crown, their officials and the former Lord Advocate have stated that they supported the Public Inquiry and it is assumed to be transparent and accountable in its decision making. Why then would it now oppose an extension of the TOR?. The Inquiry has been led by Senior Counsel to the Inquiry, Angela Graham KC "to the door" of the room in which the decisions were taken as between the Lord Advocate and Crown Counsel Ashely Edwards KC.

Inexplicably, the decision-making process was excluded, yet it is exactly this meeting that we understand how the Lord Advocate came to its decision not to prosecute those involved in the restraint of Sheku Bayoh. It is not known how or why the decision was taken to exclude the Lord Advocate from this scrutiny, but it leaves a very unfortunate situation where the only person whose final decision making is excluded from public scrutiny is a fellow Minister in the Scottish Government.

When the Crown Office is forced to admit that in a high- profile case the decision to prosecute was maliciously made, then it has no authority for claiming any sanctity to the process, to accept a blank assurance that "we've done it right". There is no magic in taking a legal decision to prosecute: Was there a sufficiency of evidence to prosecute for a crime? If so, was it in the public interest to prosecute? If not, why not. These are decisions that the Bayoh family need answers to. There is no good reason in law that this not be done.

We know from other such high-profile Inquiries that issues such as this do not go away unless the disinfectant light of public scrutiny is brought to bear. This is an opportunity to conclude these hearings now rather than have it continually re-appear. To date the evidence is such that Sheku Bayoh, his family and wider society have been seriously failed by the public bodies that ought to have protected our rights.

The fact is that the Crown Office is a public body which should be transparent and accountable to those that it serves. Extending the terms of the Inquiry would fully illuminate the process and it would doubtless be in in the public interest to do so. Failure to extend the terms of reference would mean that yet again another family would be forced to fight many years for another public inquiry to hold the Crown Office and Procurator Fiscal Service to account.

We look forward to hearing from you.

Kind Regards,

Aamer Anwar – Solicitor to the Bayoh families.

cc. Anas Sarwar MSP, Russell Findlay MSP, Alex-Cole Hamilton MSP, Pauline McNeill MSP, Patrick Harvie MSP, Lorna Slater MSP.

PBW LAW
SOLICITOR ADVOCATE

Lord Bracadale
Sheku Bayoh Public Inquiry

Sent by Email

Our ref: SCOTT01-07 PBW/MM

Date: 06 February 2025

My Lord.

Sheku Bayoh Public Inquiry
SPF, Short and PC Walker

We refer to the recent Petition for Judicial Review, and to Your Lordships' letter to the Chief Constable of 4 February 2025. We write following discussion with counsel and our clients and do so with the concurrence of R S Vaughan and Gordon Williams in respect of those they represent. Revelations made in the Answers to the Petition and in that letter cause us some surprise, and indeed concern. We explain as follows.

The background to the letter was of course the Petition, which in turn stemmed from a proposal to extend the Terms of Reference. We do not think it unfair to suggest that Your Lordship has expressed the view that the evidence which he has heard means that an extension would be appropriate. We leave to one side, for the moment, the argument that any such extension would be unconstitutional and inconsistent with the established position of the Lord Advocate.

In the letter, in seeking to address what Your Lordship understood to be a suggestion of apparent bias, he disclosed as follows:

"Since the setting up of the inquiry I have from time to time met with members of the families as part of my commitment to keep them at the heart of the Inquiry."

It is this revelation which causes the surprise and concern. We will require to consider this with our clients. In order that we may give them advice on a fully informed basis, we would respectfully ask that the following questions be answered:

1. It is a fundamental aspect of the law of apparent bias that a decision maker should, in general, not have private meetings with one party: *Kanda v Malaya* [1962] AC 322 at 337-8. What, if any, consideration was given to this principle in arranging meetings with the family of Mr Bayoh?

2. Has Your Lordship met, during the currency of the Inquiry, with any of the other Core Participants? If so, with whom, when, and with what purpose?

PBW LAW, [redacted] Tel: [redacted] E: [redacted]
LP: [redacted]

PBW LAW
SOLICITOR ADVOCATE

3. From the Answers to the Petition, it would seem that at least five meetings have taken place with the family. When did they occur? What was the purpose and content of these meetings?

4. Were minutes or notes of any such meetings taken? If not, why not?
5. If notes or minutes were taken, can they be disclosed? If not, why not?

6. In said letter, Your Lordship explains his dedication to the requirement of transparency. Having regard to that requirement, why was disclosure of the fact that he has met with the family of Mr Bayoh on various occasions not made previously, and only made in response to the Chief Constable's Petition?

As Your Lordship's letter of 4 February 2025 makes clear, accusations of apparent bias should not be lightly made. We do not intend to transgress in that regard. It is of fundamental importance that there be confidence, on the part of Core Participants and indeed on the part of the public, in the integrity of the process. However, we hope it is clear and understood that we require more fully to understand the background in order to advise our clients in light of what has been disclosed.

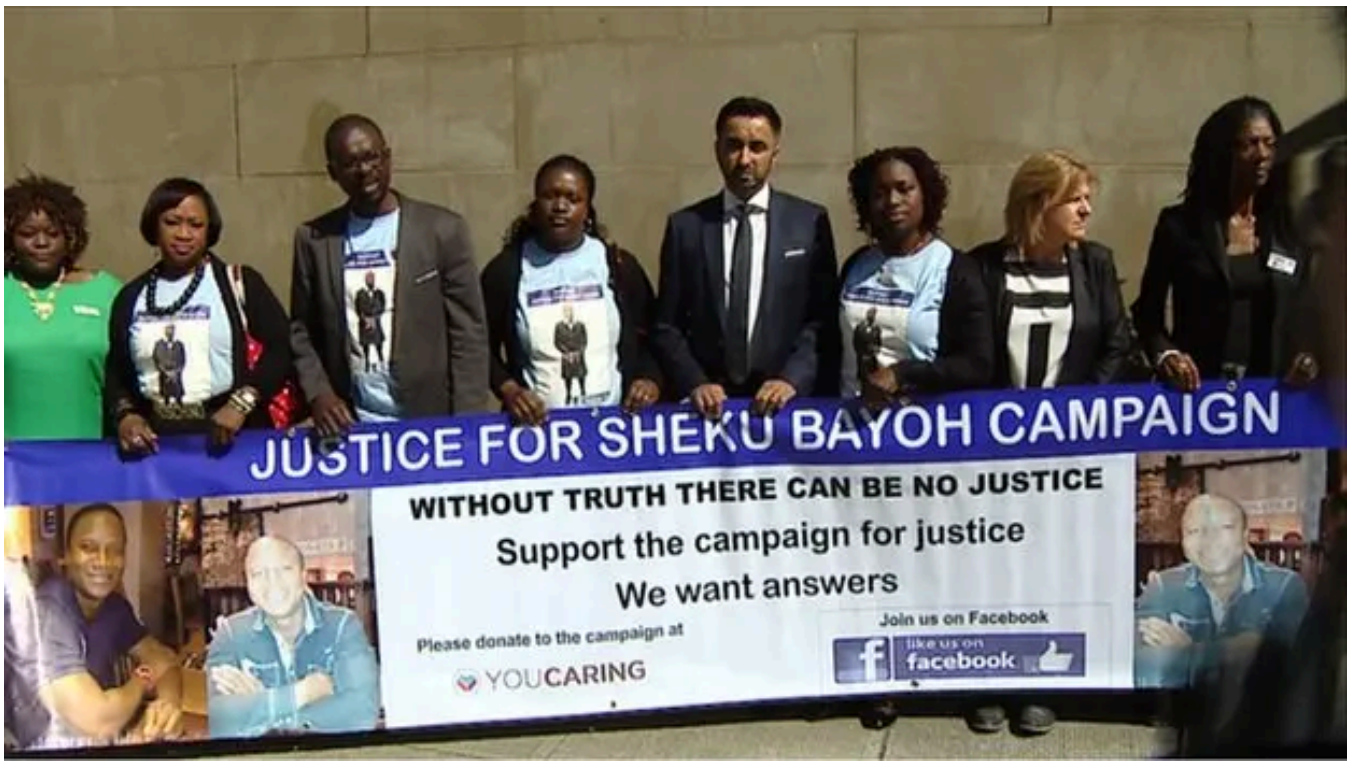
Yours sincerely

[redacted]

Professor Peter Watson
Solicitor Advocate

Sheku Bayoh death: Review call as campaign launched

25 July 2015



Mr Bayoh's family launched the campaign at an event in Glasgow

The family of a man who died in police custody has backed calls for a Scottish government review of all such deaths.

Sheku Bayoh, 31, died after being detained following an incident in Kirkcaldy in Fife on 3 May.

His death is being investigated by the Police Investigations and Review Commissioner (Pirc).

Speaking at the launch of the "Justice for Sheku Bayoh" campaign in Glasgow, his family said there were still many unanswered questions over his death.

The campaign got underway at an event organised by the Scotland Against Criminalising Communities' organisation which was also attended by other people who have lost loved ones through deaths in police custody elsewhere in the UK.

The call for a Scotland-wide probe into deaths in custody came after the UK government **announced an independent review of the issue in England and Wales**.

Lessons learned

Aamer Anwar, solicitor for the Bayoh family, said: "The family wants the truth because they know that without the truth they are never going to get justice.

"The Home Secretary announced, some two days ago, that there would be an independent review in England and Wales into deaths in custody.

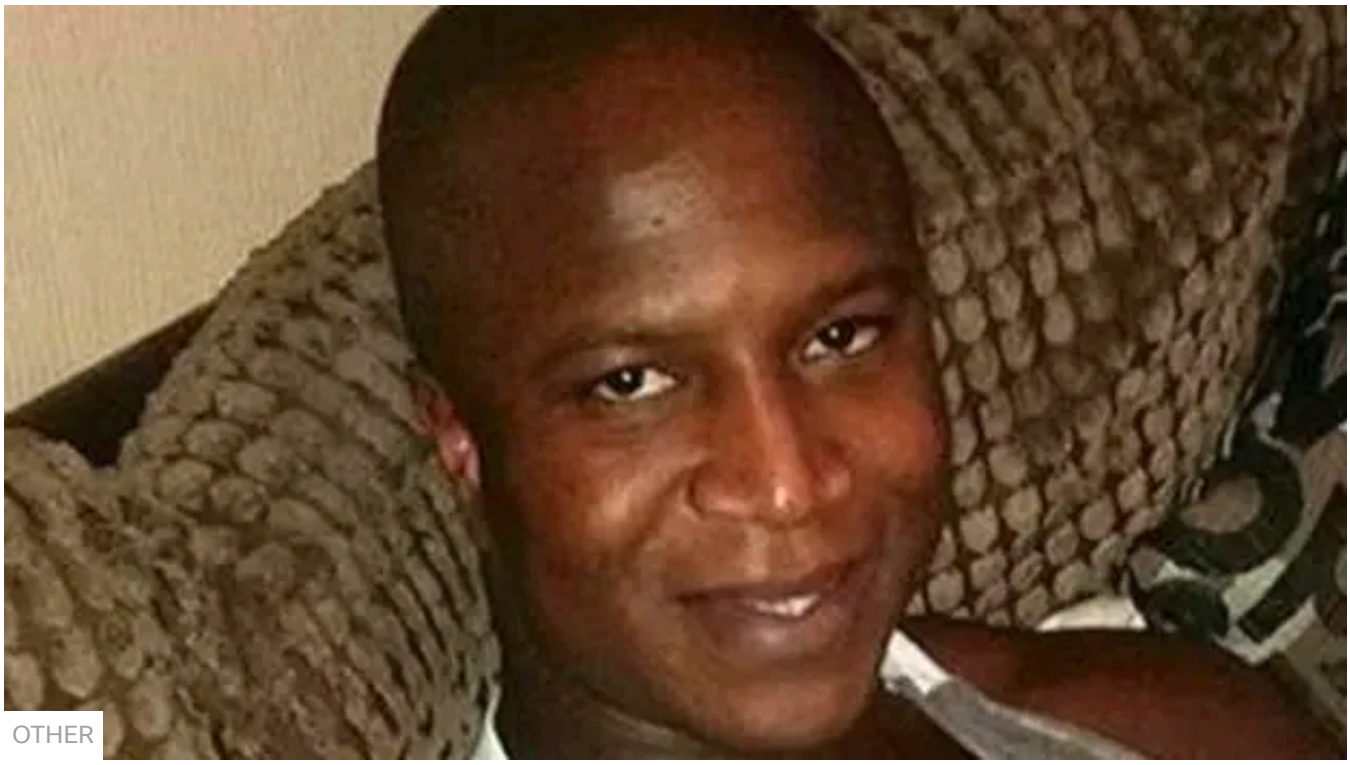
"Sheku Bayoh's family are saying they are not willing to wait 10 years for Scotland to catch up.

"It is essential that no family has to go through again what the Bayoh family has gone through and it's imperative that lessons are learned as soon as possible."

Mr Bayoh's sister, Kadi Johnson, **has previously claimed that police officers' use of "excess force" was to blame for his death**.

Speaking at the campaign launch, she said: "At the moment were are grieving but it's difficult when you don't know the truth surrounding his death - that still hurts.

"We want to know the truth and that could help us move on a bit."



OTHER

Mr Bayoh died after being detained following an incident in Kirkcaldy

Mr Anwar also called for answers about why Mr Bayoh was apparently viewed as a "terrorist threat" by some police officers.

He said: "The family of Sheku Bayoh want Chief Constable Stephen House to explain why his police officers believed that they were dealing with a terrorist threat and whether that had any role in Sheku Bayoh's subsequent treatment."

A spokesman for the Pirc said its report on Mr Bayoh's death would be submitted to the Crown Office and Procurator Fiscal Service in due course.

He added: "We fully empathise with the deceased's family at this very difficult time and their need for answers in relation to the circumstances surrounding the death of Sheku Bayoh.

"Our investigators are carrying out an extensive enquiry, which has many different facets that require to be thoroughly investigated.

"For that reason, it is only right that such serious matters are given careful consideration and the Lord Advocate is aware of progress made by the enquiry."

'Thorough investigation'

A Scottish government spokeswoman said responsibility for the investigation of deaths in custody in Scotland was a matter for the Pirc.

She added: "The Pirc is currently conducting an independent investigation, it is important we all await the findings of this robust and thorough investigation.

"The Scottish government believes that the investigative powers the Pirc has are sufficient, and the Pirc has not indicated they require any additional powers in order to undertake their role effectively."

The Scottish government also said a review of police custody arrangements in August 2014 found they had "improved significantly".

Previous criticisms of the police by Mr Anwar have been **dismissed as "completely inaccurate and misleading"** by the Scottish Police Federation (SPF), which represents rank and file officers.

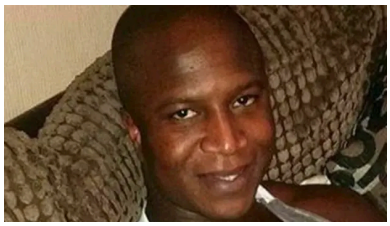
The federation has said that police were responding to reports of a man armed with a knife at the time, with a female officer suffering "significant" injuries during a struggle.

Calum Steele, general secretary of the SPF said: "The SPF is as eager as anyone for the outcome of the circumstances surrounding the death of Sheku Bayou to be made known.

"Reacting to snippets of information that may or may not be true whilst an investigation is underway is not in anyone's best interests."

Others attending the event in Glasgow included Janet Alder, the sister of Christopher Alder, 37, who choked to death on the floor of a Hull police station in April 1998, and Marcia Rigg, sister of Sean Rigg, who died after being restrained at Brixton police station, south London, in August 2008.

More on this story



Custody death 'due to excess force'

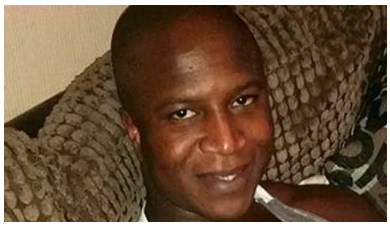
16 July 2015

Car CCTV plea over custody death

12 June 2015

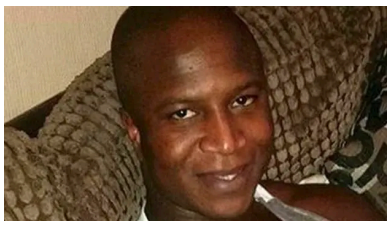
Custody death police offer statements

4 June 2015



Custody death family 'seeks truth'

14 May 2015

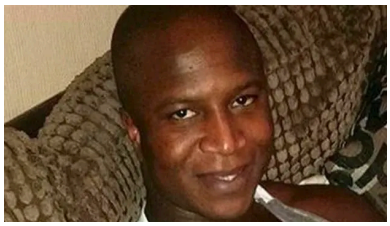


Witnesses sought over custody death

9 May 2015

Man dies after he is held by police

5 May 2015



Family 'distressed' after death

5 May 2015

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Justice for Sheku Bayoh by Kadi Johnson

Lawyers: Aamer Anwar & Co United Kingdom

Funded
on 07th June 2020

£82,540
pledged of £100,000 stretch target from 3497 pledges

Kadi Johnson
Case Owner

I am the sister of Sheku Bayoh. I ask you remember his name and feel the same outrage over his death in police custody as you do over the killing of George Floyd in the United States.

About the case Case updates 1 Comments

Latest: Nov. 26, 2020

PUBLIC INQUIRY START 30TH NOVEMBER 2020

Please support the family's justice campaign

SHEKU BAYOH PUBLIC INQUIRY OFFICIAL START 30TH NOVEMBER

Statement by the lawyer Aamer Anwar on behalf of Collette Bell and Sheku's fa…

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#BLACKLIVESMATTER IN THE UK TOO

There are devastating parallels in the deaths of George Floyd and my brother Sheku. The two men were both loving partners, fathers, sons and brothers.

George Floyd, died after a white American police officer, pushed his knee into his neck for almost nine minutes while he was handcuffed and lying face down. My brother died in Scotland in 2015 after he was held face down by up to nine police officers after subjecting him to CS spray, pepper spray, batons, handcuffs and leg restraints.

George Floyd was kneeled upon until he took his last breath. So was Sheku, only more weight and more officers kneeled upon him. George Floyd stated: "I can't breathe", so did Sheku.

Share on Facebook

But the parallels between George and Sheku end there. Four police officers have been charged in connection with the murder of George Floyd. Yet in 5 years not one officer has been disciplined, let alone charged nor will any ever face trial for Sheku's death.

Sheku's story

My brother came to Scotland when he was 17 to live with me because we thought it would be safer for a young black man to grow up in the small town of Kirkcaldy rather than London. How wrong we were. He died on a Scottish street, 31 years-old, leaving behind his two young sons.

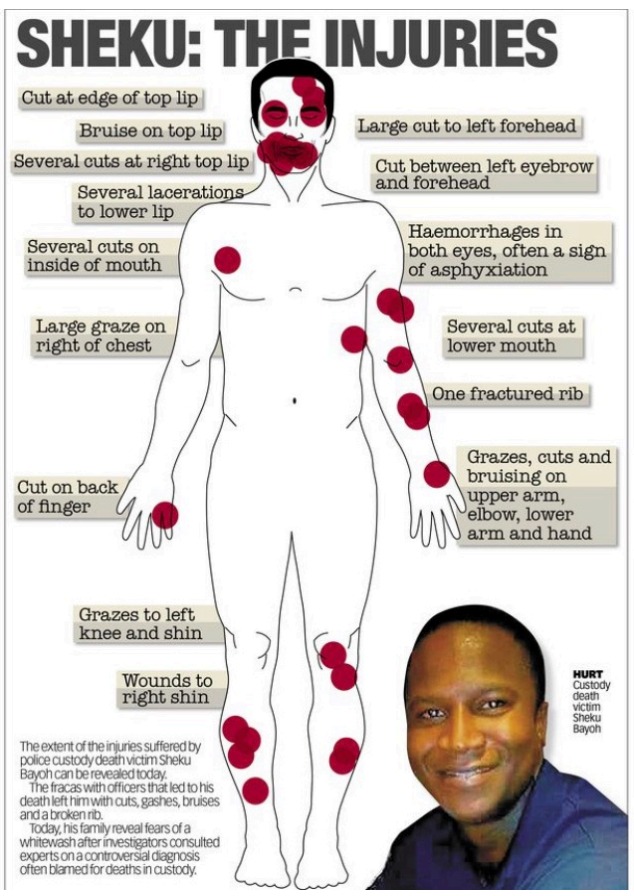
On the 3rd May 2015 around 7.15am police responded to reports of a black man acting erratically, walking down the street and holding a knife. Six police vehicles were dispatched, yet when the Police arrived Sheku was carrying neither a knife nor or any weapon.

The first four officers that arrived used CS spray, pava spray and batons on him, Sheku was brought to the ground in less than 45 seconds of the first officers arriving. He stopped breathing within in minutes never to recover.

All nine officers returned to the Police Station and sat together in a canteen for up to 8 hours whilst failing to give statements to investigators for some 32 days. In the hours that followed many lies were told including that he had attacked a police officer with a knife.

The case of George Floyd has highlighted globally the issue of racial injustice and killings at the hands of the police, but Black Lives Matter also in the UK. Since 1969, in the UK there has not been a single successful prosecution of a police officer for homicide.

A Public Inquiry has been announced which will look at the circumstances leading up to the death of Sheku, as well as the post-incident management and the investigation into his death. It will also examine whether race played a part in what happened. This Inquiry is likely to last up to two years and could conclude as late as eight years after Sheku died in police custody.



Our Legal Case

No family should be forced to set up a campaign in the midst of their grief. Families are denied access to legal aid when a death in custody takes place and we were expected to put our trust in the Crown Office which they betrayed. We need to bring about a legacy in Sheku's name to ensure no other family should endure what we have in five years.

How much we are raising and why

Share on Facebook

We have reached our initial target but aim to raise £100,000 to continue our campaign of five years and also to pay accumulated costs.

Please support our nationwide campaign, make a contribution if you can, share this page on social media with the hashtag #ShekuBayoh, follow us on twitter @BayohJustice and a facebook page which will be set up very soon, and spread the word about the injustice that has devastated our family for the last five years and fight to ensure no other family is denied justice and the truth.

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Sheku Bayoh's family in 'brutally honest' meeting with Police Scotland chief

It came after deputy first minister Kate Forbes rejected their request to extend the remit of the inquiry examining his death.

PA Media

26th Feb 2025

The family of a man who died in police custody have held a "brutally honest" meeting with Scotland's top police officer, in the wake of a decision by the deputy first minister not to extend an inquiry into the death to examine why no prosecutions were brought.

Sheku Bayoh, a father-of-two, died after he was restrained by around six police officers who were called to Hayfield Road in Kirkcaldy, Fife, on May 3, 2015.

The Crown Office decided not to take legal action against the police involved in the incident following an investigation.

Mr Bayoh's family had urged Kate Forbes to extend the terms of reference of the public inquiry investigating the circumstances of the 31-year-old's death, and whether race was a factor, to also include the Crown's decisions not to bring any prosecutions in 2018 and 2019.

However on Tuesday, Forbes confirmed the remit of the inquiry will not be changed, saying doing so would not be in the public interest.

Mr Bayoh's sister Kadi Johnson met with Police Scotland chief constable Jo Farrell on Wednesday, along with the family's solicitor, Aamer Anwar.

Speaking afterwards, Mr Anwar said Forbes had "betrayed" the promises made to the family by the Scottish Government.

"Today, Kadi Johnson, sister of Sheku Bayoh, and myself met with the chief constable in what can be described as a robust but brutally honest meeting," he said.

Ad

“The family are grateful to the chief constable for coming to meet the family, especially in the aftermath of the deputy first minister’s decision.

“Kate Forbes should hang her head in shame; she betrayed the promises made to the family by the Scottish Government, but inadvertently, she has left the door open to exposing the failure of the Crown Office.”

He referred to part of a letter Forbes had sent to him on Tuesday explaining her decision, where she said she is “confident” inquiry chairman Lord Bracadale will highlight any evidence suggesting “prosecutorial decisions may have been made on a flawed basis”.

Mr Anwar said the family had asked Ms Farrell to “consider reinvestigating the criminal complaints against police officers”, adding this is justified by the evidence revealed during the inquiry.

The lawyer also said the chief constable had confirmed in the meeting previous comments that Police Scotland is “institutionally racist” and that it needs to change.

“The chief constable apologised for the treatment of the Bayoh family and reiterated her continued support for the public inquiry, and confirmed that Police Scotland is institutionally racist and they must change so that no-one suffers the terrible trauma the Bayoh family has,” he said.

In a brief statement, Ms Johnson said she and the rest of the family are “tired” following their decade-long campaign for justice.

She said: “I am tired. It will be ten years in May, and we are still fighting for justice.”

Speaking after the meeting, Ms Farrell said she “very much welcomed” the opportunity to meet with Mr Bayoh’s family.

“I took the opportunity to express my personal condolences and reiterated those of the service,” she said.

“I am very aware of the significant impact his death had on his family, friends, the wider community of Kirkcaldy and beyond, and serving and retired officers.

Ad

“This meeting also allowed me to underline Police Scotland’s commitment to participate in every aspect of the public inquiry and to positively assist the chair in discharging the terms of reference.”

The chief constable added that she had highlighted the work being done under the force’s Policing Together programme, which she said aims to “drive a culture change towards

becoming an anti-racist, anti-discriminatory service which better reflects and represents the communities we serve".

She continued: "I repeated the assurances that both myself and the senior leadership of Police Scotland are absolutely committed to driving this work forward with a very clear determination to address any recommendations made by the inquiry."

Forbes said on Tuesday: "Mr Bayoh's family continue to have my deepest condolences.

"As set out in legislation, I may amend the terms of reference if I consider the public interest requires this.

"The inquiry's terms of reference were announced in May 2020 and I have decided it is not in the public interest to extend the remit almost five years later and after evidential hearings have concluded.

"I hope that it is now possible for the chair to deliver his independent findings and recommendations as soon as possible.

"I am confident that the terms of reference, as announced in 2020, are sufficiently broad to allow the chair to present a substantial report with detailed findings and recommendations – including on the investigation and the extent to which Mr Bayoh's actual or perceived race was a factor."

The inquiry, which has heard 122 days of evidence, will now move to closing submissions, and Lord Bracadale has pledged he will then prepare his final report without delay.

Mr Anwar said the family had told the chief constable that "charges must follow" once the inquiry ends.

"This isn't the end because, as we said to the chief constable today, charges must follow in Scotland," he said.

"Those police officers that have been shown to have lied, to have broken the law, to have engaged in criminality.

Ad

“So once the public inquiry ends, we expect the Solicitor General to do her job.”

On Tuesday, a Crown Office and Procurator Fiscal Service (COPFS) spokesperson said: “COPFS continues to be supportive of the inquiry as a source of transparency and accountability.

“We welcome every opportunity to reflect upon our work and identify any possible areas for improvement.

“The Crown examined the death of Sheku Bayoh in great detail and has reserved its right to prosecute.”

The Scottish Government has been contacted for comment.

These notes refer to the Inquiries Act 2005 (c.12)
which received Royal Assent on 7 April 2005

INQUIRIES ACT 2005

EXPLANATORY NOTES

INTRODUCTION

1. These explanatory notes relate to the Inquiries Act which received Royal Assent on 7 April 2005. They have been prepared by the Department for Constitutional Affairs in order to assist the reader in understanding the Act. They do not form part of the Act and have not been endorsed by Parliament.

2. The notes need to be read in conjunction with the Act. They are not, and are not meant to be, a comprehensive description of the Act. So where a section or part of a section does not seem to require any explanation or comment, none is given.

OVERVIEW

3. The Inquiries Act is intended to provide a comprehensive statutory framework for inquiries set up by Ministers to look into matters of public concern. It gives effect to proposals contained in a Government consultation paper, dated 6 May 2004 entitled "Effective Inquiries", which itself arose out of a memorandum, submitted to the House of Commons Public Administration Select Committee as part of its "Government by Inquiry" investigation.

4. The explanatory notes are divided into groups of sections reflecting the structure of the Act. In relation to each group of sections, there is a summary, and also some background. Commentary on particular sections is then set out in numerical order, with the commentary on the various Schedules included with the sections to which they relate.

5. The sections are grouped under 10 cross-headings:

Constitution of inquiry

These sections make provision for Ministers to set up formal, independent inquiries relating to particular events which have caused or have potential to cause public concern, or where there is public concern that particular events may have occurred. These sections also make provision for Ministers to set the terms of reference, to appoint a chairman to conduct the inquiry, and also additional panel members and assessors where appropriate.

Conversion of inquiries

These sections contain provisions that will allow inquiries established otherwise than under this Act to be converted into inquiries under the Act.

Inquiry proceedings

These sections make provision about how inquiries held under this Act are to be conducted. They provide for an inquiry chairman to have powers to require the production of evidence and for the establishing Minister or the chairman, or both, to be able to place restrictions on public access to the inquiry where appropriate.

Inquiry reports

These sections place a duty on the inquiry chairman to deliver a report to the commissioning Minister and set out what the final report may contain. They also contain a provision concerning the publication of the inquiry's report.

Scotland, Wales and Northern Ireland

These sections deal with the respective powers of United Kingdom Ministers, Scottish Ministers, Northern Ireland Ministers and the National Assembly for Wales to set up inquiries under this Act.

Inquiries for which more than one Minister responsible

Contains provisions on inquiries established jointly by two or more Ministers, including cross-border inquiries within the United Kingdom.

Supplementary

These sections create offences and also provide for the enforcement of inquiry orders by the High Court or Court of Session. They also contain provisions which will give members of an inquiry immunity from civil proceedings, place a time limit on bringing an application for judicial review (except in Scotland) and provide for the commissioning Minister to pay the costs of the inquiry panel, any assessors, any counsel and solicitor to the inquiry and anyone engaged to provide assistance to the inquiry. They also contain arrangements for payments of expenses of witnesses, including legal representation, where appropriate.

General

This group of sections contains definitions of words and expressions used in the Act. It also contains a provision which allows the Lord Chancellor, the Scottish Ministers, the National Assembly for Wales and the First Minister and deputy First Minister in Northern Ireland to make procedural rules.

Amendments etc

This group of sections contains amendments to the Financial Services and Markets Act 2000 and to section 23 of the Interpretation Act (Northern Ireland) 1954 and also introduces the Schedules of consequential amendments and repeals.

Final provisions

These include provisions about commencement.

TERRITORIAL EXTENT

This Act applies throughout the United Kingdom (see section 52). Section 28 applies specifically to Scotland, section 29 to Wales and section 30 to Northern Ireland.

COMMENTARY ON SECTIONS

Constitution of Inquiry

Section 1: Power to establish inquiry

6. This section enables any Minister to cause an independent inquiry to be held and sets out the circumstances in which the inquiry may be established. The range of inquiries in the past ten years illustrates that is not possible to specify more precisely the circumstances when an inquiry may be called. An inquiry could be called into a particular event (e.g. Dunblane inquiry 1996) or a series of events (e.g. BSE inquiry 1997). Although most

past inquiries have been triggered by events, they have also been held where there is a concern that something has failed to happen or that particular systems have not operated properly (for example, the Climbié inquiry 2001). This section allows for an inquiry to be set up when there are concerns of this type too.

7. The Act is UK-wide. Ministers from the Devolved Administrations will have the power to establish inquiries into matters within their remit.

Section 2: No determination of liability

8. The purpose of this section is to make clear that inquiries under this Act have no power to determine civil or criminal liability and must not purport to do so. There is often a strong feeling, particularly following high profile, controversial events, that an inquiry should determine who is to blame for what has occurred. However, inquiries are not courts and their findings cannot and do not have legal effect. The aim of inquiries is to help to restore public confidence in systems or services by investigating the facts and making recommendations to prevent recurrence, not to establish liability or to punish anyone.

9. However, as subsection (2) is designed to make clear, it is not intended that the inquiry should be hampered in its investigations by a fear that responsibility may be inferred from a determination of a fact.

Section 3: The inquiry panel

10. The aim of this section is to provide Ministers with the flexibility to appoint an inquiry panel that is appropriate to the circumstances under investigation. The Minister may appoint either a chairman to sit alone (e.g. Lord Cullen sat alone as the chairman to the inquiry into the shootings at Dunblane Primary School, 1996) or with one or more panel members (e.g. Michael Redfern QC chaired a three person panel for the Royal Liverpool Children's Hospital inquiry, 1999). Section 4 ensures that where the chairman will not sit alone the Minister will consult him on the appointment of any other panel members, including any appointed under section 7.

Section 4: Appointment of inquiry panel

11. This section is self-explanatory.

Section 5: Setting-up date and terms of reference

12. Section 5 requires the Minister to specify a setting-up date and terms of reference for the inquiry. The setting-up date given by the Minister is the date the inquiry formally comes into existence as an independent body. This date is purely a formality and need not relate to any other event connected with setting up the inquiry, such as an opening meeting. Before this date an inquiry will not begin considering evidence. It might, however, begin taking some practical steps to find premises and staff.

13. An inquiry is set up to investigate a particular set of circumstances. The remit of the inquiry must be set out by the Minister in the terms of reference before the setting-up date. The Minister must consult with the chairman when either setting or changing the terms of reference. The Act does not contain any specific requirement for the Minister to consult other individuals or organisations, but they can be consulted if the Minister considers it appropriate in the particular circumstances. The period of time leading to the setting-up date could be used for consultation.

14. The type of information contained in the terms of reference will vary from inquiry to inquiry. For example, the terms for the Victoria Climbié and Shipman inquiries were fuller than those used for the Bloody Sunday inquiry. In some cases it might be appropriate to specify a date by which the inquiry is asked to report, or the level of urgency. The definition of terms of reference in this Act is wide in order to allow for

appropriate terms of reference to be set for a wide range of inquiries under this section. Under subsection (6)(c) of section 5, the Minister must specify whether the inquiry is asked to make recommendations. However, section 24(1), which is concerned with inquiry reports, makes it clear that the panel may make recommendations even if this was not a requirement in the terms set by the Minister.

Section 6: Minister's duty to inform Parliament or Assembly

15. This section requires the Minister to inform "the relevant Parliament or Assembly" that he intends to hold an inquiry and to give certain details about it. As the definition of this expression in section 43 makes clear, the relevant Parliament or Assembly will depend upon whether the Minister is a UK Minister or a Minister in a devolved administration. If the inquiry is being set up jointly by Ministers from more than one administration, this section requires statements to be made to each relevant Parliament or Assembly. The Act requires statements to be made "as soon as is reasonably practical", which allows for periods of recess, for example.

Section 7: Further appointments to inquiry panel

16. This section is self-explanatory.

Section 8: Suitability of inquiry panel

17. The Minister is required to consider the factors in subsection (1)(a) and (b) of section 8 every time he makes an appointment, including any further appointments during the inquiry. He must consider the need for balance in relation to issues that are likely to be relevant to the terms of reference. So, for example, this requirement would not usually mean that the Minister needs to consider appointing an equal number of men and women to the panel, unless the subject matter of the inquiry means that the sex of the panel members is particularly relevant. What it does mean is that he should consider balance in terms of the relevant experience that the panel members bring. So, for example, the panel of the Bristol Royal Infirmary inquiry consisted of a professor of health law, ethics and policy, a professor at the Imperial College School of Medicine and practising GP, an academic specialising in family law and an executive director of nursing with 20 years' experience. That panel had a range of experience, which was balanced between different subject areas and between academic and practical experience. The requirement does not mean that the panel must contain people who would be seen as representing all the groups with an interest in the inquiry. It does mean, however, that the Minister should avoid appointing a set of panel members who, in the light of their combined experience and backgrounds, are likely to tend towards a particular viewpoint.

18. Under subsection (2) the Minister may bear in mind the contribution of assessors to the expertise of the panel for the purposes of subsection (1)(a). The purpose of subsection (1)(a) is to ensure that the panel has the ability to conduct an informed analysis of the evidence and produce a full and useful report. Assessors may provide expert assistance to the panel members, enabling them to do this. However subsection (1)(b), which provides for the need for balance in the context of the terms of reference, does not take into account the contribution of any assessors. This is because it is the panel, and the panel alone, who have responsibility for the contents of the report, and the requirement for balance is designed to ensure that this report is fair and reasoned. The panel may ask for the assistance of those working for the inquiry, including the assessors, in writing the report, but it is the panel who have the final word on what goes into the report.

Section 9: Requirement of impartiality

19. A person might be said to have an "interest" in the events which gave rise to the inquiry where the matters raised impinge on issues which he is concerned about, either personally or professionally. Therefore a "direct interest" would be present where

the individual's concern with the events is particularly strong. In contrast, "close association" focuses not so much on the interests of the individual, but on the links (whether personal or professional) that the individual has. For example, were an inquiry panel member to have ties with a witness, there might be concerns about the weight which that inquiry panel member would give to the evidence.

20. The section does not prevent the appointment of individuals with expertise in a specific subject area, as section 8 makes clear. For example, if an inquiry were set up to look into the circumstances surrounding allegations of misconduct by a doctor this section would not prevent the appointment to the panel of individuals with expertise in NHS monitoring practices who had not been involved in the case of that particular doctor. That experience in itself would probably not be regarded as constituting a "direct interest" or "close association".

21. There might be cases in which it would be beneficial to the inquiry to appoint a person with more direct experience of the area under investigation. In some specialised subject areas, it could be difficult to find panel members who did not have some sort of association with those involved, or a general interest in the subject matter. Even if a prospective panel member did have a "direct interest" or "close association", the section allows the Minister to appoint the individual, provided that the interest or association could not reasonably be regarded as affecting the impartiality of the panel as a whole.

Section 10: Appointment of judge as a panel member

22. This section deals with the circumstances in which a Minister proposes to appoint a (serving) judge as a panel member (including chairman) to an inquiry. The section sets out whom the Minister is required to consult before making such an appointment. In practice, it is likely that consultation for judges in England, Wales and Northern Ireland will be done through the Lord Chancellor.

Section 11: Assessors

23. The role of assessors will vary from inquiry to inquiry, but in essence they are experts in their own particular field whose knowledge, where necessary, can provide the panel with the expertise it needs in order to fulfil an inquiry's terms of reference. For example in the Victoria Climbié inquiry, four expert assessors, including a consultant paediatrician and a detective superintendent, joined the chairman, Lord Laming. Assessors do not have any of the inquiry panel's powers and are not responsible for the inquiry report or findings. An assessor could be appointed for the duration of the inquiry, but it would also be possible to appoint an assessor only for part of the inquiry, to assist when evidence on a particular subject was being considered.

Section 12: Duration of appointment of members of inquiry panel

24. In practice, if a panel member needs to leave the panel before the end of an inquiry, it is likely that he will resign. The circumstances covered in subsection (3), in which the Minister would be able to terminate the appointment of a panel member, are expected to arise very rarely.

Section 13: Power to suspend inquiry

25. An inquiry may be one of a number of investigations into a particular matter. Often, the respective timing of these is very important; for example, to ensure that an inquiry does not prejudice a criminal prosecution. The results of other investigations may also inform the inquiry and help prevent duplication.

26. In the event that new investigations or proceedings come to light or are commenced after the inquiry has started, it may be necessary to halt the inquiry temporarily. This section sets out the circumstances in which a Minister may, after consulting the chairman, suspend an inquiry to allow other proceedings to be completed.

Section 14: End of inquiry

27. This section sets out how an inquiry comes to an end. An inquiry is not permanent. It only exists between the setting-up date and the date on which it ends under this section. In most cases an inquiry will end when the chairman has submitted a report to the Minister and has done any further work necessary to wind up the inquiry, such as a costs assessment. However, there might be situations before the submission of the report in which it is no longer necessary or possible for the inquiry to continue. Evidence may emerge that obviates the need to hold an inquiry or demonstrates that the inquiry has the wrong focus, for example, if it emerged during an inquiry that the event being investigated was an act of sabotage rather than failings of a particular system, and ought to be dealt with by the police rather than an inquiry. Other events might occur which also need to be investigated, and it may be more appropriate to set up a single, wider-ranging inquiry, perhaps with a different panel. Something might happen, such as a fire or the death of a witness, which means that an inquiry will no longer have access to the evidence it needs to conduct an effective investigation, and it may no longer be in the public interest for it to continue. Such scenarios are unlikely, but possible. In such cases, and other unforeseen circumstances, the Minister, after consulting the chairman, is able to bring the inquiry to a close.

28. Subsection (2) provides that the Minister may not end the inquiry retrospectively. Any proceedings up to the date the Minister notifies the chairman an inquiry is ending would be valid.

CONVERSION OF INQUIRIES

Section 15: Power to convert other inquiry into inquiry under this Act

29. This section enables the Minister to convert an inquiry that is not being held under the Inquiries Act into an inquiry held under the Inquiries Act. In recent non-statutory inquiries, including Hutton and Bichard, the chairmen have stated that if formal powers were required, these would be made available to them by effectively converting to a statutory inquiry. Three recent health inquiries (Ayling, Neale, Kerr/Haslam) were converted from being held under a general power to do anything which related to the discharge of a Minister's duties (section 2 National Health Service Act 1977) into inquiries established under section 84 of the same Act which is a specific inquiry power with powers of compulsion.

30. The Minister may convert a non-statutory or statutory inquiry provided that he is satisfied that the matter the original inquiry was investigating fell within the scope of the circumstances in subsection (2), which are the same as those set out in section 1 of the Act. It is not intended that this power should be used to convert other types of inquiries, such as planning inquiries.

31. The Minister may, after consulting the chairman, change the terms of reference when converting the inquiry. This means that he can ensure that they fulfil the conditions set out in section 5. It may also be appropriate to alter the terms of reference if, for example, the inquiry is being converted because it has become clear that the scope of the original inquiry was too narrow, and a broader inquiry power is needed. The requirement to keep the relevant Parliament or Assembly advised (under section 6) applies also to converted inquiries.

Section 16: Inquiries converted under section 15

32. This section makes provision for inquiries converted under section 15. Orders made under the original inquiry may only be enforced using powers that the inquiry had at the time of making the order. For example, if the chairman of a converted inquiry had made a request for evidence prior to conversion, he could not prosecute an individual under section 35 for failure to comply. He would have to issue a notice under section 21, using the inquiry's new powers of compulsion first. Once an inquiry has been converted, the

appointment of the original panel members continues as if made under this Act and is subject to the provisions of section 12.

INQUIRY PROCEEDINGS

Section 17: Evidence and procedure

33. Subsection (3) requires the chairman to act fairly throughout the inquiry. This serves to underline the duty that already exists in the common law. In applying this duty the chairman may consider, for example, if certain participants require some form of legal advice or representation. Subsection (3) also ensures that the need to control cost is a valid consideration for the chairman when conducting and planning proceedings. The cost of inquiries will vary according to the complexity of the matters being investigated. The Minister is required, by section 39(3), to meet expenses incurred in holding the inquiry. Each decision to admit evidence, to hold oral hearings, or to allow legal representation adds to the cost of the inquiry. The requirement to have regard to cost will strengthen the chairman's ability to defend decisions in which the need to limit costly elements of an inquiry was a factor.

Section 18: Public access to inquiry proceedings and information

34. This section makes clear that, subject to any restrictions issued under the following section, the chairman is required to do what he considers reasonable to ensure public access to evidence in the ways set out in subsection (1)(a) and (b). The chairman is able to judge what is reasonable so, for example, if the panel has been sent documents that it considers to be irrelevant then the chairman may decide not to make those available with the rest of the evidence.

35. Broadcasting of inquiry proceedings is at the chairman's discretion. In the past, some inquiry chairmen have allowed broadcasting of particular stages, such as the opening statements. In deciding whether to allow broadcasting, the chairman will need to consider whether it would interfere with witnesses' human rights and, in particular, with the right to respect for a private and family life (Article 8 of the European Convention on Human Rights). Unlike inquiries under the Tribunals of Inquiry (Evidence) Act 1921, inquiries under the Inquiries Act will not be covered by section 9 of the Contempt of Court Act 1981, which places restrictions on sound recording.

36. Subsections (3) and (4) of this section provide that, in relation to the records of inquiries held under this Act, the general exemptions for the records of statutory inquiries in the Freedom of Information Act 2000 and the Freedom of Information (Scotland) Act 2002 ("the FOI Acts") will not apply. During the course of an inquiry held under the Inquiries Act, that inquiry is not a public authority for the purposes of those Acts. However, once an inquiry is over, its records are generally held by a public authority, such as a Government Department or the National Archives. Section 41 enables procedure rules to be made, which could provide for the passing of documents given to or created by an inquiry to a public authority. The exemptions in section 32(2) of the FOI Act 2000 and section 37(1)(b) of the FOI Act 2002 will not apply to information contained in those documents. This section does not affect the application of the FOI Acts to inquiries held otherwise than under this Act. Nor does it prevent any other exemption in the FOI Acts from applying to any information in inquiry records.

Sections 19 & 20: Restrictions on public access etc; Further provisions about restriction notices and orders

37. These two sections set out the extent to which inquiry proceedings can be held in private and evidence can be withheld from the public domain.

38. There may be circumstances in which part or all of an inquiry must be held in private, and over a third of the notable inquiries held in the past fifteen years have had some sort of restrictions on public access. These range from wholly private inquiries, such as

the Penrose inquiry into the collapse of Equitable Life and the "Lessons Learned" (Foot and Mouth) Inquiry, to mainly public inquiries such as the Bloody Sunday inquiry and the Hutton inquiry, in which a small amount of highly sensitive material was withheld from the public domain.

39. In some past inquiries, it has been the Minister who has specified restrictions, whereas in others the chairman has set the restrictions. Section 19 allows for both. It replaces a range of statutory provisions on public access in the legislation that is repealed by Schedule 2 including, for example, section 81 of the Children Act 1989, which states:

"(2) Before an inquiry is begun, the Secretary of State may direct that it shall be held in private.

(3) *When no direction has been given, the person holding the inquiry may if he thinks fit hold it, or any part of it, in private.*

40. Public access to past inquiries has been restricted for a variety of reasons. Section 19(4) sets out a number of matters that must be taken into account when determining whether it is in the public interest to issue a restriction notice or order. Most of these factors are self-explanatory.

41. Section 19(4)(c) is intended, among other things, to cover cases in which a person has received information that he would usually be prevented by law from disclosing. For example, the Financial Services Authority receives sensitive information about firms in its role as a regulator, but is prevented from disclosing that information generally by Part 23 of the Financial Services and Markets Act 2000. Inquiries' powers of compulsion would override those restrictions, but it might be appropriate for the chairman or Minister to consider preventing the information from being disclosed more widely.

42. Section 19(4)(d) recognises that some inquiries might be conducted more efficiently or effectively with restrictions on public access. Several recent inquiries under section 84 of the NHS Act 1977 have been held partially in private, with relatives and participants admitted but not the general public.

43. Restrictions that could be imposed on attendance under subsection (1)(a) of section 19 might range from the exclusion of the press or general public (allowing those with an interest in the inquiry to attend, as was the case in the Ayling and Neale inquiries) to the exclusion of everyone except the panel, the witness and, if appropriate, their legal representatives (as happened in the Penrose inquiry into the collapse of Equitable Life). They might be imposed on all hearings, or only where a particular witness was giving evidence or where evidence was heard on a specified topic. The nature of the restriction would depend upon the reasons for it. Similarly, a range of different restrictions might be imposed on the disclosure or publication of evidence or documents.

44. Nothing in section 19 is intended to prevent a witness from passing on evidence that he himself has given to an inquiry either whilst inquiry proceedings are ongoing or after the inquiry has ended. However, there might be situations in which restrictions under section 19 could prevent a person from passing on information that he has learnt as a result of his attendance at, or involvement in, the inquiry. If the powers in this section are exercised in any way that engages Article 10 of the European Convention on Human Rights then of course that exercise must be done in a way which complies with Article 10(2) of the Convention.

45. Section 20 allows the Minister and chairman to issue further restrictions and to vary or revoke their own restrictions at any time before the end of the inquiry. The Minister cannot vary or revoke the chairman's restrictions and vice versa. There is, however, nothing to stop the chairman from asking the Minister to consider exercising his discretion to vary a notice. The power to vary notices and orders will allow for situations in which it becomes apparent that more information can be made public than was originally envisaged, or that more people can be given access to information than

allowed by the original notice, as well as any situations in which it becomes apparent that further restrictions are necessary.

46. Section 20 provides that, except in relation to inquiry records, restriction notices and orders continue indefinitely unless otherwise specified or unless they are revoked. Orders restricting attendance will only be relevant during the course of the inquiry, but some orders restricting disclosure or publication of evidence might need to continue beyond the end of the inquiry. For example, if an inquiry chairman issued an order that the identity of a particular witness was to be kept confidential, because the witness could be at risk if his identity were disclosed, that order would need to continue to protect that witness after the inquiry had ended.

47. Subsection (6) of section 20 is designed to ensure that restrictions do not create a barrier to disclosure of information from inquiry records under the FOI Acts. In addition to this, subsection (7) allows the Minister to relax or revoke restrictions after the end of an inquiry. This is to ensure that any restrictions still in place (which apply to information other than in inquiry records) can be removed if they become unnecessary.

48. Disclosure restrictions would not prevent a person not involved in the inquiry from disclosing or publishing information that had come into his possession through means unconnected with the inquiry, even if some of that information might be included in documents or hearings that were covered by a restriction order or notice.

49. For example, suppose that an inquiry were set up into the death of a hospital patient, and that a restriction notice were issued to exclude the general public from the proceedings and to prevent the publication of transcripts of evidence, because it was considered that an inquiry held partly in private would be more effective. The inquiry might consider information already in the public domain, such as papers from the inquest, or statements of hospital policy. The fact that a restriction notice was in place for the inquiry would not prevent a member of staff at the hospital from providing a patient with a copy of the hospital policy.

50. To take another example, suppose that a Government department provided information to an inquiry held in private and that, after the end of the inquiry, a request were made under the Freedom of Information Act 2000 for some of that information. The Department could not refuse to provide the information purely because it happened to have been covered by the restriction notice, because the Department would have held that information even if the inquiry had never happened. The purpose of a restriction notice is just to restrict disclosure of information in the context of the inquiry or to restrict disclosure by those who have received the information only by virtue of it being given to the inquiry.

Section 21: Powers of chairman to require production of evidence etc

51. This section provides inquiries with statutory powers to compel evidence. The powers are exercisable by the chairman, but in a multi-member inquiry he will be exercising them on behalf of the panel. It is envisaged that most requests for information from an inquiry panel will not be made under section 21. An inquiry panel will usually ask for information informally first, and experience from past inquiries has shown that the vast majority of informal requests will be complied with. There are three main scenarios in which powers of compulsion are likely to be used:

(i) a person is unwilling to comply with an informal request for information;

(ii) a person is willing to comply with an informal request, but is worried about the possible consequences of disclosure (for example, if disclosure were to break confidentiality agreements) and therefore asks the chairman to issue a formal notice; or

(iii) a person is unable to provide the information without a formal notice because there is a statutory bar on disclosure.

52. Section 21(4) covers two reasons for which a person might refuse to comply with a notice issued under powers of compulsion. Subsection (4)(a) would cover circumstances when the person was unable to comply, for example, if he did not have the information being requested. Subsection (4)(b) is designed to cover situations in it would be unreasonable to expect a person to comply. This might be because the difficulty, time or expense involved in providing the information would be so great that a person could not reasonably be expected to do so. For example, if an inquiry chairman gave a notice requesting that an organisation produce every document it had on a particular topic within two weeks, and the organisation would have to search through thousands of files to comply, the organisation might make a claim under section 21(4)(b). The chairman would then consider, under section 21(5), whether the public interest in obtaining the information within that timeframe outweighed the cost, bearing in mind how important the information was likely to be. He might choose to vary his notice by extending the deadline, narrowing the categories of information being asked for, or by specifying that the organisation only need to search certain sites for the information. Section 21(4)(b) could also cover situations in which it would not be reasonable to expect a person to provide evidence because the evidence is unlikely to be of material assistance to an inquiry.

53. On occasion, it is possible that the evidence being requested will be an intercepted communication. To ensure that such material can be disclosed to the inquiry, there is an amendment in paragraph 21 of Schedule 2 to the Act to ensure that this is permissible under section 18 of the Regulation of Investigatory Powers Act 2000.

Section 22: Privileged information etc

54. Section 22(1) ensures that witnesses before inquiries will have the same privileges, in relation to requests for information, as witnesses in civil proceedings. In particular, this means that a witness will be able to refuse to provide evidence:

(i) because it is covered by legal professional privilege;

(ii) because it might incriminate him or his spouse or civil partner (by virtue of section 84 the Civil Partnerships Act 2004); or

(iii) because it relates to what has taken place in Parliament.

55. In some recent inquiries, the Attorney General has given undertakings along the following lines:

""To undertake in respect of any person who provides evidence to the inquiry that no evidence he or she may give before the inquiry, whether orally or by written statement, nor any written statement made preparatory to giving evidence nor any document produced by that person to the inquiry will be used in evidence against him or her in any criminal proceedings, except in proceedings where he or she is charged with having given false evidence in the course of this inquiry or having conspired with or procured others to do so."

56. If such an undertaking was given, it would be difficult for an individual to refuse to answer certain questions by claiming the privilege against self-incrimination. As for subsection (1)(b), in certain circumstances European Community law may prevent a person from disclosing information to others. An example of this is article 30 of the Directive of the European Parliament and of the Council of 20 March 2000 relating to the taking up and pursuit of the business of credit institutions, which is commonly known as the Banking Consolidation Directive.

57. Section 22(2) provides expressly that it will be possible to make in an inquiry, as it is in civil proceedings, an assertion that documents or information should be withheld from the inquiry (or from public disclosure) on the grounds that they are immune from disclosure in the public interest ("public interest immunity" or PII). Such applications have been made to inquiries in the past, including the Bloody Sunday Inquiry, for

example, on the grounds that disclosure of the information would be prejudicial to national security. The Government's policy on claiming PII is that Ministers will claim PII only when it is believed that disclosure would cause real damage or harm to the public interest and that this outweighs the public interest in open justice. A claim for PII should be made by the person whose duty it is to protect the information (which need not necessarily be the Crown) supported by evidence (usually in the form of a witness statement or ministerial certificate) that disclosure would cause real damage or harm to the public interest. It is then the responsibility of the inquiry panel, having viewed the documents or information, to balance the public interest in disclosure against the public interest in maintaining confidentiality. Having carried out that "balancing exercise", the inquiry must decide whether to uphold the claim for immunity and, if so, on what terms. The inquiry panel may decide that the information may be withheld, or that it be disclosed in whole or in part (after "redaction").

58. Section 35(4) makes clear that a person who does not produce evidence to an inquiry because it is covered by section 22 is not committing any of the offences created in section 35 relating to distortion, suppression or destruction of evidence. In the case of a refusal to comply with an order of the inquiry on the ground that the evidence was covered by section 22, this could also be relied on as a "reasonable excuse" under section 35(1) for failure to comply with an order of the inquiry.

59. The House of Lords has recently made it clear in its decision in *Three Rivers v Bank of England* [2004] UKHL 48 that legal advice privilege applies in relation to advice given to witnesses in the context of an inquiry. Such privilege extends to advice given about the presentation of evidence, since it is given within a relevant legal context. There is therefore no need for an express provision relating to the application of legal professional privilege to inquiries in the legislation.

Section 23: Risk of damage to the economy

60. Although an application under section 23 can be made only by those acting on behalf of the bodies specified (the Crown, Financial Services Authority or Bank of England), it can be made in respect of information held by any person. The inquiry panel will carry out a balancing exercise between the public interest in the information being revealed to the public and to other participants and the public interest in avoiding a risk of damage to the economy. If the inquiry panel considers that the public interest in avoiding the risk of damage to the economy outweighs the public interest in disclosure, it will be able to take this material into account in its deliberations but will not be able to refer to the material (or its existence) publicly. Section 23 does not impact upon the general principles of public interest immunity, but exists in addition to them.

INQUIRY REPORTS

Section 24: Submission of reports

61. Section 24 places a duty on the chairman of an inquiry to report its conclusions to the Minister. If an inquiry has been brought to an end early under section 14(1)(b), the chairman does not have to produce a report but he can do so if he wishes. In the unlikely event that a member of the inquiry panel disagrees with the general conclusions to such a great extent that no amount of modification under section 24(5) will produce a report that he is content to sign, he can release himself from the obligation, under subsection (4), to sign it by resigning from the panel.

Section 25: Publication of reports

62. Subsection (4)(a) would allow, for example, the person publishing the report to redact personal information (such as medical reports) as required by the Data Protection Act 1998. The factors that the person publishing the report must take into account, when considering whether any redaction is in the public interest under subsection (4)(b), are

equivalent to those for restriction notices and restriction orders (see section 19(4)), except for the references to cost, effectiveness and efficiency of the inquiry, which are no longer relevant in the context of reports.

Section 26: Laying of reports before Parliament or Assembly

63. The report published under section 25 will be the same version required to be laid before the relevant Parliament or Assembly.

SCOTLAND, WALES AND NORTHERN IRELAND

64. This group of sections deals with the respective powers of United Kingdom Ministers, of Scottish Ministers, of the National Assembly for Wales and of Northern Ireland Ministers to set up inquiries under this Act. The Act allows Ministers in each administration to set up inquiries in their administration's own areas of responsibility but contains limitations, set out in sections 27 to 30, which reflect the terms of each devolution settlement.

Section 27: United Kingdom inquiries

65. This section provides that a Minister setting up a United Kingdom inquiry cannot include anything in the terms of reference that would require the inquiry to receive any evidence or make any recommendations that are wholly or primarily concerned with a Scottish, Welsh or Northern Ireland matter without consulting the devolved administration first. It is envisaged that UK Ministers will not usually set up inquiries into devolved matters without the agreement of the relevant devolved administration and that Ministers will consider whether a joint inquiry between the two administrations would be appropriate instead.

66. The section also places similar constraints on the use of powers of compulsion into devolved matters. If the terms of reference covered devolved areas (and the Minister had therefore already consulted the devolved administration under subsection (2)), the Minister might also need to give the inquiry permission to use its powers of compulsion in all the devolved areas that would be covered by the terms of reference.

67. Even if the terms of reference mentioned only reserved areas (and no consultation had been necessary under subsection (2)), the panel might consider it necessary to take evidence on certain devolved matters in order to fulfil them. For example, suppose that a United Kingdom inquiry had been established to investigate an incident relating to gun control. The inquiry might need to take medical evidence from a Scottish hospital in relation to injuries caused. If the panel believes the evidence is relevant to its terms of reference, it is entitled to consider it, provided that the hospital is willing to provide it. Similarly (see sections 28, 29 and 30 below) devolved inquiries are entitled to take evidence on reserved and excepted areas (except as prohibited by section 30(7)) provided it is relevant to the terms of reference and is willingly given. However, there might be occasions when a person is unable or unwilling to provide evidence without a notice under section 21, compelling him to do so. For United Kingdom inquiries, this is dealt with by section 27(3). (A different approach is taken for the devolved administrations, and is described in the notes on section 28.) The inquiry can apply to the Minister for permission to use its powers of compulsion in devolved areas. Before granting permission, the Minister would have to consult the devolved administration. It is envisaged that UK Ministers will not usually grant permission without the agreement of the relevant devolved administration.

68. Subsection (6) is needed to prevent a possible gap in coverage between the powers of inquiries set up by UK Ministers and by Northern Ireland Ministers, which arises out of the way in which "Northern Ireland matter" has been defined. This is explained in the notes on section 30.

Section 28: Scottish inquiries

69. As explained above, a Scottish inquiry may take evidence on reserved matters, if the panel considers that it is relevant to the terms of reference. However, it cannot compel that evidence, except in so far as it is allowed by subsection (3). Subsection (3)(b) has the effect of allowing Scottish inquiries to compel evidence on reserved matters if this is for the purpose of inquiring into something that is wholly or primarily a Scottish matter. The reasons for this power are best illustrated by an example. Suppose that the Scottish Ministers were to establish an inquiry into the environmental effects of flooding in Scotland and that one of the causes of flooding in Scotland is the leakage of polluted water from coal mines. The inquiry might wish to compel the production of documents held by a coal mining company relating to the operation of the water pump in its coal mine. However, coal mining is a reserved matter (section D3 of Part 2 of Schedule 5 to the Scotland Act 1998) and the documents are therefore concerned with a reserved matter. It would be difficult to say that a document prepared by a coal mine operator into the routine maintenance of its water pumps, which most likely would have been prepared long before the events giving rise to public concern occurred and without any anticipation of the events that occurred, were wholly or primarily concerned with the devolved matter of environment.

70. However, it would not be possible for a Scottish inquiry to compel evidence under subsection (3)(b) from any member of the United Kingdom Government (including Government Ministers and the Departments acting on their behalf), or of the other administrations, because of the prohibition in subsection (4).

Section 29: Welsh inquiries

71. The provisions on Welsh inquiries mirror those on Scottish inquiries as explained above.

Section 30: Northern Ireland inquiries

72. The provisions on Northern Ireland inquiries are similar to those on Scottish inquiries described above, but reflect the differing circumstances of Northern Ireland and its devolution settlement.

73. The definition of "Northern Ireland matter" in section 30(8) covers some reserved matters in relation to which Northern Ireland Ministers have functions (see paragraph (b)), as well as transferred matters. However, section 30(6) creates some exceptions to the circumstances in which Northern Ireland inquiries can exercise their powers of compulsion in relation to those matters, in order to make the scope of inquiries' powers equivalent to the scope of the Northern Ireland Assembly's powers to summon witnesses and compel evidence. Since those exceptions are in section 30(6), rather than in the definition of "Northern Ireland matter", section 27(6) is needed to ensure that they are not also excluded from the scope of inquiries established by United Kingdom Ministers.

74. In addition to the general restrictions on terms of reference and powers of compulsion, subsection (7) provides that an inquiry established by a Northern Ireland Minister must not receive evidence or make any recommendations on matters falling within paragraph 17 of Schedule 2 to the Northern Ireland Act 1998, which deals with national security.

75. Whilst there is a suspension of devolved government in Northern Ireland, functions conferred on a Northern Ireland Minister may be discharged by the Secretary of State for Northern Ireland, by virtue of section 45.

Section 31: The relevant part of the United Kingdom and the applicable rules

76. Subsection (1) provides that when an inquiry is set up, the Minister or Ministers who established it must specify what is "the relevant part of the United Kingdom" for the

purposes of those provisions of the Act that use this expression. This will determine, for example, which law on privilege will apply and which court should have the powers to enforce orders of the inquiry (see sections 22(2) and 36(3)). It will not necessarily correspond to the administration setting up the inquiry. For example, if a United Kingdom Ministers were to establish an inquiry into a reserved matter in Scotland, which conducted its hearings mainly in Scotland, it would make sense for the relevant part of the United Kingdom to be Scotland. The relevant part of the United Kingdom will usually be the part in which the inquiry is being held, but it is possible that an inquiry may have several venues so for clarity it is important that the Minister or Ministers specify which part it is to be.

77. Subsection (2) applies (typically) where there is an inquiry involving two administrations each of which has made rules under the power conferred by section 41. It requires the Ministers responsible for the inquiry to specify which set of rules is to apply. For example, in the case of a joint inquiry set up by a United Kingdom Minister and the Scottish Ministers, the Ministers might specify the rules made by the Lord Chancellor or the rules made by the Scottish Ministers, or some of each. Subsection (4), on the other hand, gives power to a United Kingdom Minister setting up an inquiry into non-devolved matters in, say, Scotland to specify not only that the relevant part of the United Kingdom is Scotland but also that some or all of the rules applicable to the inquiry are to be rules made by the Scottish Ministers.

INQUIRIES FOR WHICH MORE THAN ONE MINISTER RESPONSIBLE

Section 32: Joint inquiries

78. In practice, this section would probably be used in situations where the subject matter of the inquiry fell within the responsibilities of more than one Minister. For example, the Victoria Climbié inquiry was established by the Home Secretary and the Secretary of State for Health. Sometimes, a joint inquiry might involve Ministers from more than one administration. For example, if devolution had been in place at the time of the Dunblane inquiry, which related both to firearms (a reserved issue) and safety in schools (a devolved one), the Scottish and UK Ministers might have chosen to set up a joint inquiry. Inquiries involving more than one administration are dealt with in more detail in the next section.

Section 33: Inquiries involving more than one jurisdiction

79. This section applies specifically to joint inquiries for which the responsibility is shared between two (or more) administrations – for example a joint inquiry set up by a United Kingdom Minister and the Welsh Assembly, or even a joint inquiry set up by the Scottish Ministers and the Northern Ireland Assembly. (The wording of subsection (1) reflects the fact that there are several United Kingdom Ministers and several Northern Ireland Ministers, whereas the Scottish Ministers and the National Assembly for Wales are each a single legal entity.)

80. This section sets out how the restrictions on terms of reference and powers of compulsion will work. Subsection (2) means that the terms of reference of the joint inquiry can cover matters that any one of the relevant Ministers would be able to establish an inquiry into. For example, the terms of reference of a joint inquiry established by Scottish Ministers and the National Assembly for Wales could require the inquiry to receive evidence or make recommendations that are wholly a primarily concerned with a Welsh or Scottish matter, but not on anything else. The terms of reference of a joint inquiry established by United Kingdom Ministers and Scottish Ministers could require the inquiry to receive evidence or make recommendations about anything not wholly concerned with a Welsh or Northern Ireland matter, and could extend to Welsh and Northern Ireland matters only if the UK Minister had first consulted the relevant administrations. The restrictions on powers of compulsion will operate in the same way.

Section 34: Change of responsibility for inquiry

81. This section might be used if it became clear, during the course of the inquiry, that its focus was more properly within the responsibilities of a Minister other than the commissioning Minister. For example, if a United Kingdom Minister had established an inquiry into events in Scotland that was expected to examine primarily reserved matters, and it subsequently became clear that there were significant implications for devolved matters, the establishing Minister might agree with the Scottish Ministers to share responsibility for the inquiry, making it an inquiry to which section 33 applied. This section might also be used to pass responsibility for an inquiry from one Minister to another within the same administration.

SUPPLEMENTARY

Section 35: Offences

82. This section provides sanctions for non-compliance with an inquiry, or for actions that are likely to hinder the inquiry. The offences created are similar to some of those created by section 250 of the Local Government Act 1972, which have been applied to a number of different types of inquiry in the past, including some under powers being repealed by this Act.

83. The offences created in this section are summary offences and would be dealt with by magistrates (or, in Scotland, in the Sheriff or District Court). The maximum penalty given is the maximum for summary offences. Level three on the standard scale is currently £1000. The maximum term of imprisonment for summary offences is currently six months, but it will be extended to 51 weeks in England and Wales once section 281(5) of the Criminal Justice Act 2003 is commenced. Section 44(3) ensures that the maximum term will be read as six months before that section is commenced.

84. In particular section 35(1) makes it an offence to fail, without a reasonable excuse, to comply with a formal notice requiring attendance at the inquiry or the production of evidence. Subsections (2) and (3) go wider, making it an offence to deliberately distort or conceal relevant evidence. These sections are drafted in such a way that it should not be possible for a person to commit an offence unwittingly (for example, by destroying a document that he does not realise is relevant). Subsection (4) ensures that a person does not commit an offence under subsection (2) or (3) if he is withholding evidence because he is allowed to do so by section 22 or, for example, if the evidence is covered by legal professional privilege. Subsection (4) also ensures that offences of suppressing or distorting evidence do not cover actions authorised by the panel (for example conducting a forensic test on a piece of evidence). The fact that the evidence was covered by section 22 or a privilege could also be relied on as a "reasonable excuse" under subsection (1).

85. In England and Wales and Northern Ireland, only the chairman can institute a prosecution for non-compliance with a notice issued under powers of compulsion. This is because it is for the chairman to decide whether to enforce notices issued under his powers of compulsion, and how best to do this. He has two possible options: prosecution for an offence under section 35 or enforcement of the notice by the appropriate court under section 36. It is considered to be undesirable for someone else to be able to begin a prosecution under section 35 when the chairman has decided instead to certify the matter to the High Court (or equivalent) under section 36.

86. Prosecutions for offences under subsection (2) or (3) may be brought only by or with the consent of the Director of Public Prosecutions in England, Wales and Northern Ireland. This serves to ensure that it is not open to those with an interest in the outcome of the inquiry to bring private prosecutions against witnesses with whose evidence they disagree. It also ensures that prosecutions can be brought after the inquiry has ended (which would not be possible if the chairman had to bring them). Some offences of this

nature might come to light only after the end of an inquiry. In Scotland, prosecution of any offence is the responsibility of the Crown Office and Procurator Fiscal Service.

Section 36: Enforcement by High Court or Court of Session

87. This section provides for an appropriate court (the High Court or Court of Session) to enforce notices issued under powers of compulsion, restriction notices and any orders of the inquiry, including restriction orders. Where a person breaches a notice or order, or threatens to do so, the chairman of the inquiry (or the Minister, after the end of the inquiry) can certify the matter to the court, which can then take steps to enforce the order. This is similar to the mechanism that would have been used to enforce orders issued under the Tribunals of Inquiry (Evidence) Act 1921.

88. In the case of notices issued under powers of compulsion in section 21, enforcement by the appropriate court is an alternative mechanism to prosecution, and could be used in cases where a prosecution might not be the best method of obtaining the relevant evidence. However, the court could also be asked to enforce a wider range of orders, for example, to prevent someone revealing the name of a witness whose identity was covered by a restriction order. This example could occur after the end of an inquiry, when the chairman is no longer in a position to certify the matter to the court, so section 36 provides for the Minister to certify matters to the court after the end of the inquiry.

Section 37: Immunity from suit

89. This section provides immunity for the inquiry panel, the inquiry's legal advisers and assessors, and other people engaged to assist it, from any civil action for anything done or said in the course of carrying out their duty to the inquiry. Subsection (1) will change the current practice whereby sponsor Departments usually have to provide indemnities to the inquiry, which can cause delays at the beginning of an inquiry. The lack of such protection was identified as an undesirable omission in the Tribunals of Inquiry (Evidence) Act 1921 in the report of the Royal Commission on Tribunals of Inquiry in 1966 (the "Salmon Report").

90. This section also provides that witness statements and inquiry reports will be covered by the same privilege, for the purposes of defamation law, as proceedings before a court. This privilege was already afforded to witnesses under the Tribunals of Inquiry (Evidence) Act 1921 but not under some subject-specific legislation.

Section 38: Time limit for applying for judicial review

91. The aim of this section is to reduce the time limit for judicial reviews of decisions that could delay an inquiry. This is because the prospect of a challenge to a procedural decision can halt the inquiry until it has been resolved by a court. For example, a challenge regarding a decision as to whether a witness could give evidence anonymously (perhaps to ensure his right to life was protected) would mean that the inquiry could not require evidence from that individual until the court had decided the matter. This time limit does not extend to challenges about the contents of reports or interim reports.

92. Unlike that in the Civil Procedure Rules, the time limit set by this section runs from the date on which an applicant became aware of the decision, not from the date on which the decision was made. Subsection (2) ensures that this change cannot serve to increase the time limit beyond the standard time limit in the Civil Procedure Rules or the Northern Ireland equivalent.

Section 39: Payment of inquiry expenses by Minister

93. This section sets out what the establishing Minister is obliged to fund and what he has discretion to fund.

94. Under subsections (4) and (5), the Minister is not obliged to fund activities that he has certified to the panel as being outside the inquiry's terms of reference.

95. The withdrawal of funding may be temporary and the Minister will resume funding if he is satisfied the inquiry is working back within the terms of reference. It is envisaged that any withdrawal of funding would only occur in exceptional circumstances. The Minister would be expected to notify the chairman if he had any concerns that the inquiry was working outside terms of reference, giving the inquiry an opportunity to address those concerns and avoid the need to remove funding.

96. Under subsection (6), the Minister is required to publish the total amount that he has paid for the inquiry under section 38. This requirement to publish costs would not cover all those costs to which the chairman must have regard under section 17(3), such as costs borne by witnesses themselves.

Section 40: Expenses of witnesses etc

97. Legal costs of participants often constitute the most significant part of the total cost of an inquiry. The non-statutory position adopted in recent inquiries has been for the Minister to decide, in consultation with the chairman, to fund those participating in the inquiry who are considered to have such a direct interest in the inquiry that they require representation but who may be unable to pay for representation themselves. The Government would not normally meet the costs of large organisations. This section enables this practice to continue. The chairman automatically has the power to pay costs, but the Minister can place qualifications on that power. The Minister will generally set out any broad conditions under which payment may be granted, and the chairman will then take the individual decisions.

98. The legal costs of Government witnesses might be met by the sponsoring department under the mechanism set out in this section, but not necessarily. If the witnesses were from a different department, their own department might pay for their representation, putting them in the same position as any other large organisation, to whom the inquiry would not usually grant funding.

GENERAL

Section 41: Rules

99. It is envisaged that the Lord Chancellor will make procedural rules for United Kingdom inquiries under this section. There is however no requirement for such rules to have been made before an inquiry may be established under the Act.

100. Subsection (2) enables rules to make provision for assessment of costs by a Costs Judge, among other things.

101. It is for the devolved administrations to make rules for their own inquiries. The rules will generally be subject to annulment by the relevant legislative body, as explained in subsections (5) and (6). However, there is no need for subsection (5) to make provision for Wales, because sections 66(2) and 67(3) of the Government of Wales Act 1998 set out the procedures for all general subordinate legislation made by the National Assembly for Wales.

Section 42: Notices

Section 43: Interpretation

102. These sections are self-explanatory.

Section 44: Transitory, transitional and saving provisions

103. Section 44 contains provisions for inquiries that have been set up under legislation that is being repealed by the Act. It will ensure, for example, that inquiries set up before this Act was introduced will not be affected by the provisions contained in this Act and will be able to continue as if the old legislation were still in place. It also provides that a Minister may still in the future set up an inquiry in ways other than under this Act, whether on a statutory basis or otherwise.

Section 45: Suspension of devolved government in Northern Ireland

104. This section ensures that during suspension of devolved government, the Secretary of State for Northern Ireland can exercise the powers of Northern Ireland Ministers to establish Northern Ireland Inquiries under section 30 and to make rules of procedure under section 41. The Secretary of State will be consulted, in place of the Northern Ireland Ministers, when consultation is required under section 27 or section 51.

AMENDMENTS ETC

Section 46: Inquiries under the Financial Services and Markets Act 2000

105. This section amends section 14 of the Financial Services and Markets Act 2000 ("FSMA") which provides a mechanism for the Treasury to appoint a person to hold an independent inquiry in various circumstances relating to the regulatory framework for the financial services industry. The amendment is intended to extend the possible scope of inquiries under FSMA to cover failings in the previous regulatory system (albeit only where the events triggering the inquiry have occurred after December 2001). References to *subsections* below are to those of section 14 of FSMA.

106. An inquiry may be held in two types of cases. The first case, set out in *subsection (2)*, relates to events concerning persons carrying on regulated activities or collective investment schemes. To trigger the power, it must appear to the Treasury that two conditions are met. The first of these is that the events posed, or could have posed, a grave risk to the financial system, or that they caused, or could have caused, significant damage to the interests of consumers. The second condition is that a serious failure in the regulatory system, or in the operation of that system, might have caused or exacerbated the risk or damage, or potential risk or damage.

107. The second case, set out in *subsection (3)*, relates to events concerning the listing function under Part VI FSMA and significant damage to holders of listed securities. Here the Treasury must be concerned with the damage, or potential damage, that might have been caused by a serious failure in the listing regime or its operation.

108. In both cases, the power to arrange an inquiry relates to serious failure in the regulatory system established by FSMA. Subsections (2) and (3) of the section expand the scope of *subsections (2)* and *(3)* to include serious failure in the regulatory system under predecessor legislation, albeit that the event triggering an inquiry (e.g. grave risk to the financial system or significant damage to consumers) is subject to a separate requirement (see below)

109. Subsection (4) of this section inserts a new *subsection (5A)*. This provides that an inquiry cannot be triggered where events described in *subsection (2)* and (3) occurred before 1 December 2001. An inquiry into similar events after 1 December 2001 could though consider circumstances surrounding these events, regardless of when these circumstances occurred.

Section 47: Inquiries etc under Northern Ireland legislation

110. This section amends the Interpretation Act (Northern Ireland) 1954 which applies the powers set out in Schedule 8 to the Health and Personal Social Services (Northern

Ireland) Order 1972 (referred to below) to inquiries and investigations set up by Ministers. Schedule 8 is being repealed by this Act. Subsection (2), which introduces Schedule 1 to the Act, ensures that any legislation under which these powers have been implicitly given to inquiries by virtue of the Interpretation Act (Northern Ireland) 1954 will be unaffected.

Section 48: Minor and consequential amendments

111. Schedule 2 to this Act contains minor and consequential amendments to other legislation. Many of the amendments are to pieces of legislation relating to other types of inquiry that explicitly incorporate the powers in Schedule 8 to the Health and Personal Social Services (Northern Ireland) Order 1972, which is being repealed by this Act. The relevant provisions of that order are reproduced in a new schedule to the Interpretation Act (Northern Ireland) 1954 which is inserted by Schedule 1 to the Act, so that they can continue to apply to the legislation that will remain in force.

Section 49: Repeals and revocations

112. This section repeals the Tribunals of Inquiry (Evidence) Act 1921 and also introduces Schedule 3. The provisions being repealed in Schedule 3 are mainly ministerial powers to hold inquiries that could, in future, be established under the Inquiries Act.

FINAL PROVISIONS

Section 50: Crown application

113. This section ensures that the Act binds the Crown, so that the powers conferred on inquiries by this Act can be exercised in relation to Government Departments.

Section 51: Commencement

Section 52: Extent

Section 53: Short title

114. These sections are self-explanatory.

COMMENCEMENT

115. The provisions in the Act will come into force on a day appointed by the Lord Chancellor by order, after consultation with the devolved administrations (see section 51).

HANSARD REFERENCES

116. The following table sets out the dates and Hansard references for each stage of the Act's passage through Parliament.

Stage	*Date*	*Hansard reference*
House of Lords		
Introduction and First Reading	25 November 2004	Vol.667 Column 161
Second Reading	9 December 2004	Vol.667 Column 984-1017
Grand Committee First Day	18 January 2005	Vol.668 Column GC 191-248
Grand Committee Second Day	19 January 2005	Vol.668 Column GC 249-306
Report First Day	7 February 2005	Vol.669 Column 615-654

Stage	***Date***	***Hansard reference***
Report Second Day	8 February 2005	Vol.669 Column 692-734
Third Reading	28 February 2005	Vol.670 Column 13-48
House of Commons		
First Reading	1 March 2005	House of Commons Votes and Proceedings
Second Reading	15 March 2005	Vol.432 Column 149-218
Standing Committee 1st sitting	22 March 2005	Standing Committee B Column 1-36
Standing Committee 2nd sitting	22 March 2005	Standing Committee B Column 37-80
Standing Committee 3rd sitting	24 March 2005	Standing Committee B Column 81-106
Third Reading	6 April 2005	Vol.432 Column 1492-1499
House of Lords		
Consideration of Commons Amendments	7 April 2005	Vol.671 Column 889-911
Royal Assent		
House of Lords	7 April 2005	Vol.671 Column 950
House of Commons	7 April 2005	Vol.432 Column 1641

Statutory Inquiry: Anthony Grainger

Statement made on 17 March 2016

Statement UIN HCWS629

Statement made by

Mrs Theresa May

The Secretary of State for the Home Department

Conservative

Maidenhead

Commons

Statement

I am announcing today the establishment by the Home Office of an inquiry, under the Inquiries Act 2005, to investigate the death of Anthony Grainger who was fatally shot by an armed officer of Greater Manchester police in March 2012.

The Inquiry will be chaired by His Honour Judge Teague QC. In accordance with section 3(1) of the Act, I have decided that this inquiry be undertaken by Judge Teague alone as Chairman.

Judge Teague is a circuit Judge who was nominated by the Lord Chief Justice to lead the investigation and inquest into Mr Grainger's death. It has been necessary to convert the inquest to a statutory inquiry so as to permit all relevant evidence to be heard by the Judge. I have agreed with Judge Teague that the inquiry will have the same scope as the current inquest, which is being adjourned prior to the setting up of the inquiry.

The Inquiry Terms of Reference are therefore:

To ascertain when, where, how and in what circumstances Mr Anthony Grainger came by his death during a Greater Manchester Police operation, and then to make any such recommendations as may seem appropriate. In particular it will investigate:

1. The objectives and planning of the operation;
2. The information available to those who planned the operation, and the accuracy, reliability, interpretation, evaluation, transmission and dissemination of such information;
3. The decision to deploy armed police officers and to make arrests, and the criteria applied in reaching those decisions;
4. The command and control of the operation, its implementation, the actions of officers during the arrest phase, and the circumstances in which the officer who fired the fatal shot came to discharge his weapon;
5. The suitability or otherwise of the firearms, ammunition and other munitions deployed in the operation;
6. Any relevant firearms policies, protocols or manuals in force at the material time, together with any subsequent revisions or amendments;
7. Whether (and, if so, to what extent) the judgment, reactions or operational effectiveness of any of the planners, commanders or firearms officers were compromised by extended hours of duty or by limitations in their professional capabilities;
8. The extent to which Mr Grainger's injuries would have incapacitated him whilst he remained conscious;

9. Whether, after Mr Grainger was shot, his life could have been saved.

The arrangements for the inquiry will now be a matter for Judge Teague. The Ministry of Justice and Home Office will provide support to him.

Statement from

Home Office

Linked statements

This statement has also been made in the House of Lords

Home Office

Statutory Inquiry: Anthony Grainger

Lord Bates

The Parliamentary Under-Secretary of State, Home Office

Conservative, Life peer

Statement made 17 March 2016

HLWS612

Lords

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Friday, 20 January 2017
(10.30 am)
THE CHAIRMAN: Yes, Mr Beer.
MR BEER: Good morning, sir. Could we call, please, Marina Schofield.
MS MARINA SCHOFIELD (sworn)
THE CHAIRMAN: Thank you, Mrs Schofield. Would you like to sit down or are you happier standing up?
A. I will stand up.
THE CHAIRMAN: Certainly.
Questions from MR BEER
MR BEER: Mrs Schofield, my name is Jason Beer, I am counsel to the Inquiry. I am going to ask you in a moment to read a statement that you have prepared in relation to Anthony. I think there is a copy of the statement in large font available. In your own time, please read the statement.
A. My name is Marina Schofield, I am the mother of Anthony Paul Grainger who was shot in the chest by an officer from Greater Manchester Police on 3 March 2012. My beautiful boy was born on 26 January 1976. I loved him from the moment I saw him. I was 17 years old at the time. My mother had died when I was 12 and I was brought up by my dad along with my brother. My dad played a big part and helped me bring

up Anthony. I had three other children, Natalie, Stuart and Michael. Natalie died when she was nine hours old.
Anthony loved being a big brother to Stuart and Michael. When Anthony was six years old I split up from his father. Anthony helped me raise his two brothers.
When he was 15 to 16 years old he started to get into trouble due to being friends with a bad crowd. He was addicted to cars, he should have been a rally car driver. Unfortunately he began to steal cars for a joyride. When he was 16 he was sent to HMPYOI Stoke Heath, when he came home he seemed to turn a corner after meeting the love of his life, Rachel. Unfortunately this only lasted until their relationship broke down in 2002 and my granddaughter was born and Anthony adored her. Stuart and Michael loved having a niece.
In 2004 I married John. Anthony was the best man and his daughter was a flower girl. Anthony was the most loving and caring person and was made to be a dad. He was fantastic with children, even the neighbourhood kids loved him.
For a while after [redacted] was born Anthony kept his nose clean. He had his driving licence and his own car. When his daughter was one he started to have problems with his kidneys and when she was five he had

to have a transplant. He used to tell her the scar was from a shark bite. In 2007 his son was born and he was ecstatic. Three years later his relationship broke down with their mother and she moved to Carlisle. He would try and see his children as often as possible.
Anthony was a fantastic dad. He used to go to Carlisle to see his kids every weekend. If they ever wanted anything he would do his best to provide it. I remember once his daughter wanting a puppy, Anthony found the puppy she wanted straight away and was up in Carlisle that afternoon meeting her from school with a new puppy as a surprise.
I am worried about the Inquiry will affect the children, until now they have been shielded from publicity but I expect that the incident will now be in the newspapers and I worry as to how I can protect them from this --
THE CHAIRMAN: Don't worry.
A. -- asked me why a policeman shot her dad when the police are there to protect us. It is not easy to answer questions like that. Anthony had always worked with cars. He had known Colin Waters 20 years, they worked from the same yard for as many years as I can remember. I am not sure what their working arrangement was and whether they were partners or whether they operated

separately, but certainly Anthony used to be busy driving a recovery wagon and buying and selling car parts. He would recover vehicles after accidents and did a lot of trading on the internet.
Anthony started to get in trouble again after the children moved to Carlisle. He started to withdraw from me and John during this time. I believe it was because he didn't want to cause us any hassle with the police as a result of his dealings with them. I last spoke to Anthony at Christmas time in 2011. I know he did speak to John a few more times before his death.
On 3 March 2012, six police officers came to my house, it was approximately 11.35 pm. They told me that Anthony had been shot in Culcheth by police. My whole world fell apart. All I could think about was how I am going to tell his two young children that their daddy was gone forever and that the police did it. My son will never see his children grow up or walk his daughter down the aisle. I have since been diagnosed with post traumatic stress disorder. I am currently waiting to see a counsellor, I look at his photograph every night and I cannot believe that he is not here anymore.
No mother should have to bury their own child, I have always said. I have days when I struggle to move on with my life, even thoughts of ending my own life to

be with my son but I realise I have to fight for justice for my son and my grandchildren. I cannot understand how an unarmed man sat in a car in a quiet car park can be shot by a police officer. To me it is murder and he should not be working. We have had to pay Anthony's funerals ourselves even though his life was taken from him by Greater Manchester Police. I had to borrow the money to cover these costs.

This has ruined my life and I feel as if my heart has been ripped out of me. I just want this nightmare to end and Anthony to get the justice he deserves. It has taken five years to get to this point where the public Inquiry is due to start and has put an enormous stress on me and John and the family. We also suffered terribly when GMP leaked a copy of the IPCC report to Manchester Evening News and it was published in the paper before we were even aware of the contents.

I am left with a deep distrust of the police, I am scared of them and even moved away from my address that I have lived in for many years because of worries about harassment. I remain worried that they will harass me once the Inquiry finishes.

MR BEER: Mrs Schofield, thank you very much indeed.

THE CHAIRMAN: Thank you, Mrs Schofield.

Can I just briefly address the lady -- I think you

are a press representative.

A MEMBER OF THE PRESS: Yes.

THE CHAIRMAN: The intention was there should be no reference to the names of either of Mr Grainger's children and there has been an inadvertent reference to the name of one of them. I should be grateful if the names would not be included in any report of this hearing.

MR THOMAS: Sir, I was about to ask you the same thing.

A MEMBER OF THE PRESS: That is fine by me. The names are in some of the statements that have gone on to the website, are they not?

THE CHAIRMAN: I think they have been redacted, but that brings me to the next topic which is that when the transcript of today's hearing is uploaded, I propose that any anyone inadvertent reference to the names of either of the children should be redacted.

MR BEER: Yes, sir --

THE CHAIRMAN: Does anybody have any objection to that, it seems to be the right course to adopt?

MR THOMAS: Yes, sir.

MR BEER: It is entirely inadvertent, what had happened was that Farleys had requested that we redact the names out. We did.

THE CHAIRMAN: Yes.

MR BEER: I think this morning Mr Thomas provided his client with a copy of the statement to read and unfortunately the copy provided included the names in it.

THE CHAIRMAN: Yes.

MR BEER: It is completely inadvertent.

THE CHAIRMAN: We are going to do our best to make sure it doesn't go on the website and I should be grateful in that particular detail is not included.

Thank you very much, I am most grateful to you for your cooperation.

MR THOMAS: Sir, there is one second statement that is the identification statement that needs to be read. A short.

MR BEER: I don't think it is necessary for Mrs Schofield to read the identification statement.

THE CHAIRMAN: That can be taken as read insofar as it is necessary.

MR THOMAS: So be it.

THE CHAIRMAN: Thank you, Ms Thomas.

MR BEER: Ms Gail Hadfield-Grainger, please.

MS GAIL HADFIELD-GRAINGER (sworn)

THE CHAIRMAN: Pause, take a breath.

Ms Hadfield-Grainger, would you be more comfortable sitting down?

A. No, thank you.

THE CHAIRMAN: Are you sure? All right.

Questions from MR BEER

MR BEER: Ms Hadfield-Grainger, my name is Jason Beer and I am counsel to the Inquiry. I think there is a statement that the usher is going to hand to you. That is your statement about Anthony. Could you please read it to the court, thank you.

A. It is not easy to stand in front of strangers and describe the love that Anthony and I shared. I dreamt of doing that in front of our loved ones at our wedding and I never thought that I would have to do this in a courtroom because of the way that Anthony was killed.

It is difficult to find the words to explain how much we loved each other. The best way that I can describe it is to read a poem that Anthony wrote for me in 2012 on Valentine's day.

Sorry.

"You are all of my beautiful dreams, the best I have ever had, you are my secure when I am afraid and a smile on my face when I am sad.

"You are in every single thing I do and in every single step I take, you are the soul of this body of mine, the breath from which I take ..."

I can't even see.

THE CHAIRMAN: Take your time.

A. Anthony did not find it easy to write, especially about his feelings, so this Valentine's card will always mean the world to me. I have had this poem tattooed on me so these words will never leave me and I will be able to take them to the grave for when we are together again.

Anthony and I fell in love back in 2009 and then we began to live together with my two children in October 2011. Anthony was very much a family man and he was great, a great help to me and my children and great around the house. I grew to know and love Anthony, not just as my life partner but as a loving father to my children.

When I used to -- when I was breastfeeding my daughter Anthony would just sit beside us and stroke her head until she fell to sleep, and then as his children got older we spent the days out together. There was days at Diggerland where Anthony tried to build my daughter a princess castle out of mud and a trip to Knowsley Safari Park because my son wanted to see meercats.

On one of our trips to Blackpool the seafront became covered in bubbles because a shipment of Fairy liquid came apart and the kids loved it.

When the children got restless, Anthony would take them to a soft play centre and he would run around like

a big kid with them.

I grew to love Anthony, also through the love of his own children. He was very much a part of their life. He got up every weekend to drive and see them, to see his son and daughter in Cumbria and when it used to be snowing up there he would send a picture of the mountains to me from his phone.

In the month before Anthony died, we had been viewing houses with enough room for six of us. We were also trying for a baby together and we had already chosen the names, they were going to be called Bobby and Frankie. We chose two names because there are twins on both sides of my family so we were kind of hoping to have twins and we used to joke that we would need a minibus.

Anthony came home on one evening and told me that he had found a church where he wanted us to get married. He took me to see it and it was so beautiful. We were just standing there looking at it together, talking about how we had the rest of our lives together.

Anthony could be quiet in company but when it was just us two he talked a lot and he had a brilliant sense of humour. He was always there for me and we would text each other throughout the day every single day. Until this day I still look at my phone waiting for him to

ring.

On the day that Anthony had been killed -- was killed, he was playing computer games with my son and talking about boy stuff. When Anthony went out he paused the game and he told my son that he would finish it later that day. So after Anthony went out, I had my son practice for the game because he wanted to impress Anthony for when he got back. My son went to bed that night with a game console in his hand, wondering why Anthony had not come back home to play.

So later I bought a dog to help my son deal with the grief and my son decided to name it after the game they were playing, and called it Carbon. I've got a photo album at home which is very important to me. It has got photographs of Anthony doing all sorts of things, like when he went to see Harry Potter with my friends, having pillow fights with the kids in the house and when he won a prize at Blackpool for my son.

I also have a special box in which I have Anthony's things, little pieces of paper which have got his handwriting on, his clothes that were in the washing basket on the day that he died. A little bracelet that he bought for me when he was out with the kids in Cumbria and his trainers.

They are all the things that I have left of him,

along with my memories. No matter what Anthony will never be forgotten.

Thank you.

MR BEER: Thank you very much.

THE CHAIRMAN: Thank you, Ms Hadfield-Grainger.

MR BEER: Sir, that is all of the evidence for today, indeed for this week.

THE CHAIRMAN: Yes.

MR BEER: We will next convene a fortnight on Tuesday in open session at 10.30 am.

THE CHAIRMAN: Yes.

MR BEER: We will next convene in closed session this Tuesday coming at 10.30 am.

THE CHAIRMAN: Thank you very much, Mr Beer.

(10.51 am)

(The Inquiry adjourned until 10.30 am on Tuesday, 24 January 2016)

Press release

Inquiry launched into the death of Jermaine Baker

Home Secretary has established an inquiry to ensure all of the relevant evidence can be properly considered.

From: **Home Office (/government/organisations/home-office)** and **The Rt Hon Priti Patel MP (/government/people/priti-patel)**

Published 12 February 2020

This was published under the 2019 to 2022 Johnson Conservative government

Home Secretary Priti Patel has today (Wednesday, 12 February) announced an inquiry to investigate the circumstances of the death of Jermaine Baker during a Metropolitan Police operation on 11 December 2015.

The inquiry will be chaired by His Honour Clement Goldstone QC, who was appointed last year to conduct the inquest into Mr Baker's death.

HH Goldstone wrote to the Home Secretary requesting that a judge-led, statutory inquiry be established under the Inquiries Act 2005.

The Home Secretary agreed that an inquiry should take place and confirmed this to Parliament in a Written Ministerial Statement this morning.

Home Secretary Priti Patel said:

> “Establishing an inquiry is important to ensure that all of the relevant evidence can be properly considered as part of an effective investigation into Mr Baker’s death.
>
> “HH Clement Goldstone QC is an experienced retired judge who has the expertise necessary to deliver the inquiry.”

The inquiry will have the same scope as the current inquest which will be suspended after the establishment of the inquiry.

Arrangements for the inquiry will now be a matter for the Chair. The Home Office will provide support and ensure that the Inquiry has the resources that it needs.

Published 12 February 2020

OGL

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Wednesday, 16 June 2021
(10.00 am)
THE CHAIRMAN: Good morning, everybody.
MS BLACKWELL: Good morning, sir. We are going to begin today's proceedings by hearing the opening statement of Ms Kaufmann, Queen's Counsel, on behalf of the family.
THE CHAIRMAN: Right.
MS BLACKWELL: She has been kind enough to indicate that she expects to take about 90 minutes, and so may I invite you to perhaps take our mid morning break once she has completed her address.
THE CHAIRMAN: Ms Kaufmann, if that suits you, with pleasure.
MS KAUFMANN: It certainly does. I do hope I will stay within that estimate.
THE CHAIRMAN: If you decide after about an hour or so that it is not going to be quite as quick as you hope or think, then take your break at an earlier stage. I will leave it entirely up to you.
MS KAUFMANN: I am grateful, and if I appear though to be rambling on and not looking like I am coming to the end perhaps somebody could tell me, that I've got quite a lot still to go --
THE CHAIRMAN: You have a lot of people surrounding you, don't look at me.

MS KAUFMANN: I am sure they will. I am asking them now, I am pleading, because I will lose all sense of time no doubt.
THE CHAIRMAN: Thank you.
Opening submissions by MS KAUFMANN
MS KAUFMANN: Sir, we make this statement on behalf of the family of Jermaine Baker, in particular on behalf of his mother Margaret Smith, his daughter Alexia Demetrio-Baker, Alexia's mother and Jermaine's girlfriend Eftehia, also know as Tia, Demetrio and Jermaine's younger brother Jordan Smith.
It is fitting that the first witness to this inquiry will be Margaret. She will place Jermaine and his memory at the heart of these proceedings.
She extends her assistance to this inquiry as Jermaine's mother, as a representative of his family and of his loved ones.
She also represents the fundamental and acute public interests in the circumstances in which the Metropolitan Police Service have shot dead another unarmed black man.
Jermaine was born on 16 March 1987 and he was 28 years old when he died. He was the elder son of Margaret and the father of two children. He was a devoted, loyal, loving and much-loved father, son, brother, partner and friend. A young man with all the

wonder, complexity and potential that involves.
Margaret will inform the inquiry about who Jermaine Baker really was and who he has left behind. She will inform the inquiry as to how she witnessed Jermaine being prematurely judged, devalued and written off at school and later by potential employers and by society at large. She has never sought to excuse Jermaine for his involvement in the events of 11 December 2015, and she makes no attempt to do so before this inquiry.
Margaret says he should have been arrested and prosecuted along with the others involved. But she will provide some context to how he came to be in that position.
Margaret is categorically and unequivocally clear that whatever Jermaine was doing on 11 December 2015, he should not have paid with his life. That his death was entirely unnecessary and unjustifiable, and that it was the result of truly reprehensible failures on the part of the police officers involved. She has been deeply saddened to see in the evidence an attitude by the officers to Jermaine that tragically mirrored treatment he had suffered in life. This was not an operation that had regard to the value of Jermaine's life. On the contrary, it was because these officers diminished and

devalued Jermaine that his life was ultimately brought to an end, including by the unreasonable and premature judgment of W80.
Tia will give evidence to the inquiry on her own behalf and on behalf of Alexia, the daughter she had with Jermaine. She too provides from her own perspective a more complete picture of Jermaine than that told by his involvement in the events of 11 December 2015. She knew him as a sweet, funny and caring young man who became her soulmate and, in time, a loving and devoted father to their daughter. She will explain the loss suffered by both her and Alexia and the way in which the legal processes over the last five and a half years have stood in the way of their ability to process that loss and come to terms with their grief.
Alexia is an intelligent, inquisitive and engaged child. At the age of eight she has many questions about Jermaine's death, but she is of course unable to understand fully the events which have led to her growing up without a father. That learning will be a lifelong process for Alexia, and Tia seeks to impress upon the inquiry the vital role that it will play in that process. As Alexia grows and develops, so will her questions about her father's death and it is, inevitably, to this inquiry's report that she will look

there is anything he wishes to say.
MR SIMPSON: I am grateful, sir, I have made it plain that the IOPC does not see its role to take an active part in these proceedings, we are here to assist you and indeed the other parties insofar as we can and certainly it is not our intention, or not my intention now to make any form of opening statement.
Thank you.
THE CHAIRMAN: I will assume, and have already assumed, that that is the stand to be taken and perfectly understandably so by the IOPC.
But when we come to the conclusion of the inquiry, and before closing submissions are made, I will obviously give you an opportunity to consider their position at that stage.
MR SIMPSON: I am very grateful, on behalf of my clients for that.
THE CHAIRMAN: I think I know what the response will be but one can never say never and one can be certain that if that opportunity were not afforded to you, it would be one that you would have wanted to take.
MR SIMPSON: I am very grateful and, as I have said to counsel to the inquiry this afternoon, the intricacies of IOPC procedures are complicated to say the least and there may be occasion on which I want to clarify that

I hope for the benefit of everyone. That is as far as I see our role in closing submissions at this stage.
I am very grateful that we will have the opportunity to address you if need be at the end of proceedings.
THE CHAIRMAN: Thank you very much.
Ms Blackwell.
MS BLACKWELL: Sir, that conveniently brings us then to the end of the first part of this inquiry, which was opening statements. It is now 2.50. The remaining part of this afternoon is going to be dedicated to a pen portrait and also some evidence from Jermaine Baker's family.
May I invite you then, please, to rise for 15 minutes and to come back at 3.05, so that we can make arrangements for that evidence to be given.
THE CHAIRMAN: Ms Kaufmann, is that sufficient?
MS KAUFMANN: Yes.
THE CHAIRMAN: Very good, 3.05 it is.
MS BLACKWELL: Thank you.
(2.51 pm)
(A short adjournment)
(3.22 pm)
THE CHAIRMAN: Yes, Ms Blackwell.
MS BLACKWELL: Thank you, sir. We are now going to play the pen portrait that has been prepared by Jermaine Baker's family and friends.

THE CHAIRMAN: Thank you.
(Pen portrait video played to the inquiry)
(3.39 pm)
MS BLACKWELL: Sir, we are just going to take a very quick break for five minutes, please, before we hear from Margaret Smith.
THE CHAIRMAN: Okay.
MS BLACKWELL: Thank you.
(3.39 pm)
(A short adjournment)
(3.44 pm)
THE CHAIRMAN: Yes, Ms Blackwell.
MS BLACKWELL: Thank you, sir, I am going to ask that Ms Smith be sworn, please.
THE CHAIRMAN: Certainly.
MS MARGARET SMITH (sworn)
THE CHAIRMAN: Yes.
MS EFTEHIA DEMETRIO (sworn)
MS BLACKWELL: I am going to ask you first, Ms Smith, some questions, please, in order to obtain the requisite registration details that the chair needs in this inquiry.
Could you confirm that you were Jermaine Baker's mother?
MS SMITH: I can.

MS BLACKWELL: And his full name was Jermaine Reynard Reece Baker?
MS SMITH: It was.
MS BLACKWELL: That he was born on 16 March 1987 at North Middlesex Hospital?
MS SMITH: Yes.
MS BLACKWELL: At the time of his death, Jermaine was unemployed.
Sir, just so that you know, we have been provided with the address at which Jermaine lived at the time of his death and that is on our record, I don't intend to read it out now.
THE CHAIRMAN: Very good.
MS BLACKWELL: Could I then ask, please, that you, Mrs Smith, read out the evidence which I know you have prepared to give on his behalf?
MS SMITH: Yes, okay.
MS BLACKWELL: Thank you.
MS SMITH: I am giving this evidence to the inquiry about my son Jermaine, who he was and what his loss has meant to me, to his family and his loved ones.
I have never tried to make excuses for Jermaine for what he was doing on 11 December 2015. I have said publicly that he was involved in a crime and should have gone to prison like the others involved. But this

inquiry should understand that there was so much more to Jermaine than that. He was a very much loved son, father, brother, partner, grandson, cousin and friend.

It is also important that the inquiry understands how someone like Jermaine with so much going for them could find themselves involved in something like that.

I will start by explaining a little about who Jermaine was. He was born on 16 March 1987 and he was my eldest son. He loved his family and we were the centre of his life.

Jermaine's dad left when Jermaine was two years old and Jermaine never had any contact with him after that. I was determined that Jermaine would have all the love and support that he needed and I made sure of it. Jermaine and I were always together and it meant that we had a really special bond. I devoted myself to looking after him. It was hard, we didn't have a lot of money and we struggled at times but I feel very proud to have given him a loving and stable home. He was a happy and loving young boy.

I was surrounded by my family who were always there for me and Jermaine. Throughout Jermaine's childhood we lived close to my sister Amy. We were right next door for several years. Amy had children of similar ages. She was like a second mum to Jermaine and I was the same

to her children. Our children all grew up together and Jermaine was very close to his cousins Daniel and Chevene.

Amy's partner had a place on a farm in Bedfordshire and she would take Jermaine there along with her children. Jermaine loved the animals there. One of pictures shown in the video is Jermaine with one of the dogs from the farm. We were also very close to my sister Marcia and my brother Randolph. Jermaine was surrounded by a large, loving extended family and he was happy there.

We also lived very close to our mum, Jermaine's nan. She had a very special place in Jermaine's heart and we would see her all the time. Jermaine adored her from a young age and he would do absolutely anything for her, right up to his death. That was what Jermaine was like, just the most loyal and caring person. I saw that at its best with his nan and how he was with his brother Jordan, who was nine years younger than Jermaine.

From the day Jordan was born, Jermaine adored him, he was the most loving and protective older brother. Even as Jermaine grew up and began spending time out on the streets with his friends and then later getting into some trouble, he never wanted any of that for Jordan. He wanted Jordan to go to school, to work hard and to go

to college. Jermaine knew what the streets were like and wand something else for Jordan. Jordan loved and looked up to Jermaine, but he went a different way in his life. He never got into any trouble, he worked hard at school and college and he is now a deputy manager at Halfords, living happily with his girlfriend.

I loved to see the relationship between Jermaine and Jordan. They had so much love and respect for one another. I know Jordan has found it very hard losing Jermaine and misses him very much, although it is not something he likes to talk about.

In time Jermaine started his own family, I remember so well the day I learned that he was going to have Alexia, it was Tia who told me and I was delighted for them. Alexia was born in September 2012, and I saw a new side to Jermaine then. He was at the hospital with Tia throughout her labour. After Alexia was born he came out to see me and he just burst into tears. He was so overwhelmed he couldn't even say anything. He, Tia and Alexia lived together for a few years after Alexia was born. That was his own little family and he loved them both so much.

He wasn't one of those dads that was scared to push a pram or change a nappy. He was really involved. When Tia was working Jermaine would look after Alexia all

day. He was always taking her to see my mum or to the park. We would always have dinner together on a Sunday afternoon and Jermaine, Tia and Alexia would come over for that. Even after Jermaine and Tia separated, he remained a devoted father and saw Alexia all the time.

The time that Jermaine and Alexia spent together meant they had the loveliest relationship and loved each other so much. It has been devastating to see the impact his death has had on Alexia, she misses him so much.

Alexia was Jermaine's second child. His son Reece was born in 2009. Jermaine loved Reece very much. He really wanted to build a relationship with him, but for various reasons he was not able to have the contact he would have liked. That contact would have been made easier as Reece grew older and I know Jermaine would have done all that he could to be good father to Reece. It is very sad that this will never be possible.

When I look at Jermaine's life, so rich and full of family and friends I find it very hard to understand why he was there at Bracknell Close that day. He has been in trouble on and off since a teenager and has even spent a period of time in prison, but he had never been involved in anything like this. He must have considered that he would have got caught and I do not understand

why he would have risked that.
I think that even though -- I think that even though he clearly had so much going for him and so much potential, he just couldn't see this himself. Outside his family, he was constantly being written off and I think eventually he wrote himself off. It was hard for him not having his dad around. Most of the time you would never know it, but there were times when he would let something out and show how much it had hurt him that his dad had left.
The way he was treated at school also had a real impact on him. He was happy at primary school but as soon as he went to secondary school the teachers took really against him. There was one in particular who just bullied him. I know Jermaine was no angel, I certainly never excused his misbehaviour but he was still a child and he was being bullied by an adult in a position of power. Eventually Jermaine couldn't put up with it any more and got into a physical fight with the teacher, which led to him permanently being excluded.
That was in year nine, when he was only 14 years old. He was sent to a pupil referral unit. I went to the unit for a meeting with the staff there and I could not believe what I saw. The children were openly making

joints and there was no control at all. It was not the caring and supporting environment that Jermaine needed. It was somewhere to send kids who had been written off. I couldn't let him stay there and he never went back.
I work as a teaching assistant and I am really proud of where I work and the support that I and my colleagues give to the children that we work with. We really do move heaven and earth to give them all the help that they need and the more difficult the child, the harder we work to help them. That is what Jermaine needed, but there was no one in the school to do that for him. He was barely a teenager but it was like he was being written off for life.
I saw him being written off and I think he did too. It seems to be the same when he got older and was looking for jobs. He really did try but no one ever seemed willing to give him a chance. He used his time in prison to get a qualification in painting and decorating. Even then, although he was able to get the odd piece of work he never seemed to get the chance that he needed.
I will never understand why Jermaine was there on 11 December 2015. But I do understand that if you tell someone often enough that they are a failure and that society doesn't value them, then they will believe it.

I don't say any of this to excuse what Jermaine did, but it is important to see the full picture of who he was and how a young man with so much good in him could end up making some very bad decisions. It is also important to understand that this could happen to anyone. Jermaine's life was exceptional and unusual in the way that it ended, but the story of being written off as a child could be told about so many black boys and young men. I can't help sometimes thinking what the future might have held for Jermaine if he had lived. He would have gone to prison, that is what happened to the others who were involved and they have now served their sentences.
I saw the impact prison had on Jermaine last time and I believe he would have made good use of his time again. More so as he was older this time, at 28, and he had Alexia in his life. He would have hated being apart from Alexia for a length of time and the prospect of losing what he had with her would have motived him to change. It would also have been a wake-up call for us as a family. None of us could have imagined he would ever have been involved in anything like this. It would have been such a shock to us all. Once he was out of prison, we would have done anything we could to support him to get his life back on track.

That is where I should be now, with my son helping him rebuild his life, not in an inquiry learning about his death. Nobody needed to die on 11 December 2015. I know this could have and should have ended differently. When I look at what happened that day, I see Jermaine being treated by the police officers in the same way as by the school teachers and others in his life. He wasn't seen as a human being whose life was unique and valuable. The value of his life was forgotten in these police officers' plan and in the end his life was written off by the premature and unreasonable judgment of W80.
The loss I suffered when Jermaine died cannot be put into words. I carried him for nine months before he was born and we were together ever since. We had times that were happy and some not so happy, but we stayed together. After five and a half years, I have not even begun for grieve for him properly. All that has been put on hold until this point.
I have held on through IOPC investigation, the CPS decision, the judicial reviews, the inquest hearings, the inquiry process, all of the delays. Nothing in my life has moved on in those years. I have to shield those around me from this, to pretend I have moved on when I haven't. I worry people will get bored of

hearing about it from me and get bored of my pain. So there came a time when I started keeping to it to myself and on the outside I just smiled. It takes all of my energy and it is exhausting, but I had no choice. I have to hold on because I need the truth about why he died.

That truth is what I want from this inquiry. I will be here from start to finish listening to the evidence. I want the witnesses who come and stand in front of me to have the integrity and decency and the courage to tell me and my family the truth. I want the inquiry itself to be determined and fearless enough to follow the evidence wherever it goes.

It is upsetting and frustrating to me that there will be evidence that I will never hear. I cannot change that, so I can put my trust in the inquiry to give the evidence in particular the fullest possible scrutiny.

I would ask the inquiry when it does so to remember what I have said today and to feel at least a little bit of my desperation for the truth. I ask the inquiry not to make the mistakes about Jermaine that so many have, judging for what he was doing, I make no excuses for that but I do not lose sight of the value of his life and do not write him off.

THE CHAIRMAN: Thank you very much.

MS BLACKWELL: Thank you, very much.

Sir, I am now going to turn to Tia Maria Demetrio and ask her to provide her evidence, which I know she too has prepared.

Before I do that, please may I display a photograph of Jermaine, which is at BHM5.

THE CHAIRMAN: Thank you.

MS BLACKWELL: Thank you.

MS DEMETRIO: I am giving this evidence to the inquiry on my own behalf and on behalf of Alexia. The daughter Jermaine and I had together. I am doing it so the inquiry can understand a little more about who Jermaine was, what he meant to us and the impact of losing him.

I first met Jermaine in 2005. He was my teenage sweetheart and the first love of my life. He was incredibly charming, enthusiastic and just full of life and energy. He was a joy to be around and for those first years we couldn't be separated.

I moved in with Jermaine in 2008 and we lived together initially in Margaret's house. We were together on and off like lots of young couples but we were very much in love. When Alexia was born in 2012, we were both incredibly happy. Jermaine was just besotted by her, I even remember him crying when she was

born. He was a very attentive father and was completely involved. He would be there changing her nappies and always wanted to play and spend time with her.

He was very playful and it was precious to see how they would interact together. They had a real bond together from straight away and it just grew from there. She was the most important person in his life and he would have done anything for her. Alexia was very bright and intelligent from a young age. Jermaine was very proud of that and nurtured it by teaching her her alphabet and how to count.

We lived together as a family until Jermaine and I separated in late 2014. Even when we broke up, it wasn't because we didn't love each other, but we were young parents and the pressure of that was hard on both of us. Jermaine remained devoted to his relationship with Alexia. He was very worried about how the separation would affect their relationship and was determined that it would stay strong. He made sure he was always in her life. He looked after her during the day while I worked, taking her to the park and teaching her to ride her bike. For Alexia, Jermaine was her safe place and you would always find them napping together in a corner. When she started going to nursery, he would pick her up and bring her home, feed and bath her and

also cook me some dinner for when I got home. It felt like we were still a team, even though we weren't together anymore.

Jermaine cared about family more than anything. Every Sunday he would take Alexia for lunch at Margaret's. If anyone in the family needed any help or support, it was Jermaine's phone they would call. If his nan needed shopping done or his auntie wanted blinds put up, Jermaine would be round there the same day and he took pleasure in that, he like to be relied on and feel that he was being useful.

He was completely devoted to his nan. He would check in on her most days and would take Alexia round to her place and would even escort her to doctor's appointments and things like that.

Having Alexia changed Jermaine, it was the first time I saw him have real joy in his life. He wanted to be a role model for her and was very keen to get a job. He applied for lots of jobs, I even helped him make a CV and we would go round together handing them out.

He was able to get some work with my step dad. He became really close to my family after Alexia was born but he was never able to get any permanent job and he felt that having been in prison was causing a real problem. That really depressed him. He wanted to be

able to provide for me and Alexia, but instead it was me going out to work and he found that difficult. It affected our relationship and that was at the heart of why we separated.

Losing Jermaine has been a real-life nightmare for me and for Alexia. I have struggled to adjust to life without him as part of it. All the milestones in Alexia's life he won't be there for. Simple things like Alexia's first sports day were really emotional for me. I can't imagine what it will be like when she gets married or has her own child. It is heartbreaking to think he will not be there for any of that.

I will never forget when the IOPC came to my house on the evening of 11 December 2015 to tell me Jermaine was dead. They just stood in front of me and told me that Jermaine had been shot by a police officer. I was so confused I just couldn't understand how that could have happened. There seemed to be no logical explanation for how he could have been in a situation where that could have happened. Nothing has ever been the same since.

Very soon after Jermaine died there were media outside my house and at my front door. They printed really upsetting stories about Jermaine being in a gang. None of it was true. It got worse from there. Alexia

was only three when Jermaine died and telling her about it was just awful. I don't think she properly understood it, but that night she wet her bed which she never usually did. Her life since then has been completely shaped by Jermaine's death.

The way that Jermaine died at the hands of police has meant that I have had to face many difficult decisions about what I should say to her. My natural instinct is to protect her and to keep much of the detail from her.

I have thought long and hard about it and have worked with a child psychologist specialising in children who have lost parents. With that help, I have come to the decision that I have to tell her what happened and that is what I have done in stages over the years.

I have come to realise that, because there is so much that is uncertain and insecure in her life, she needs to be able to rely on me to tell her the truth, so I have told her that her father was shot by the police, but I cannot not allow her to grow up believing people just get shot by the police out of the blue and I need her to understand right and wrong. So I have had to tell her that he was doing something wrong at the time, but of course it is not possible to leave there because

it is so important she understands that Jermaine's wrongdoings did not mean it was okay to kill him and that leads to other questions about the mistakes that the police made leading to his death.

This is an ongoing issue that we constantly have to deal with. The various court processes have made it more difficult.

Only recently she picked up when it emerged that W80 was training other police officers. I couldn't lie to her about it, but she found the truth very upsetting. These are complex issues that an eight year old should not have to deal with and it feels deeply unfair that she has been forced to grow up before her time.

I know that however much I would like to shield her, it is just not possible. It would be worse to allow her to learn about Jermaine's death from her friends at school, speculation in the media or through her own internet searches.

Sorry.

There are even pictures of Jermaine's body on Google. Nonetheless, I deeply resent that her childhood has been shaped by all she has had to learn. I resent all the ways that Jermaine's death has impacted her life. She now has to grow up without a father and it will be a lifelong process for her to come to terms with

that, with the circumstances in which he died.

She is in many ways just like other children and spends much of the time very happy, but she gets very anxious and I can tell she feels that she is more vulnerable than other people.

I also resent the impact Jermaine's death has had on my own life. I can see now that I have spent several years after his death on an autopilot zombie state. I love being Alexia's mum, but I have never wanted to have to raise her by myself. I have a loving and supportive family, but it is not the same as having a father around.

I don't know why, but I even feel guilty that she has no dad. There have been times where I have sobbed and pleaded with God to take the pain away, to make me understand why Jermaine is no longer with us and to give me the strength because I could not see a life without him in it. My relationships with my family and friends have been strained. I have been depressed and anxious and I have suffered with trauma since Jermaine's death.

I have spent the last five years involved in investigations and other legal proceedings. None of this is what I have wanted for my life in my late 20s and early 30s. This is the mess that was left when Jermaine died and despite all the time that has passed,

I still don't understand why he died.
I know now what he was doing on the morning of 11 December 2015 and I think he was a complete idiot for getting involved in that, but I do not know why he was there, what he was thinking. We had arranged to take Alexia to see Santa after nursery on 11 December 2015, Jermaine had messaged me the night before to check that we were still doing that. It was really weird because I had the sensation that I wanted to tell him that I loved him. I didn't though. We had managed to get a really good coparenting agreement and I didn't want to confuse that.
I don't think I will ever understand what led Jermaine to get involved. He had been in trouble before, even gone to prison, but I had never known him to be involved in anything like this.
It still shocks me to the core. I wish I had known what he was going to do, so I could have talked some sense into him. I would have told him to think about Alexia and everything else that was good in his life and I would have tried to make him see that he had so much potential for a happy life. I think the problem was that Jermaine never did believe in himself. He was a very clever man but he never believed he was capable of anything.

He got kicked out of school for fighting with a teacher that bullied him. His father leaving was a really difficult subject for him. He wanted to know his father and he was hurt because his father didn't seem to want to know him. He was a very strong person and never weak, but he was definitely vulnerable. That wasn't something he would let people see. He wanted to be strong for everybody else.
Jermaine was having a hard time before he died and he was struggling to find somewhere to live.
I sometimes feel guilty and wonder if there was more I could have done. As strong as he was, Jermaine depended on me and I felt responsible for him but my priority had to be Alexia. I had to make sure there was routine and stability in her life and I couldn't disrupt that by having Jermaine stay on and off.
But whatever reason Jermaine had for being there that day, I know he shouldn't have been killed. I want to know what went wrong that day and why me and Alexia will have to live the rest of our lives without him.
Waiting five and a half years for any sort of answer really has been torture. We have got bits and pieces of information over the years, but we still don't know the full picture of what happened. One of the hardest things is that I feel like I am being judged, I feel

like people in the press and the legal system make assumptions about the type of person that I must be and that I constantly have to justify myself.
I feel a similar thing is done with Jermaine. He was committing a crime that day and he should have been arrested and prosecuted for it. I understand that, but I feel that because he was involved in a crime, his life is seen as less valuable, and that is just not right.
Jermaine was not a thug and he was not a gangster. He was a young man who had a lot of potential and was trying to find his way in life. He was vulnerable in his own way and he made mistakes, like many young men do. He should have had years ahead of him to continue that journey and grow into the man he could become, but his life was cut short.
I have a letter that my daughter has written and I would like to read it out.
THE CHAIRMAN: Of course you may.
MS DEMETRIO: "To the inquiry, not having my dad around has made me feel lonely and different from other kids. I was very young when my dad died but I still notice his absence and we were very, very close. I miss the way he would blow raspberries on my belly and make me laugh. My dad made me feel safe and happy.
"I understand my dad was up to something he

shouldn't have been doing, but I also know my daddy was a good person and no matter what he was doing, he shouldn't have died. I want the inquiry to find out why my dad was shot and killed. I want to know why he was not arrested like the other two people with him. It doesn't make any sense to me why my dad is not here anymore but the two other people who were with him are. My heart hurts when I think about my dad and what has happened to him. I don't think anyone should be able to kill anyone, but it seems this police officer can.
"I feel very scared when I see the police. I usually look away. I don't want to feel scared anymore. While this officer is still a policeman I don't think I will ever feel safe.
"I was so angry to find out this officer is training other firearms officers. How could anyone think this would be a good idea when this officer has killed my dad? It is not right and it is not safe. Why after all this time has no one got in trouble for killing my dad? How are we going to make sure this doesn't happen to someone else's dad?
"If we can do anything, I want to us to prevent other families and children from going through this. It is not a nice thing to have happened to my dad or what losing my dad has made us feel. I still cry for him and

I will always miss him.
"From Alexia Demetrio-Baker."
THE CHAIRMAN: Thank you.
MS BLACKWELL: Thank you both.
I know, sir, that both Ms Smith and Ms Demetrio was very keen that their evidence should be given on oath in the usual way that evidence is going to be taken during this inquiry, so that it is formally on record.
THE CHAIRMAN: May I just say that the only feeling that I as the chairman to this inquiry have is that you both gave your evidence bravely and with great dignity.
MS DEMETRIO: Thank you.
THE CHAIRMAN: Thank you.
MS BLACKWELL: Sir, that concludes our business for today.
May I invite you to rise until 9.30 tomorrow morning, when there will be some legal applications prior to us hearing evidence.
THE CHAIRMAN: Yes.
Can I just spell out what as I understand it the timetable for tomorrow is.
We have an outstanding application in relation to whether or not there should be a further core participant.
MS BLACKWELL: That's right.
THE CHAIRMAN: That is unlikely to take more than

three-quarters of an hour to an hour, and we will be in a position I am sure to resume evidence in an open hearing by no later than 11.00.
MS BLACKWELL: Yes.
THE CHAIRMAN: At the conclusion of the open evidence tomorrow, we will be going into a closed hearing.
MS BLACKWELL: Yes, we will.
THE CHAIRMAN: I don't know, you may not know at this stage whether the open hearings will finish before lunch or whether they will go into the afternoon.
MS BLACKWELL: I am hoping to finish before lunch, but I can't guarantee that, I am afraid.
THE CHAIRMAN: How long is it thought that the closed evidence tomorrow afternoon then will take?
MS BLACKWELL: Well, as you know, sir, we are not scheduled to be sitting on Friday of this week.
THE CHAIRMAN: No.
MS BLACKWELL: We will go into closed session on the current estimate tomorrow afternoon and we will remain in closed session next Monday.
THE CHAIRMAN: Right.
After we cease to be in an open hearing tomorrow at about lunchtime --
MS BLACKWELL: Yes.
THE CHAIRMAN: -- we will not be resuming in open session

until --
MS BLACKWELL: Tuesday at some point.
THE CHAIRMAN: -- Tuesday at some stage.
What we will have to do is to make sure that anybody with an interest can be, as it were, kept up to date as to when on Tuesday we will be resuming in an open hearing.
MS BLACKWELL: Yes, we will ensure that everybody is kept in the loop.
THE CHAIRMAN: Okay.
MS BLACKWELL: Thank you, sir.
THE CHAIRMAN: Thank you all very much and I will see you tomorrow at 9.30.
(4.18 pm)
(The inquiry adjourned until 9.30 am the following day)

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Public Inquiry (Azelle Rodney)

Volume 508: debated on Tuesday 30 March 2010

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The Secretary of State for Justice and Lord Chancellor >

(Mr. Jack Straw)

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I am announcing today the Government's intention to establish an inquiry under the Inquiries Act 2005 to investigate the death of Azelle Rodney in April 2005. The inquiry will be established by the Ministry of Justice

It is intended that this inquiry will be chaired by a retired judge and that, subject to his or her views, it will determine the matters which an Article 2 compliant inquest would have determined had it been able to take place. These are: how, when and where Mr. Rodney died, and the broad circumstances which led to his death.

The inquest into the death has been adjourned by the north London coroner since August 2007. The coroner and, most importantly, the bereaved relatives of Mr. Rodney have been given advance notice of this decision.

During debate on the Coroners and Justice Bill, I said that any inquiry established because an inquest cannot be held would be subject to a protocol between Ministers and the senior judiciary. This protocol is intended to cover the procedure from the point the inquest cannot continue until when the inquiry is established.

I have been working with colleagues across Government on the terms of the protocol but it has raised some complex issues and is not yet ready for use. As the inquest into Mr. Rodney's death is already adjourned and cannot continue, I have decided that an inquiry should be established to avoid further delay for Mr. Rodney's family. A further announcement on the inquiry chair and its terms of reference will be made as soon as possible.

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Tuesday, 4 September 2012

(10.15 am)

SIR CHRISTOPHER HOLLAND: Yes, Mr Underwood?

MR UNDERWOOD: Good morning, sir. I was at the point of opening the intelligence log kept by Silver and Detective Sergeant Heerey. We find it at page D5476.

SIR CHRISTOPHER HOLLAND: Just give me one moment.

MR UNDERWOOD: It is referable to paragraph 92 of my --

SIR CHRISTOPHER HOLLAND: D5?

MR UNDERWOOD: D5476. (Pause).

We have done some work on this so that it's fit for publication; without, I hope, taking out anything at all relevant. On the front page, we explain some of that.

There are two names that have been changed to -- or identities changed to Associate 1, which transpired to be Frank Graham, and Associate 2, who transpired to be Mr Rodney. There are some "dot, dot, dots" where we have taken some words out, and there are some phrases that we have reduced by way of gistings or cipherings, and those are in italics.

So if we go to 5477. This is part of the log kept by Silver, and it is at 10.30 pm on 28 April 2005; which is, as you will recall, pretty much the time when he came on the scene, having been given some information by S3. And we can see that at this stage, he has got the

MR UNDERWOOD: I apprehend that nobody bought this evidence on oath.

SIR CHRISTOPHER HOLLAND: No. Absolutely not.

MR UNDERWOOD: Sir, unless there is any specific objection, everybody has had advance notice of this statement.

SIR CHRISTOPHER HOLLAND: Except me.

MR THOMAS: I would simply ask Mrs Alexander to read our her witness statement.

SIR CHRISTOPHER HOLLAND: Well, if you just give me a moment, I'm the person whose been left out of the loop at the moment. So if somebody could provide me with a statement.

MR THOMAS: Yes, of course. Sir, can I provide --

SIR CHRISTOPHER HOLLAND: No, you need a statement. (Handed). Over to you, Mr Thomas. Thank you very much.

Questioned by MR THOMAS

MR THOMAS: Sir, unless there is any objection, I would simply Ms Alexander to read her statement.

SIR CHRISTOPHER HOLLAND: Well, I have no objection, certainly.

MR THOMAS: Could you start by telling us your full name, please.

A. Susan Lorraine Alexander.

Q. And, Azelle Rodney, who was he to you?

A. He's my son. My first son.
Q. Could you read your statement out please?
A. I make this statement in connection with the untimely death, on 30 April 2005, of my eldest son, Azelle Rodney.

His full name was Azelle Winston Junior Rodney and his nickname, from when he used to play football, was Speedy. And with the father of Azelle Rodney, I have two younger sons also.

When he was killed, Azelle had been in a long term relationship with Monique Gilbert, who was in her eighth month of pregnancy.

This statement has taken almost seven years to finalise as I began writing it as long ago as November in 2005, little knowing it would take this long to reach this point in late August 2012, where I could conclude this statement as my evidence to a public hearing concerning Azelle's death.

I am devastated that it has taken so long to reach this stage. The Government has already apologised to me about that delay, placing its apology on record at the European Court of Human Rights in February 2012, admitting that my right to a prompt investigation into Azelle's death had been breached since at least April 2009. But no apology can ever heal the damage

that this long wait was caused me. Waiting for so long to hear the evidence about Azelle's death has had a massive effect on my life, which perhaps no-one else can understand. I don't think I'll every recover from it and it has had such a big impact on my state of mind, my work and my personal life.

No one should have to wait for so many years to find out why their son or daughter died at the hands of --

SIR CHRISTOPHER HOLLAND: Ms Alexander, would it help if you let Mr Thomas read it? Do you think that might be a good idea? I mean --

A. I'll just carry on for a bit longer.

SIR CHRISTOPHER HOLLAND: You carry on. I mean, I'm in your hands.

A. Okay.

With the evidence finally being heard from 3 September, my main concern now is to see a robust, effective and transparent inquiry. Everyone needs to know what happened on 30 April 2005 and why my son died that day.

Azelle was educated at Gayton High School and then went on to Holland Park Comprehensive School and then to Henry Compton for Years 11 and 10. However, he left school with no formal qualifications because of a very bad injury he received to his hip when he was just

15 years old.

Until his injury, Azelle was a very keen sportsman and held many trophies.

MR THOMAS: Shall I continue?

A. Okay.

MR THOMAS: "He held many trophies and medals for football, swimming and athletics. In fact, he held certificates for playing in football competitions that were sponsored by the Metropolitan Police Service. This was when he was in a club called Ealing Whistlers.

The accident that happened to Azelle when he was 15 years old caused him to be in hospital for about three months and left him feeling very low for about two years. It left him with a limp but he was against applying for benefits or relying on the state for help.

Leaving school without qualifications, and with the background of his injury, it was difficult for Azelle to plan a career. He showed a definite interest and aptitude for sports education. I know that he went on an instructor's course and did a short placement somewhere near Billingsgate Market.

I know that Azelle was a very popular young man, with many friends, particularly from the Fulham area, where he grew up before he moved out to Bedfont area.

In the months before Azelle was killed, he was

spending a lot of time with Monique Gilbert, which was of course natural, given that Monique was due to give birth. As far as I understood it, however, when I saw Azelle for the last time a few weeks before the shooting, he did not have his own place but was planning to find somewhere to live near Monique's address in Fulham. I knew that he was staying at Monique's place with her parents a fair amount.

As far as I was aware, a couple of months before he was killed, Azelle had left an address in the Hendon area that he had been renting. It had been a few weeks since I had seen Azelle when I learnt that he was killed by a police officer in a shooting in Hale Lane, Edgeware.

As I did not see Azelle on 30 April and was not a witness to what happened, I can only say that I am still shocked that guns were found by the police in the car that Azelle was traveling in when he was killed. I do not accept, from what I have heard, that the police had good reasons to shoot at him, let alone killing him.

Since 30 April 2005, my life has been in turmoil. During the seven years it has taken to get to this point, I have had to learn what happened over a long drawn out process. I guess there were about three phases of disclosure: (a) the CPS decision letter in

July 2006 and (b) the IPCC redacted report in December 2006, followed by partial and redacted disclosure in July 2007 and (c) more significant disclosure from the Azelle Rodney Inquiry during 2011 and this year.

As a result, I can, of course, see, even before the evidence is formally heard in court, that Azelle was suspected with good cause of being involved in a serious crime on 30 April 2005. Two other men in the car also subsequently pleaded guilty to firearms offences. But, to state the obvious, they were at least able to walk away alive on 30 April and have long since served their prison sentences, while it seems to me that Azelle was executed that day and as a result never even got to see his baby daughter."

Just pausing there, may I just ask you, when was his daughter born?

A. The day before Azelle's funeral.

Q. And what's the date?

A. Well, it wasn't until late May, because the funeral wasn't held for quite a long time. I just can't recall the date at the moment.

Q. "I also wish to make clear that, whilst I have seen a lot of evidence relating to the events leading up to and after Azelle's death, and I will hear more about this at

this inquiry, some evidence continues to be shrouded in secrecy and I remain worried that I am being prevented, and will be prevented, from seeing or hearing every single relevant piece of evidence. I cannot help feeling that some evidence may still be suppressed.

Also, I want everyone to know that I am angry about being denied a timely inquest, say in 2007, because it partly involved some people saying to me by my lawyers that I could not be trusted to see some sensitive evidence which left me feeling like a criminal or suspected criminal. That is intolerable and unjust and the reasons given to me for not holding an inquest years ago are unacceptable.

Despite all the above, I sincerely hope the inquiry will now leave no stone unturned in the search for the truth and accountability for my son's death, any lessons are now finally learned and that similar deaths in the future are made less likely."

And you've signed that and there's a declaration that you believe your witness statement to be true, is that correct?

A. Yes.

MR THOMAS: Sir, there's only one matter, only one small matter --

SIR CHRISTOPHER HOLLAND: No, you feel free.

MR THOMAS: -- that I want to ask about and can we have up a photograph of your son. (Picture shown).

Sir, the photograph that we're about to see is the photo which is from the briefing pack that the surveillance officers had on 30 April and the question that I have is how does this photo compare, in terms of likeness, to your son in April 2005?

A. That's Azelle. That's him. It's an excellent likeness. True likeness.

SIR CHRISTOPHER HOLLAND: It's an excellent likeness?

A. Yes.

MR THOMAS: Sir, those were all the questions that I wanted to ask.

(3.37 pm)

SIR CHRISTOPHER HOLLAND: Just a minute. Mr Underwood?

MR UNDERWOOD: No, thank you.

SIR CHRISTOPHER HOLLAND: Anybody else? Well, thank you very much indeed.

A. I just wanted to say thank you to you for coming out of retirement to take the inquiry as well. It's important.

SIR CHRISTOPHER HOLLAND: You sound like my wife. Thank you very much.

(3.58 pm)

10.15. Now just mark my card for tomorrow.

MR UNDERWOOD: We have S2 followed by S1. I apprehend that

they're not likely in fact to take all day, now that we have some answers by way of my learned friend Mr Collery's opening. But nonetheless that's what we slated for tomorrow.

SIR CHRISTOPHER HOLLAND: Well, I mean, if I can just say generally, it's inevitably going to be difficult for you and the team to judge timing with the witnesses. I mean, it's notoriously difficult in any litigation and it won't surprise me if, on occasions, we have a short day, on occasions we have a day overlapping into the following day. These things happen.

MR UNDERWOOD: Thank you.

SIR CHRISTOPHER HOLLAND: 10.15.

(3.59 pm)

(The hearing adjourned until 10.15 on Wednesday, 5 September)

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CHIEF CORONER

GUIDANCE No. 41

USE OF 'PEN PORTRAIT' MATERIAL[1]

1. An inquest is an examination of the relevant facts of a death. The coroner (in some cases with a jury) is carrying out a fact-finding exercise designed to determine the answers to four key questions: who, when, where and how a person died.

2. Over several years, the practice has developed of permitting material to be adduced before the coroner (or the coroner and jury) concerning the life of the person at the heart of the inquest. In 2018, 30,700 inquest conclusions were recorded. In the same period 423 inquests were held with juries. Many inquests are relatively short (an hour or so) and if the family are present, the coroner will generally ask them to let the court know something of their loved one in life – what he or she did, their interests and hobbies and details of their wider circle of family and friends. They may be asked if they have any family photographs that the coroner can see. The Chief Coroner welcomes and endorses such an approach.

3. Not all families will want to do this. Exceptionally, cases may also arise in which it would not be appropriate to allow the use of pen portraits. Subject to those rare exceptions, however the coroner should inform the family in advance that they will be allowed to present such material should they wish to do so. A number of recent inquests of national importance have used pen portraits to humanise the process and give dignity to the bereaved. It is a practice that can help the coroner to determine one of the four statutory questions, i.e. 'who' the deceased was.

4. Inquests tend to fall into one of four categories: documentary inquests, inquests where only the coroner and some family members are present, inquests with some interested persons, with or without lawyers, and inquests with coroner and jury.

(i) <u>Documentary Inquests held under Rule 23 of the Coroners (Inquests) Rules 2013</u>

[1] The Chief Coroner would like to thank the Coroners Court Support Service and INQUEST for their assistance with this Guidance note.

In these inquests pen portraits do not usually arise because there is just the coroner in the courtroom and no family members are present.

(ii) Inquests where only the coroner and family members are present

This is normally quite an intimate hearing when a family might tell the coroner something about their loved one. The more informal and relaxed nature of the proceedings enables this approach to occur.

(iii) Coroner sitting alone without a jury but with interested persons present

The Chief Coroner would expect a coroner sitting without a jury to adopt a relaxed and flexible approach to the admission of 'pen portrait' material. A family may well wish to adduce material before the coroner about their loved one and it will be incumbent on the coroner conducting the inquest to decide what is permissible and when the material is to be adduced. Such material is acceptable and easy to manage by the coroner, although advance notice of a family statement is preferable. Occasionally it may be appropriate to talk about the impact of the death on the bereaved.

(iv) Coroner sitting with a jury

In inquests heard by a coroner and a jury, photographs and other imagery of the circumstances of the death may well form part of the evidence placed before the court. In such circumstances, families may well wish to include some photographs or imagery from the life of the deceased. The type of material to be permitted, the amount of it and the timing of its admission will be a matter of judgment for the coroner.

It would be sensible for the coroner conducting the inquest to seek disclosure from the family of the material they would like to adduce by way of a 'pen portrait', as well as the format for such material to be presented, for example by way of written statement, photographs or video presentation. Directions given at a Pre-Inquest Review should cater for this. In many cases, a family member will wish to read out a statement rather than have a lawyer do so, but some families find this difficult and prefer a lawyer, coroner's officer or other person to do it for them. Depending on what is said the coroner may have to warn the jury that what was said is not evidence. Experience shows that many families accept there have to be boundaries and appreciate the opportunity to tell everyone in court about their loved one and their qualities and sometimes their shortcomings.

The coroner should make it clear to the jury that the pen portrait is a reflection of the person in life rather than in death and is not a matter of evidence to be taken into account when deciding on the conclusion.

HHJ THOMAS TEAGUE QC
CHIEF CORONER

5 July 2021

The Inquest Hearing

KEY MATERIALS

Legislation

Coroners (Inquest) Rules 2013, rule 26
Coroners (Investigations) Regulations 2013, reg 27
Children and Young Person's Act 1933, s.36

Introduction

1. By virtue of s.6 of the Coroners and Justice Act 2009 (the Act), once an investigation has commenced it must culminate in an inquest unless the investigation has been discontinued in accordance with s.4 of the Act or is suspended and not later resumed under schedule 1 of the Act.

Accessibility and location of inquests

2. A coroner must hold all inquest hearings in public unless the limited circumstances under the Coroners (Inquest) Rules 2013 at r.11(4) or r.11(5) arise. This means not merely open to the public but arranged in such a way that it is possible for a member of the public to attend in person.[1] The coroner must be in the publicly accessible courtroom and, in accordance with the principle of open justice, members of the public and press do not need to provide any reason for wishing to attend a court hearing.

3. Whilst the expectation will be that an inquest is normally held within the area of the coroner who is conducting the investigation, the Act allows inquests to be held anywhere in England and Wales, so there is flexibility as to the location of any inquest

[1] *Storer v British Gas plc* [2000] 1 WLR 1237

or pre-inquest review (PIR) hearing. Therefore, where the nature of an inquest requires a particular type of accommodation that is not available within the coroner's own area the inquest can be held in another place outside the coroner's area. This will commonly arise when there is a lack of available and appropriate court space for a jury inquest with multiple interested persons (IPs), or where it may be in the best interests of bereaved relatives to hold the inquest at a different location. Often this will be an adjoining jurisdiction, although at times (most commonly judge-led inquests) holding an inquest in a central venue in a major city may be appropriate.

4. Where a coroner has been appointed to sit in two areas there may be occasions when it is expedient for the coroner to hold PIR hearings or to hear inquests in cases from those different areas from a single courtroom on the same day. Provided there has been adequate public notification given of the venue of the hearing this may be a proportionate use of coronial and court time.

5. When considering whether to sit outside the coronial area the coroner should take due account of the views of IPs, in particular the bereaved, and the distance participants may have to travel to attend a hearing in person.

Age limits on attending Court

6. Whether attending remotely or in person there is no statutory age limit on who may attend a coroner's court as a member of the public. Under s.36 Children and Young Person's Act 1933 no child (other than an infant in arms) may attend a *criminal* trial except where their presence is required as a witness, or for the purposes of justice, or with the court's consent. However, in the absence of any equivalent provision in coronial law it is suggested that permitting a child to attend a coroner's court falls within the coroner's common law power to control their own proceedings.

7. The matter should be considered by weighing up the relevant issues including the administration of justice, the interests of open justice and, if relevant and ascertainable, the wishes of the child (having regard to their age and understanding) and whether attendance would be in the child's best interests.

8. Facilitating school age students to observe court proceedings can aid diversity in the legal profession. Having a blanket ban on the attendance at court of children of a particular age as public observers is likely to be unlawful. Each case must be considered on its merits. It would be reasonable to have (and publish on the coroner's website) a policy that children of a specified age can attend court without needing to request specific permission, but that children under a specified age (for example 14 years) should seek the coroner's consent on an individual basis.

An inquest script

9. Most inquests held by coroners are brief and uncomplicated hearings and can follow the format below. Whilst coroners may of course use their own words adapted for the particular case, it is important that the record is clear and complete for every inquest. Therefore, if several brief hearings are being held on the same day a formal introduction to each hearing is advised.

10. It is important to remember that those IPs who attend without the assistance of lawyers should always have the basic court procedure and legal principles explained to them by the coroner so that they can better understand the process in which they are participating. Giving an early explanation of the 'level of confidence' that must be applied in inquests will assist all participants to understand the basis upon which any factual findings and conclusions will, eventually, be made.

11. When issues of law are likely to arise at the end of the hearing, it may be helpful for the coroner to give a brief outline and explanation of those legal considerations in advance of the evidence being heard. For example if a likely issue at the end of an inquest will be whether a killing was unlawful then a basic outline of the law of gross negligence manslaughter or self-defence (if relevant) might be given. Such explanations, even provisional ones, can help unrepresented IPs to feel that their presence matters and that they are being kept informed and consulted throughout the inquest process.

12. The outline below may be a helpful script to follow in a simple inquest:

At the outset of the hearing

- introduce yourself and note the date;
- give any permission required for remote attendees to observe the proceedings;
- state the name of the deceased and their date of death (if not in issue);
- confirm (if this is the case) that this is a resumed inquest and give the date of the opening;
- identify the IPs, starting with the bereaved;
- if legal representatives are present, ask them to introduce themselves and say who they represent and who is attending court with them;
- if appropriate, introduce others present in the courtroom;
- inquire of the bereaved what name they prefer to be used when referring to the deceased;
- advise that the purpose of the inquest is to identify the medical cause of death, and to answer four statutory questions: who died, when and where they died, and how they came by their death.
- advise that the court must also come to a conclusion about their death, (coroners may wish to explain that this used to be called a 'verdict' although that word is no longer used).
- advise that an inquest is not a trial, that no person or organisation is on trial and it is not the coroner's role to attribute blame;
- explain the level of confidence that the coroner/jury will apply to findings of fact and conclusions;
- explain the intended scope of the investigation and inquest;
- explain any legal considerations that it is anticipated will need to be addressed at the end of the evidence;
- state that in order to address those matters within the scope of the investigation 'the following evidence will be called' then cite the witness list indicating whether a witness will attend in person or their evidence will be read;
- explain that you shall be asking questions of all the live witnesses first and then offer the bereaved and other IPs the opportunity to ask questions of the witnesses, with the witnesses' own legal adviser going last (if they have one);

- explain the effect of r.23 and under which sub-section the evidence to be read is admitted. Make it clear that the evidence is either not disputed or where not accepted by all, explain why the witness' attendance is not required.
- confirm with the IPs present that no one objects to the evidence being read.[2]
- check that all IPs have received the advance disclosure and there are no preliminary housekeeping matters.
- Note that evidence of identity was given at opening and by whom.
- Call any pen portrait material that is to be presented.[3]
- Call the first factual witness or read the first documentary evidence.

At the end of the evidence

- indicate that this is all the evidence you had intended to hear regarding the death.
- ask if any IP suggests there is any other evidence that should be considered.
- ask if any IP wishes to make any submission of law regarding the available conclusions.
- deliver a brief ruling on available conclusions if required.
- explain that as the evidence is now concluded you will retire for a short while to consider the evidence and your conclusions.

Findings and conclusions

- state that the following are the findings and conclusions for the purposes of the inquest.
- summarise the relevant evidence. Explain how the court interprets the medical evidence, and any other expert evidence, in simple language.
- make findings of fact based upon the evidence, stating 'why' or 'because' where appropriate.

[2] This step is required in compliance with rule 23(2)(c). It is particularly important where the bereaved are not represented as they may not understand their right to object to evidence being read. If any objections are raised at this stage they must be considered and, if not acceded to then, as a minimum, brief oral reasons for the decision not to call the witness must be given.
[3] See §12 below.

- indicate what medical cause of death is found to be from the evidence as 1a *etc*……. and this is what shall be recorded on the Record of Inquest.
- state what shall be recorded in box 3 of the Record of Inquest as the time, date, place and circumstances of the death.
- give the conclusion as to the death and that it shall recorded as this in box 4 of the Record of Inquest.
- where appropriate, give the details required for the registrar as in box 5.
- if necessary, announce that a report with a view to preventing future deaths will be written.
- announce that this concludes the inquest, thank those attending and express necessary condolences.

13. There is no longer a statutory requirement for coroners to take and keep their own notes of evidence at an inquest.[4] Coroners' own notes are no longer disclosable and cannot be inspected. However, as good practice coroners will still keep their own notes for their rulings, conclusions and summing up.

Pen portraits

14. The practice has developed of permitting material to be adduced before the coroner (and the jury where relevant) concerning the life of the person at the heart of the inquest. This has become known as a 'pen portrait'. Not all those bereaved will wish to do this, but it is appropriate for the opportunity to be offered when the bereaved will be attending an inquest. Exceptionally, cases may also arise in which it would not be appropriate to allow the use of pen portraits (for example, where the deceased committed an unlawful killing and a pen portrait would cause the victim's family unjustifiable distress).

15. Pen portraits do not usually arise in documentary inquests because there is often just the coroner in the courtroom and no family members are present, although a written pen

[4] As there was previously under r.39 and r.57(1) of the Coroners Rules 1984

portrait can be considered at documentary inquest, even if the bereaved do not wish to attend.

16. In other relatively short but attended inquests where the bereaved are present, the coroner will generally ask them to let the court know something of their loved one in life – what he or she did, their interests and hobbies and details of their wider circle of family and friends.

17. The coroner should inform the bereaved well before the inquest hearing that they will be invited to present such material should they wish to do so. In more complex cases or jury inquests the directions given at a Pre-Inquest Review should cater for the presentation of pen portraits.

18. In many cases, a family member will wish to read out their own tribute, at other times the bereaved may find this difficult and prefer a lawyer, the coroner or a coroner's officer to do this for them. Families may wish to include some photographs or imagery from the life of the deceased. The type of material to be permitted, the amount of it and the timing of its admission will be a matter of judgment for the coroner.

19. It is not obligatory for pen portrait material to be presented under oath, as it often does not form part of the inquest evidence, but if the bereaved person is also giving registration particulars or other factual evidence it may be necessary for them to take an oath at the outset.

20. The coroner should make it clear to any jury that the pen portrait is to be a reflection of who the person was in life rather than any information about how the death occurred. It is not a matter of evidence to be taken into account when deciding on the conclusion. Depending on what is said the coroner may have to warn the jury that what was presented is not evidence.

21. Even where there have been multiple deaths arising from the same incident it should be considered extremely unusual to introduce pen portrait material for a person who is not the subject of the inquest proceedings. An alternative course is for the coroner to acknowledge at the outset of the proceedings that others also died, although their deaths

are not being inquired into in the current inquests,[5] and perhaps also name the other deceased if appropriate.

The content of pen portraits

22. An advance copy of any pen portrait should usually be given to the coroner and all other IPs. It will be incumbent on the coroner conducting the inquest to scrutinise the pen portrait material and decide what is permissible and when the material is to be adduced. On occasions it may be appropriate for the coroner to refer to the pen-portrait material again or quote directly from it at the end of the inquest when closing the proceedings.

23. Coroners should always carefully review whether the material put forward by the bereaved goes beyond what is appropriate to include within a pen portrait. The pen portrait process should not stray from its intended purpose and be used, whether intentionally or unintentionally, to make pejorative observations on the actions of others or to pass comment on the evidence yet to be heard. A pen portrait should not be used as a means of making inadmissible commentary within the courtroom on the matters the coroner is investigating. It should not include material that undermines the rule 27 prohibition on addressing the facts. Those delivering pen portraits should not be allowed to make speeches addressing their view of how the death occurred which seek to persuade the coroner or the jury what facts to find or which conclusion to return.

24. As pen portraits are read out in court they become an integral part of a judicial coronial process. That pen portraits are usually not delivered under oath should make no difference to the need for them not to stray beyond their intended focus as a tribute to the deceased and the person they were in life.

Photographs displayed in court

[5] This might arise in cases of multiple deaths abroad, where the bodies of those who are the subjects of the inquest were returned to England or Wales.

25. The family may bring photographs of the deceased to court that they wish the coroner (and, where there is one, the jury) to see. It is appropriate for such images to be shown as requested, they are an important recognition of the person to whom the inquest relates. However on occasion a bereaved person may ask that an image of the deceased remains on display in the courtroom during the inquest. The coroner will need to determine whether to permit such display throughout the hearing. It may not be appropriate to do so if such imagery might distract the jury or might affect the witnesses and so impact upon their ability to give their best evidence. One approach is to place the photograph where it remains visible to the coroner, but not to others.

Language in court and equal treatment

26. The Equal Treatment Bench Book ('ETBB') provides important guidance for all judges and coroners and it should be taken into account where applicable in coronial proceedings. The ETTB aims to increase awareness and understanding of different people's circumstances, and it makes suggestions regarding steps coroners may wish to take, in different situations, to ensure that there is fairness for all those who engage in proceedings in coroners' courts.

27. The ETBB is regularly updated and so care should be taken not to over-rely upon printed and therefore potentially out of date copies. Its contents are not repeated here beyond some salient points about the use of language in court.

28. There are expressions and terms which should not be used at inquests as they may cause offence. In particular, coroners will want to avoid the following:

- saying 'committed suicide' as this suggests a criminal act. The words 'died by suicide' are more acceptable.
- referring to a 'successful suicide attempt': this may distress the bereaved. Similarly where someone has survived an earlier suicide attempt coroners should avoid describing this as 'unsuccessful' or 'failed'.
- talking about people as if they are medical conditions: for example avoid saying 'a dyslexic' or 'a diabetic' – use instead 'a person with dyslexia/diabetes'.
- using negative terms such as 'suffers from' – use instead 'has', 'experiences' or other more neutral terminology.

- comparisons with ‘normal’ and referring to ‘the disabled’ as if they were a distinct class.
- referring to someone as ‘handicapped’ – use instead ‘disabled person’. Similarly avoid the term ‘mental handicap’ – use instead ‘learning disability or disabilities’ or ‘learning difficulties’.
- referring to someone as being an ‘addict’, ‘drug abuser’, ‘clean’ – use instead ‘has a substance misuse disorder’, ‘has an addiction’, ‘is abstinent from drugs/in recovery’.
- using the term ‘mental illness’ except when discussing a diagnosed clinical condition, otherwise use instead ‘mental health issues’ or 'mental ill health’.
- Using the term ‘mental capacity’ incorrectly; it is a very specific phrase which has a technical legal meaning under the Mental Capacity Act 2009.

Signing the Record of Inquest

29. The Record of Inquest must be signed by the coroner (and, if there is a jury, those members of the jury who agree with it). Most coroner areas now use software systems whereby forms are signed electronically by the coroner and ‘wet ink’ signatures are becoming rare.

30. Coroners are reminded that any use of pre-signed forms should be avoided. The signing of a blank or incomplete form by a coroner is a misuse of the coroner’s judicial functions. The signature is an acknowledgment that the form is complete and accurate for its legal purposes, which it is not if left to be completed by someone else. If somebody else, such as a coroner’s officer, then completes the details on the signed form, that becomes a purported judicial act which is not permitted. Only coroners can carry out judicial functions. Such practices are unlawful and could put the coroner at risk of an investigation by the Judicial Conduct Investigations Office.

Translators and interpreters

31. Witnesses at inquests who are not sufficiently proficient to give evidence in the language being used in the court must have the assistance of an interpreter, preferably a professional one. In inquests held in Wales, the Welsh language may be spoken by any

person, not just a witness.[6] A coroner sitting in Wales will need to establish at the PIR whether any persons intend to exercise their right to speak in Welsh at the inquest. A person who is bilingual in Welsh and English should not be required to speak in English if they do not wish to do so. It will also be prudent to ensure at an early stage that an interpreter will be present to translate from Welsh to English for the benefit of any persons present who are not bilingual.

32. A witness who has a hearing or speech impediment may also need special assistance from an interpreter, although in some cases assistance may be given by an intermediary.

33. IPs may be witnesses, in which case they are entitled to give evidence through an interpreter. Where they are not witnesses, they may be entitled to interpreter assistance provided by the court, as it is necessary in the interests of justice that IPs should be able to participate sufficiently in the investigation and inquest process. Coroners have a positive duty to ensure that sufficient participation is achieved, indeed this is one of the requirements of an Article 2 inquest.

34. It may be tempting to continue without an interpreter if a bereaved family member or witness says they can manage in the language being used in the court, however a coroner should exercise caution about accepting such reassurances. It is preferable only to accept the assistance of a family or friend where the person they are assisting does have a grounding in English/Welsh and simply needs assistance with a few words, phrases or constructs.

35. Guidance on the use of a translator or interpreter has been set out in the Equal Treatment Bench Book.[7] Ultimately, it is the coroner's responsibility to ensure that there is a fair hearing.

36. It is a matter for the discretion of the coroner how to achieve fairness in the particular case. Where someone has limited ability in the language being used in the court then a professional interpreter is likely to be required.

[6] Welsh Language Act 1993, s22(1), therefore this includes IPs, their advocates and the coroner.
[7] For further guidance see the Equal Treatment Bench Book at chapter 8 – 'How to communicate through an interpreter and translation difficulties'.

37. Once satisfied that translation and/or interpreting services are required, the coroner will decide which method in §36 below is most appropriate. This will depend upon the circumstances of the case, the extent to which the inquest is contentious, the nature of the documentation and the evidence (whether straightforward or involving complexity, difficulty, or experts). A coroner who fails to provide such services when they are truly necessary for the bereaved or another IP to participate in the proceedings is likely to be vulnerable to challenge by way of judicial review.

38. Assistance in translating or interpreting may be achieved in several ways:

- where the coroner requires professional translation or interpreting services this should be funded by the local authority. Often the local police may be able to assist to identify a locally based translator;
- in non-contentious cases a friend or relative of the person may help if the person is not fully fluent in English and just needs assistance with a few words or phrases, but a friend or relative should not be relied upon where extensive translation is required;
- assistance may be obtained on a voluntary basis from a local foreign nation association or relevant charity, however the coroner will need to be satisfied that the translations will be (a) accurate and (b) strictly confined to translation with no extraneous comment or gloss;
- an IP may be represented and have either private or public funding or be able to obtain funding for translation and interpreting;
- there are some helpful free translation services available on the internet where it is only a matter of clarifying specific words or technical terms;
- it will rarely be appropriate to use anything other than a professional interpreter in cases that are likely to be contentious.[8]

39. Sometimes it may be necessary to remind an interpreter to say the words of the question and the words of the answer and nothing more. Coroners must be satisfied, as best they can, that the interpreter is carrying out the task strictly and with true independence. All

[8] For these purposes services for translation or interpreting may be treated as an 'unusual allowance, fee or expense' under Regulation 7 of the Coroners Allowances, Fees and Expenses Regulations 2013, or, for interpreting in court, as an 'additional expense' relating to a witness under Regulation 11.

interpreters, including family members assisting without any charge, should be asked to take an oath or affirmation.

The interpreter's oath.

I swear by Allah/Almighty God, etc., that I will well and faithfully interpret and true explanation make of all such matters and things as shall be required of me according to the best of my skill and understanding.

The interpreter's affirmation

I do solemnly declare that I will well and faithfully interpret and true explanation make of all such matters and things as shall be required of me according to the best of my skill and understanding.

Inquest recordings

40. All inquest hearings must be recorded.[9] This includes pre-inquest review hearings and, where practicable, openings.[10]

41. A recording (which is a 'document' for the purposes of the rules and regulations) must be kept for at least 15 years.[11] All recordings should be digital and stored with appropriate back-up or held in a secure cloud-based system.

42. Coroners' officers or administrative staff should be able to set-up the recording device for each hearing. The coroner should take reasonable steps to ensure that the device is working at all times. At each inquest hearing coroners should consider informing those present that the hearing is being recorded and advise them to be careful about asides or comments which might be picked up by the court microphones.

43. It is a contempt of court for any person to use in court or bring into court for use any instrument for recording sound, except with the leave of the court.[12] However, there

[9] rule 26, Coroners (Inquests) Rules 2013
[10] Coroners may wish to consider at the end of each hearing, with a view to possible future requests for a recording, whether a note (oral or written) should be made to indicate if redaction of the recording may be necessary, such as where there is a risk of prejudicing law enforcement action or the administration of justice, affecting national security, putting anyone's safety at risk, identifying an anonymous witness, naming children, breaching medical confidentiality or breaching a contempt of court order.
[11] regulation 27(1), Coroners (Investigations) Regulations 2013
[12] section 9(1), Contempt of Court Act 1981

are now several artificial intelligence transcription applications available which can greatly assist those otherwise expected to take verbatim notes of a hearing. With this in mind, any application for leave from IPs, their legal representatives or members of the media might be treated sympathetically, subject to clear restrictions being placed upon the use of any recording made. If leave is granted, conditions may be attached.[13]

Copies of recordings

44. Coroners (either themselves or through a coroner's officer) may wish to inform bereaved families that they can request a copy of the recording after the inquest.

45. In accordance with the disclosure provisions of Part 3 of the Coroners (Inquests) Rules 2013[14] a copy of a recording must be made available to an IP on request. The coroner may either provide a copy or make the recording available for 'inspection', subject to the restrictions on disclosure in rule 15. However, a recording need not be provided of any hearing or part of a hearing where the public was excluded.[15]

46. A copy of a recording may also be provided by the coroner 'to any person who in the opinion of the coroner is a proper person to have possession of it'.[16]

47. In the latter case coroners have a discretion whether to provide a recording. They should exercise their discretion on a case by case basis; a policy to restrict groups of people would be unlawful (fettering the coroner's discretion). The coroner needs to be satisfied that there are reasonable grounds for disclosure, however, the presumption of openness for court proceedings gives rise to a presumption of disclosure.[17]

[13] section 9(2), Contempt of Court Act 1981
[14] see in particular rule 13
[15] rule 13(2)(c)
[16] regulation 27(2)
[17] A coroner may charge for providing a copy of a recording after an inquest (but not before) in accordance with the Coroners Allowances, Fees and Expenses Regulations 2013 (see regulation 12). The statutory fee for a 'document' provided otherwise than by email, and therefore including a recording on disk or memory stick, is £5 per recording: regulation 12(4). It is however preferable to offer recordings via a secure cloud based service, although no fee may be charged: regulation 12(2).

Use of inquest recordings

48. It is an offence under s.9(1)(b) of the Contempt of Court Act 1981 to publish an inquest recording, or any recording derived directly or indirectly from it, by playing it in the hearing of the public or any section of the public.

49. Where a recording is provided to any person it should therefore be accompanied by a written notice advising that the misuse of the recording may amount to contempt of court punishable by imprisonment.[18]

50. Whilst the recording of a court hearing cannot be broadcast without breaching the Contempt of Court Act 1981, the same rules do not apply to a transcript taken from a recording. There appears to be no general bar to transcripts being published, quoted from, re-voiced or re-enacted. Of course, anyone publishing these types of information must comply with any relevant prohibitions, for example there is a general prohibition against publishing the names of living victims of sexual offences, there may be reporting restrictions, an anonymity order, or an order made under s.39 Children and Young Persons Act 1933 in effect etc. A warning notice should be given to recipients of recordings to explain this.

51. In advance of receiving a copy of the recording the intended recipient should sign to acknowledge receipt and understanding of the warning notice. A suggested warning notice is below.

Inquest Recording: Warning Notice

It is an offence under s.9(1)(b) of the Contempt of Court Act 1981 to publish an inquest recording, or any recording derived directly or indirectly from it, by playing it in the hearing of the public or any section of the public.

You should not provide the inquest recording or a copy of the inquest recording to another person without the prior agreement of the coroner.

[18] See, by analogy, *AG v Scarth* [2013] EWHC 194 (Admin) (Lord Judge CJ), which involved the contemnor making and publishing on the internet his own audio recording of court proceedings.

Use of an inquest recording or any part of it by copying, publishing, transmitting, or broadcasting the inquest recording in any way (including on the internet), may be a contempt of court punishable with imprisonment. However, you may listen to the inquest recording yourself and use it to produce a written transcript.

There is no general prohibition on using the information gained from a recording or transcript to quote, re-voice or re-enact an inquest, or part of an inquest.

However, if you are considering publishing information about an inquest, you should be aware that:

- there are specific provisions preventing the publication of some types of information; and
- it is possible for the publication of information to cause harm to others (see for example, the Samaritans' media guidelines on reporting suicide).

If you are unfamiliar with the law around the publication of information, you may therefore wish to consider taking legal advice.

If you use the recording to produce a transcript, the transcript must not be presented as a court-approved transcript unless it has been seen and approved as such by the coroner. Only an approved transcript of an inquest recording should be used for the purpose of any further legal proceedings.

Signed (by the coroner)

Dated

Inquest transcripts

52. Unless the inquest is one where a contemporaneous transcript has been created during the proceedings,[19] it is not expected that a coroner will provide post-inquest transcripts at their own expense. Only a recording is required to be provided.

53. Where a recording is deployed by an interested or other person to produce a transcript of the inquest for the purpose of any further legal proceedings (such as a judicial review application), then that transcript should be provided to the coroner and checked to confirm its accuracy. Any warning notice sent out with a recording should therefore include that provision.

[19] As is more often the case in high media profile judge-led inquests.

54. Where, exceptionally, the court produces the transcript, a fee may be charged for transcription in line with regulation 12(5) of the Coroners Allowances, Fees and Expenses Regulations 2013.[20]

[20] At the time of publication for a copy consisting of 1440 words or more, £13.10 for the first 1440 words and 70p for each additional 72 words or part thereof.

November 23, 2023

Lecture by the Chief Coroner: Death and Taxes – the past, present and future of the coronial service

Chief Coroner (https://www.judiciary.uk/subjects/chief-coroner/)

Speeches (https://www.judiciary.uk/news-types/speeches/)

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1. In November 1875, an election took place for the office of county coroner for Suffolk. There were three candidates. One was a lawyer, one was a doctor, and the third was an auctioneer. You have probably already guessed who won. It was, of course, the auctioneer.

2. The editor of the *Spectator* was incandescent:

> "We wish other counties would follow the example, and elect Coroners still more unfitted for the office by training and pursuits. There would then be a fair chance that this anomalous absurdity in our system, the election of a judge with serious powers and duties, by a mob, would be summarily abolished, and the Coroners chosen, like

> the County Court judges, on the responsibility of the Lord Chancellor. The only effect of the present system is to keep up a thoroughly bad precedent, and degrade an office which, if a few more duties were thrown on it, might be made extremely useful."

3. It took another 13 years for Parliament to abolish the system of choosing coroners by holding elections, but instead of entrusting the appointment process to the Lord Chancellor, as the *Spectator* had urged, the Local Government Act 1888 handed the task to the newly-created county and borough councils. The question what kind of professional qualification coroners should hold remained undecided. In 1879, a Parliamentary Select Committee had recommended that the office be confined to legal professionals assisted by medical assessors, but the prorogation of Parliament prevented that proposal from passing into law.

4. At the beginning of the nineteenth century, the coroner service was in a dire state. Yet it had its defenders. The radical journalist William Cobbett described it as "the institution for the protection of life and limb". For the *Times* newspaper, the coroner was "eminently the magistrate of the poor". In 1834, the physician Thomas Wakley, founder of the *Lancet* journal, wrote that the coroner's office was "especially designed to protect the interests of the people, to shield the weak against the tyranny of the strong, to guard the peaceful citizen against the fury or unbridled rage of the cruel agent of power, to trace out the first steps of crime, and thus relieve the innocent from the curse of undeserved suspicion, and impose on the guilty the last and most weighty responsibilities of the law".

5. There were many reasons for this early nineteenth-century perception of the coroner's inquest as a popular tribunal through which abuse of power and disreputable conduct by the authorities could be exposed to the public gaze. Not only was it the people who elected the coroner, but the franchise was wider than for Parliamentary elections – all freeholders, including women, were entitled to vote. Jurors, too, were drawn from a larger pool than in criminal or civil proceedings. In cases involving deaths in custody (which Thomas Wakley and others argued should

include workhouse deaths), prisoners would sit as members of the coroner's jury. The inquisitorial nature of the process meant that jurors were used to asking their own questions and would even call witnesses whom the coroner regarded as unnecessary or irrelevant.

6. Above all, the system provided free and comparatively easy access to a public judicial investigation. Lawyers were rarely involved and it was the local magistrates, as the forerunners of modern local authorities, who had to bear the cost. What's more, no minimum standard of proof or suspicion was required to justify the launching of an investigation. In 1728, the Dorset coroner conducted an inquest into the death of a youth whose body had been found on a riverbank on the strength of a reported sighting of the lad's ghost. Mind you, it's worth remembering that at that time, coroners were still entitled to claim a separate fee for each individual case that they investigated.

7. Not everyone held the inquest process in high esteem. For some, it was blighted by a lack of professionalism on the part of coroners. In 1824, Thomas Denman – afterwards Lord Chief Justice – observed that the coroner was "rarely a person of high legal attainments". Some years later, the physician Sir Dominic Corrigan described the coroner system as "a gross burlesque on jurisprudence" and "an absolute disgrace to the administration of justice". Even his colleague Thomas Wakley, who by this time had got himself elected as coroner for West Middlesex, castigated what he called the "imbecility and ignorance" of coroners.

8. It was even worse in Ireland, where coroners enjoyed – if that's the right word – a reputation for drunkenness and corruption. In 1818, the Reverend Peter Browne, Dean of Ferns, wrote to Prince Frederick, Duke of York and Albany, complaining that coroners in Ireland were, as he put it, "generally speaking the lowest and most contemptible characters".

9. Of course, matters were not helped by the circumstances in which inquests commonly took place. There were no coroners' courts in those days. The usual place of hearing for an inquest was the local public house. Wakley's Victorian biographer, Sir Samuel Squire Sprigge, did not approve, deriding the typical inquest as "a dreary

farce … where the majesty of death evaporated with the fumes from the gin of the jury".

10. Charles Dickens witnessed inquests in his capacity as a journalist, and even served on a coroner's jury. As it happens, the coroner on that occasion was none other than Thomas Wakley. In a trenchant article in *Household Words*, Dickens castigated the practice of hearing inquests in taverns, but he reserved his most pungent criticism to a scene in *Bleak House*, published a couple of years later in 1852:

> "At the appointed hour arrives the coroner, for whom the jurymen are waiting and who is received with a salute of skittles from the good dry skittle-ground attached to the Sol's Arms. The coroner frequents more public-houses than any man alive. The smell of sawdust, beer, tobacco-smoke, and spirits is inseparable in his vocation from death in its most awful shapes. He is conducted by the beadle and the landlord to the Harmonic Meeting Room, where he puts his hat on the piano and takes a Windsor-chair at the head of a long table formed of several short tables put together and ornamented with glutinous rings in endless involutions, made by pots and glasses. As many of the jury as can crowd together at the table sit there. The rest get among the spittoons and pipes or lean against the piano".

11. Now, the public house was not, perhaps, quite as unseemly a venue as Victorian society came to think. There was a perfectly good reason to use such establishments – and no, it isn't the reason some of you probably have in mind. The fact is that during the eighteenth and nineteenth centuries, there was a shortage of public buildings. In many towns, the local inn provided the only available space for a large gathering, whether civic or otherwise. Nor were coroners the only people who used them for such purposes. Public houses also served as auction rooms, magistrates' courts and even, believe it or not, places of solemn worship. Until the Catholic Relief Acts lifted the last restrictions on building new Catholic

churches, it was commonplace for itinerant priests to ride from town to town, celebrating Mass in local taverns.

12. All the same, we must admit – not, in my case, without a faint twinge of regret – that the practice of conducting inquests in taverns could not continue. Now, you will find it confidently asserted by various authorities that it was abolished by the Coroners Act of 1887. That is not so. The 1887 Act was completely silent about it. The earliest prohibition I have been able to find is contained in section 21 of the Licensing Act 1902, which forbade coroners to use public houses for inquests "where other suitable premises have been provided". Section 21 was repealed in 1910 and I cannot trace any successor to it, raising the tantalising possibility that there currently exists no legal prohibition – not even a qualified one – against holding inquests in pubs. If so, it occurs to me that I might, perhaps, consider issuing some measured guidance on the topic.

13. How did the custom of investigating death in a tavern ever come about in the first place? To answer that question, it's necessary to take a brief detour into the origin of the modern coroner.

14. It is usually said that the office of coroner dates back to the twelfth century, more specifically to the Articles of Eyre of 1194. That is certainly the earliest date that is properly documented, but it does not exclude the possibility of an even remoter genesis. On any view, the position of coroner is today the oldest surviving judicial office in England and Wales.

15. From early accounts of inquests, whether fictional or otherwise, we get little sense that the bereaved were at the heart of the process. That is a modern development about which I shall say more a little later. In the olden days, the person at the heart of the process was the King. That is because the original point of the coroner was to raise revenue on behalf of the Crown. His jurisdiction was not confined to death investigation but embraced many other responsibilities. His duty was to "keep the pleas of the Crown", that's to say that he had to enforce the monarch's financial prerogatives. He was, in effect, a tax collector. The reason he investigated unnatural deaths was not for the benefit of the bereaved, but because the instrument of such a death, known as a 'deodand', was forfeit to the

Crown. It might be the horse that threw its rider and killed him or it might be the sword with which one man slew another. Whatever it was, it had to be assigned a monetary value, which is why indictments for murder used to specify the value of the weapon that was alleged to have been used to inflict the fatal wound. But the royal interest in revenue was not confined to cases of death. The coroner also claimed jurisdiction over shipwrecks and treasure trove, as well as other potential sources of royal revenue.

16. With the passage of the centuries, the coroner's tax-collecting responsibilities gradually disappeared or fell into disuse or were transferred to other officials. It was section 44 of the Coroners Act 1887 that purported to extinguish the last trace of the coroner's revenue-raising responsibilities:

1.

> "A coroner shall not take pleas of the Crown nor hold inquests of royal fish nor of felonies except felonies on inquisitions of death; and he shall not inquire of the goods of such as by the inquest are found guilty of murder or manslaughter, nor cause them to be valued and delivered to the township."

17. Yet the ancient revenue duties did not entirely dissipate. To this day a faint echo still reverberates in the coroner's residual jurisdiction over treasure. With that sole exception, nothing now survives of his ancient role of royal debt enforcement. On the contrary, the coroner is now primarily charged with the solemn duty of conducting public, judicial death investigations, at the heart of which lie the deceased and their bereaved families.

18. The slow rate at which the office of coroner evolved over many centuries has perhaps concealed the magnitude of the distance travelled. So gradual was the development from one extreme to its opposite that it went largely unnoticed. As with so many other social reforms, it was during the Victorian age that people woke up to the need for change. The inquest system was by then long overdue for modernisation, and at the forefront of that project lay the need to professionalise its judiciary.

19. But the case for modernisation demanded the resolution of two separate yet related questions. In the first place, it's all very well advocating professionalisation, but what are the limits and purpose of a modern inquest? Should it be confined to a medico-legal inquiry into the cause of death or should it extend to a wider forensic investigation embracing questions of culpability? Secondly, in order to professionalise the coronial process, it was first necessary to identify the profession to which it ought properly to be entrusted (presumably not auctioneers). But should inquests continue to be conducted by people with a legal background, or was there a place for the emerging medical profession?

20. These two issues – the definition of the scope of a coronial investigation and the professionalisation of the office, although strictly distinct, overlapped to some extent. Neither was finally resolved until recent times and even today some tensions still linger.

21. During the nineteenth century, the dominant question was: who should conduct inquests, lawyers or physicians? The proper scope of the inquest was not, at that time, as controversial as it later became. Everyone understood that some inquests would necessarily involve questions of blame. In cases of murder, for instance, the coroner's inquisition formed the basis of the indictment on which the person accused would later stand trial at the assizes. It was the Criminal Law Act 1977 that finally abolished that particular function of the inquest. It is said that the last person to be committed for trial by a coroner's court was Lord Lucan. Nowadays, of course, section 10(2) of the Coroners and Justice Act 2009 prohibits coroners from even appearing to determine any question of civil liability or any question of criminal liability on the part of a named person.

22. During the nineteenth century, however, coroners' juries were far less inhibited. Let me mention a particularly inflammatory example from Ireland during the terrible famine that followed the failure of the country's potato crop. Sir Robert Peel's administration had set up a Relief Commission for Ireland, headed by Sir Randolph Routh. Its principal purpose was to oversee the funding and distribution of relief to the Irish poor. In January 1847, an inquest took place at the Galway workhouse into the death from malnutrition of a woman called Mary Commons. By

that date, Peel had left office and the new Prime Minister was Lord Russell. The coroner's jury sought to return a verdict in these terms:

> "We find that the deceased, Mary Commons, died from the effects of starvation and destitution, caused by a want of the common necessities of life; and as Lord John Russell, the head of her Majesty's government, has combined with Sir Randolph Routh, to starve the Irish people, by not, as was their duty, taking measures to prevent the present truly awful condition of the country, we find that the said Lord John Russell and the said Sir Randolph Routh, are guilty of the wilful murder of said Mary Commons".

The coroner refused to accept the verdict and compelled the jury to adopt a modified form of words which nevertheless preserved an element of condemnation of government policy. Even so, the case powerfully illustrates the strand of popular radicalism that characterised some Victorian inquests, traces of which still occasionally surface.

23. The common assumption that inquests would determine questions of culpability may help to explain why the Victorians regarded the definition of the proper scope and limits of an inquest as less urgent than the question who should conduct it. It was the emergence of the modern medical profession that sharpened that particular debate.

24. Although there was no formal requirement that coroners should be trained in either law or medicine, they tended in practice to have a legal background. Their knowledge of medicine was, at best, rudimentary.

25. It was, you may not be surprised to hear, Thomas Wakley who led the campaign for medically qualified coroners through the medium of his new journal, the *Lancet*. He did not spare the lawyers:

> “The training of the mind to act for the law, and to fulfil all its injunctions in the court of the Coroner, is not to be effected in the red-and-black-ink shops of scribbling and miserable-minded attorneys, but in those high marts of natural law, the Temples of Medical Science…. Attorneys are elected coroners, and there they sit, untroubled, ungalled, unstimulated, unnoticed by the public, careless if unnoticed, insolent if reproached, afraid to be touched – in point of fact shrunk from, as holders of the very whip which should be administered on their own backs.”

26. This debate was not confined to the pages of learned journals. That it became familiar to the educated public is shown by the inclusion of an extended reference in George Eliot’s great novel, *Middlemarch*, which, although published in the early 1870s, was set 40 years earlier. Picture a dinner party at which the guests include two physicians, Dr Lydgate and Dr Sprague, as well as the local coroner, Mr Chicheley. Mr Chichely is a lawyer – a circumstance of which Dr Lydgate rather tactlessly loses sight:

> “’Hang your reforms!’ said Mr Chichely. ‘There’s no greater humbug in the world. You never hear of a reform but it means some trick to put in new men. I hope you are not one of the *Lancet*’s men, Mr Lydgate – wanting to take the coronership out of the hands of the legal profession: your words appear to point that way.’
>
> ‘I disapprove of Wakley,’ interposed Dr Sprague, ‘no man more: he is an ill-intentioned fellow who would sacrifice the respectability of the profession, which everybody knows depends on the London Colleges, for the sake of getting some notoriety for himself. There are men who don’t mind about being kicked blue if they can only get talked about. But Wakley is right sometimes,’ the Doctor added,

> judicially. ‘I could mention one or two points in which Wakley is in the right.’
>
> ‘Oh, well,’ said Mr Chichely, ‘I blame no man for standing up in favour of his own cloth; but, coming to argument, I should like to know how a coroner is to judge of evidence if he has not had a legal training?’
>
> ‘In my opinion,’ said Lydgate, ‘legal training only makes a man more incompetent in questions that require knowledge of another kind. People talk about evidence as if it could really be weighed in scales by a blind Justice. No man can judge what is good evidence on any particular subject, unless he knows that subject well. A lawyer is no better than an old woman at a *post-mortem* examination. How is he to know the action of a poison? You might as well say that scanning verse will teach you to scan the potato crops.’
>
> ‘You are aware, I suppose, that it is not the coroner’s business to conduct the *post-mortem*, but only to take the evidence of the medical witness?’ said Mr Chichely, with some scorn.”

27. I wish I had time to recite the whole of this exchange, which occupies two full pages, but I must confine myself to the author’s characteristically waspish comment:

> “This was one of the difficulties of moving in good Middlemarch society: it was dangerous to insist on knowledge as a qualification for any salaried office.”

28. The question which profession better equips a person to perform the duties of a coroner is one that has persisted into the present century. The third report of the Shipman Inquiry, published in 2003, declared that “the conduct of inquests apart, the job of coroner requires medical knowledge far more often than legal knowledge, and entails a medical judgement far more often than a legal

one.” In the same year, however, the Fundamental Review led by Tom Luce concluded that “a legal qualification and experience of practice as a barrister or solicitor should be required for coroners”. In the end, it was the Luce view that prevailed. The Coroners and Justice Act 2009 provides that all coroners must satisfy the normal judicial appointment criteria. Subsequent experience has, I think, vindicated Tom Luce, not to mention Mr Chichely.

29. We should not overlook the important part played by the Coroners’ Society of England and Wales in professionalising the inquest system. Founded in 1846, the Society’s original purpose was to foster co-operation between coroners, in the words of Serjeant William Payne, “ for the more effective discharge of the duties of their office”. The mutual support and collaboration that resulted undoubtedly served to raise professional standards and promote better practice in the decades that followed.

30. The cumulative result of the changes I have already described, coupled with the passage of the Coroners and Justice Act 2009, is that the landscape coroners today inhabit has been transformed. In August 2020, providing written evidence to the Commons Justice Committee, Tom Luce had this to say:

> “When in 2001–3 my Fundamental Review colleagues and I reviewed the service it was customary to refer to it as ‘quasi-judicial’; I am now confident that the ‘quasi-’ qualification should be dropped. It is developing into a properly judicial service and continues to deepen that essential characteristic of its work to an impressive extent worth public recognition”.

31. And so, while we should never be complacent about continuing professional development, I think we can now confidently say that coroners have earned the right to be regarded and treated as members of the wider judicial family on an equal footing with their colleagues from other jurisdictions. When it comes to the modernisation of the inquest process, too, considerable progress has been achieved, yet that task remains unfinished.

32. Now, the reason we are marking the tenth anniversary of the modern reforms this year is that although they were enacted in 2009, they were not implemented until 2013. Even then, some of the Act's provisions were either delayed – for example the introduction of the Medical Examiner System – or, like the provision for appeals from coroners' decisions to the Chief Coroner, abandoned altogether.

33. The 2009 Act changes introduced an element of central oversight of the coronial service through the new office of Chief Coroner, improved some aspects of its organisation and subjected coroners to the same professional standards as their judicial colleagues in other jurisdictions.

34. The policy of all three Chief Coroners who have held the position since 2013 has been to use this reformed structure to create a more modern, consistent, open and just service, with the object of reducing unnecessary delays and putting bereaved families at the very heart of the process. Over the past 10 years, despite the unprecedented difficulties caused by the Covid-19 pandemic, there have been many positive steps towards achieving these objectives. Before turning to the challenges we still face, let me pay tribute to those who brought about those improvements.

35. The first Chief Coroner was His Honour Judge (now Sir) Peter Thornton KC. He almost found his office abolished before he could take it up, but fortunately the Government of the day relented. It is to Sir Peter's pioneering work that the service owes the present system by which the Chief Coroner's office operates. He issued the first law sheets and guidance notes, and his successors have adopted the template he established. It was Sir Peter who oversaw the drafting and publication of the first-ever bench book for coroners. He also set up the training system, assisted by the Judicial College. He had to forge a constructive working relationship with the Coroners' Society of England and Wales, overcoming understandable early reservations from some coroners along the way.

36. Sir Peter Thornton was succeeded by His Honour Judge Mark Lucraft KC, now the Recorder of London, who continued and consolidated the practices introduced by his

predecessor and began work on the new and expanded edition of the bench book (due to be published shortly), a project that one of the deputy Chief Coroners, Her Honour Judge Alexia Durran, has overseen. However, the outstanding event of Judge Lucraft's tenure of office was, of course, the Covid-19 pandemic. Not only did he have to steer the service through the extraordinary challenges caused by the rise in deaths, he also had to handle the serious welfare implications for coroners and their officers and staff, who faced even greater difficulties than those in other occupations apart from healthcare. One of his initiatives was the decision to set up an informal group of senior coroners to provide mutual support and disseminate good practice throughout the lockdowns that followed. That group led directly to the creation in 2021 of the more formal system of regional leadership coroners that we now have.

37. It was Judge Lucraft who appointed the first two Deputy Chief Coroners, Her Honour Judge Alexia Durran and Derek Winter, Senior Coroner for Sunderland. They have provided a welcome degree of stability and continuity to the work of the Chief Coroner's office and they continue to undertake a generous proportion of the Chief Coroner's day-to-day responsibilities – so much so that in certain aspects of my role it would be truer to say that I deputise for them than that they deputise for me.

38. I became the third Chief Coroner on 24 December 2020. I have enjoyed the advantage of being able to reap where my predecessors have sown. If there is one single event that might be said to have defined my own term of office, I suppose it is the national tour that I carried out between January 2022 and March 2023. That tour, the first of its kind ever undertaken by a Chief Coroner, has enabled me to make an informed and up-to-date assessment of the current state of the coroner service and its likely future trajectory.

39. In 2004 there were 127 coroner jurisdictions in England and Wales. The average caseload per jurisdiction was then just over 1,500 reported deaths. Many of the old coroner 'districts' have been merged since then, so there are now 80 coroner areas, with some future mergers anticipated. Larger areas support a greater number of coroners, allowing a more collegiate approach, improving

‘out of hours’ cover, and introducing economies of scale for local authorities.

40. Chief Coroner guidance has been issued on a wide variety of topics and successive Chief Coroners have provided direction through regular communications and training events, all of which have led to greater consistency between coroner areas. The move towards a smaller number of coroner areas has also helped to increase consistency of practice.

41. As technology has developed, we have seen significant modernisation of the coroner service, including the ability to undertake remote hearings, the increased use of scanning in appropriate cases rather than fully-invasive autopsy, and the digitisation of coroners’ workflows and processes. Access to and use of technology vary between coroner areas, but in general IT advances have significantly improved the way the service is managed and delivered.

42. During the past two decades, the way in which coroners and others involved in disaster victim identification and the management of cases resulting in mass fatalities has changed radically for the better.

43. The provision of national leadership has meant that in addition to the excellent support that has for many years been provided by the Coroners Society for England and Wales, coroners have had new opportunities to share best practice through regular training events, conferences and communications. The appointment of regional leadership coroners has improved collaboration and is, I hope, helping to provide better welfare support.

44. What about the other side of the balance sheet? I am afraid I have to say that in spite of all the considerable improvements that have taken place since 2013, Tom Luce’s description of the coroner system as a largely “forgotten service” remains recognisable.

45. In all but a handful of areas, teams of coroners’ officers are understaffed and overworked, resulting in avoidable delays to cases, lack of resilience, and damage to the officers’ welfare. The consistent picture across England and Wales is that current staffing levels are far too low.

Recruitment processes within police forces and some local authorities are often so cumbersome that even where it is recognised that more officers or administrative staff are needed, it can take an excessive length of time to fill vacancies.

46. Another source of concern is the unsatisfactory nature of the premises some coroners and staff are obliged to put up with. Too many buildings are dilapidated and there are still some coroner areas that have no dedicated courtrooms at all. In some areas, the irreducible minimum requirements of a coroner area of any sort are just not being met. During my tour, I challenged many local authority representatives about the inadequate accommodation they provide. We have achieved some notable successes, but I'm afraid the process of change is painfully slow.

47. I believe there is scope, in some areas, for partial relief of resourcing pressures through the adoption of more efficient working practices. I therefore encourage coroners to exchange ideas for improving practice through training events and by means of items published in the Chief Coroner's newsletter.

48. In many areas there are not enough coroners, particularly salaried area coroners. This places senior coroners under excessive pressure, jeopardising their welfare and undermining performance. We have already managed to achieve some rebalancing of the ratio of fee-paid to salaried coroners, but there is still work to be done in improving the composition of the service. Too many areas still rely exclusively on fee-paid assistant coroners to support the senior coroner, even though most assistant coroners have competing professional commitments which prevent them from offering the flexible support that is really needed.

49. Many of the problems I have identified can be traced to the unique system of governance that still prevails in a majority of coroner areas. The involvement of police forces and local authorities in resourcing most coroner areas creates a 'triangle of responsibility', with the senior coroner, relevant local authority and policing body having to agree many aspects of how the service will function. These complicated arrangements can delay or even

paralyse decision-making and are liable to generate disagreement to the detriment of performance.

50. Although coroners' officers and other staff work to the direction of the coroner, they are formally employed and line-managed by either the local authority or police force. This can generate conflict and confusion. There are frequent misunderstandings about the boundary between independent direction by the coroner and legitimate line-management by the employer.

51. For local authorities and police forces, supporting a small part of the judiciary is but one of their many responsibilities. This means that they often lack the expertise to recognise the practical implications of protecting judicial independence, and they may not appropriately allocate funding in the face of competing priorities, especially when their own financial situation happens to be precarious.

52. With a view to moving away from the 'triangle of responsibility', I have encouraged local authorities and police forces to consider simplifying the funding model in their coroner areas by arranging for the relevant local authority to assume responsibility for providing and line-managing the coroner's officers. In practice, this can only be achieved by agreement, with all three components in the 'triangle of responsibility' negotiating a satisfactory outcome in each individual area.

53. Court security arrangements vary considerably and are rarely adequate. The local organisation of the coroner service means there is no central organisation comparable with His Majesty's Courts and Tribunal Service to develop and implement security standards. Arrangements must be made and funded by local authorities, most of which have little or no wider experience of judicial security requirements.

54. We must frankly acknowledge that the additional pressure the coroner service has experienced since 2020 is not a purely temporary consequence of the pandemic. Anecdotal evidence from my tour – corroborated to some extent by statistics published by the Ministry of Justice – suggests, first, that the numbers of reported deaths are

rising and will continue to do so and, second, that the complexity of coronial investigations is on the increase.

55. I think the main reason for the higher numbers of reported deaths is that recent changes in medical practice have meant that more people are dying from natural causes without having been seen recently by a medical practitioner, with the result that there is no-one who can sign a medical certificate of cause of death. When such a certificate cannot be issued, the patient's death must be reported to the coroner, so the number of coroner referrals has gone up as a result.

56. I have liaised with the Government about the increase in the number of natural deaths reported to coroners resulting from recent changes in medical practice, and I hope we will soon see a principled solution to the problem.

57. This increase in work has been compounded by a corresponding increase in case complexity, which appears to result from a combination of factors. The increased professionalism of the coroner service has imposed more stringent processes and demands. The introduction of the medical examiner system means that complex cases in which reportable factors might previously have been missed are now rightly being identified. Coroners also face increased demand to expand the scope of their investigations in the more contentious inquests. In particular, the limited availability of state funding for bereaved families except where it is required under the European Convention on Human Rights has fuelled persistent demands for coroners to decide that Article 2 is engaged, a state of affairs about which the Court of Appeal has recently expressed concern.

58. One of the key purposes of the 2009 Act reforms was to accelerate the inquest process. Unfortunately, delay remains a significant challenge for the service. It is true that the average time taken to process a coronial investigation has reduced slightly since last year, but inquests are still taking too long to complete.

59. Although long-delayed cases represent only a small proportion of the total number of reported deaths the coronial system handles each year, it is important to recognise their disproportionate impact. It is well

understood across the justice system, that delays can affect the quality of evidence, and that being able to deal with cases within a reasonable timeframe is one of the essential elements of achieving a just outcome. Delays to death investigations force grieving families to wait for answers and corrode public confidence in the system. As my predecessors and I have said on many occasions, it is essential that we keep the bereaved at the heart of the inquest process. Providing an efficient system that avoids unnecessary delay is, in my view, the single most important element of achieving that objective.

60. Delays can also impact on public learning, which in the worst circumstances could result in a risk of future deaths not being identified in time to prevent further fatalities. In the eyes of many, that danger is compounded by the absence of any effective system of monitoring the outcome of reports for the prevention of future deaths that coroners issue. Coroners themselves have no power to monitor responses to such reports. That is as it should be, for they are judges, not regulators.

61. Against a backdrop of continuing backlogs, the increasing volume and complexity of cases, and given also the understaffing and lack of resources that I have described, it is scarcely surprising that avoidable delay persists.

62. A common cause of such delay is the difficulty in obtaining *post-mortem* examination reports, particularly where specialist evidence is needed. This problem was comprehensively explored and diagnosed by Professor Hutton as long ago as 2015, and it is something that coroners and their officers repeatedly raised with me during my tour. In some areas, specialist pathologists, and even forensic pathologists, are so scarce that obtaining a report can take more than 12 months.

63. There is an urgent need for action to tackle the shortage of pathologists. It is a problem that is not confined to the coroner service, but causes serious delay in other proceedings where *post-mortem* evidence is required. I'm glad to say that the Government, led by Ministers at the Ministry of Justice, is now taking this situation seriously with a view to resolving it.

64. Unlike other judicial appointments, which are handled by the Judicial Appointments Commission, the selection of coroners remains in the hands of local authorities. The 2009 Act introduced a requirement for the Chief Coroner and Lord Chancellor to consent to each appointment. My predecessors and I have taken an active interest in coroner recruitment in order to ensure that local authorities apply and follow a fair process and also to satisfy ourselves that successful candidates are of good character. However, the Chief Coroner has no role in interviewing candidates or making appointment decisions. When the Chief Coroner, or the Chief Coroner's nominee, attends an interview, he or she is there simply to observe. As one of my predecessors succinctly put it, the Chief Coroner has a veto, but no vote.

65. During my time in office, I have overseen more than a hundred coroner appointment competitions, of which no fewer than a dozen have been for senior posts. In most of those senior coroner competitions, I have personally attended the interviews. I recognise, of course, that the task of appointing a judge is a weighty one requiring specialist expertise that local authorities cannot always be expected to possess. While we have been fortunate in the successful candidates, I do have reservations about the robustness of the process that is used to select senior coroners. There is no judge on the interview panel and usually no one with a detailed knowledge of coronial law. Although the Deputy Chief Coroners do an excellent job of providing suitable questions for the panel to use, this does not guarantee that interviews are always properly conducted.

66. The role of senior coroner is an important leadership position. He or she is responsible for the management and effective operation of the area and for working with the local authority and police to ensure that the area receives the resourcing it needs. Above all, however, it is a judicial position; the senior coroner must have the legal knowledge, judgement and skills necessary to be effective as a judge. I am not convinced that the current recruitment process enables those requirements to be properly tested.

67. One way to address the weaknesses I have identified in the selection of senior coroners might be to include judicial members in recruitment panels.

68. Coroners do not receive the same press support, or Human Resources support as their colleagues in other jurisdictions, nor are they included in many of the national policies that apply to other judges. Their unique position as judges appointed, but not employed, by local authorities also means that local authority policies often do not apply to them. Indeed, it would not usually be appropriate for such policies to apply to members of the judiciary.

69. The past decade has seen significant progress in modernising the coroner service through a combination of area mergers and national guidance, training and oversight provided by successive Chief Coroners. That progress will continue. However, the structure of many coroner areas has not yet been updated to accord with the deeper implications of those national reforms. My tour has exposed the need for structural reform to simplify and streamline the governance and management of individual coroner areas.

70. It is vital that the coroner service completes and consolidates the process of professionalisation that I have described by doing what it can to replicate the best working practices of other jurisdictions. There are measures that local authorities can take to streamline and modernise the service they provide, for example through the recruitment of more salaried coroners to reduce the excessive reliance on fee-paid assistants, improving recruitment practices, and by moving away from the ‘triangle of responsibility’ to adopt a simpler system.

71. Coroners provide a vital service to the community, but they do so with inadequate resources. They will continue to face significant challenges for the foreseeable future, and there is a limit to what can be achieved within the framework of the 2009 Act reforms. Of course, as a judge, I do not intervene on matters of policy. The structure of the coronial service and its funding model are matters for the Government and Parliament to consider.

72. Yet, despite the concerns I have expressed, I take vicarious pride in what coroners and their staff have managed to achieve since 2013. They are hardworking, dedicated people for whom service to the public, and above all the deceased and the bereaved, is a true vocation. The work they do is important to those who seek answers about the deaths of their loved ones, as well as to

society at large. They continue to provide the best service they can in the difficult circumstances that prevail, and I am confident that they will show the same dedication in the years that lie ahead.

73. I have already referred to the immense burden of work undertaken by the Deputy Chief Coroners. I cannot close without also mentioning the contribution of the Chief Coroner's private office. Its tiny but exceptionally able team, comprising just six civil servants, has been led throughout the past decade by the brilliant and indefatigable James Parker. His presence since the office of Chief Coroner was first set up makes him the embodiment of the institution's collective memory. My predecessors and I are deeply grateful to him, to the Deputy Chief Coroners and to all members, past and present, of the Chief Coroner's private office. I thank them all.

74. As I have tried to show, the focus and indeed the very purpose of the coronial death investigation process has evolved over the centuries. I do not think I can improve on the description of its modern purpose which the Commons Select Committee on Constitutional Affairs offered in 2006:

> "The death certification and investigation systems have essential roles, providing each person who dies with a last, posthumous service from the State; they serve families and friends by clarifying the causes and circumstances of the death; and they contribute to the health and safety of the public as a whole by providing information on mortality and preventable risks to life."

75. That summary makes explicit the close connection between the inquest process and death certification. More importantly, it underlines a profound truth about the focus of death investigation, a truth that is sometimes in danger of being overlooked. My predecessors and I have often spoken of putting the bereaved at the heart of the process. The Government of the day used a similar expression in the position paper it issued in advance of the 2009 Act. But a duty to put the bereaved at the heart of the process

cannot exist in a vacuum. It presupposes the existence of a prior duty to the deceased. Surely, the ultimate reason for the centrality of bereaved families is that the coroner's inquest exists to discharge a posthumous duty to the dead whom they represent? That is why I like to say that it is the deceased, and by extension the bereaved, who should be at the heart of the process.

76. Hardly anyone denies the continuing power and influence of those who have gone before us. What is tradition if not, in G. K. Chesterton's words, "the democracy of the dead"? Our law upholds and enforces dispositions of property contained in validly executed wills. The common law itself may be said to rest, at least in part, upon the authority of the dead. That, perhaps, is what lies behind the legal convention that used to prevent judges and counsel from citing living authors. Even the desire of some to erase the past testifies to its continuing sway.

77. There may be cases where the interests of the deceased and the bereaved do not perfectly align. In those rare situations, the inquisitorial nature of an inquest guarantees that the court's duty to the deceased will prevail. Recognising the ultimate priority of the deceased also serves to remind us that the coroner's inquest touches not a corpse, but the death of a person. That is why, to take one example, recent guidance encourages coroners to admit pen portrait material at inquests. In the end, it is only by upholding and defending the centrality of the deceased that we can protect their families against the risk of being marginalised.

78. It is time for me to finish. To me, history is not a dustbin. It is more like a long-neglected attic, full of once-treasured relics, waiting to be explored. I hope you have enjoyed shining a torch into some of its dark and dusty corners as much as I have. I conclude with some words taken, as it happens, from a judgment of the late Lord Denning concerning treasure trove. Let us now "leave the old authors and let them rest in their graves".

79. Thank you.

The Chief Coroner, HHJ Thomas Teague KC, delivers his speech.

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Should Judges conduct public inquiries?

Jack Beatson*

A. Introduction

I am honoured to have been invited to give the fifty-first Lionel Cohen lecture. My discussions with the Dean about a topic indicated that a public law subject was likely to be of more general interest than a private law one. Of the possibilities we discussed, his preference was for something on public inquiries, and this does indeed seem an appropriate subject for a Lionel Cohen Lecture.

Why is this so? First, both Britain and Israel have regularly had recourse to inquiries to address widespread public disquiet about a matter. In Israel notable ones are conducted by a judge and under the procedure established by the Commissions of Inquiry Act 1968. In Britain inquiries are conducted by retired civil servants, distinguished legal practitioners and academics as well as by judges, and may be statutory[1] or non-statutory. The Israeli Act, in part based on the United Kingdom's Tribunals of Inquiry Act 1921 and the 1966 Report of the Royal Commission chaired by Sir Cyril Salmon,[2] provides for such an inquiry when it appears to the Government that a matter of vital public importance requires clarification. In both countries the

* A Justice of the High Court of England and Wales (Queen's Bench Division), formerly Rouse Ball Professor of English Law, University of Cambridge. This paper is based on the 51st Lionel Cohen Lecture given in Jerusalem on 1 June 2004. I am most grateful to Sir Louis Blom-Cooper QC, Dr A Klagsbad, David Lloyd Jones QC, Irith Nassie, Lord Rodger of Earlferry, President M Shamgar, Professor S. Shetreet, and Justice I. Zamir who generously answered my many questions. I am also very grateful to Claire Fox and Jason Goodman for their research assistance.

[1] As well as the Tribunals of Inquiry Act 1921, there are numerous specific statutory provisions for inquiries: e.g. Health and Safety at Work Act 1974, s 14; National Health Service Act 1977, ss. 2, 87; Merchant Shipping Act 1995, ss. 268-269; Police Act 1996, s. 49. For examples of non-statutory inquiries, see n 38 below.

[2] (1966) Cmnd. 3121. There was a supplementary report on contempt (1969) Cmnd. 4078. Sir Cyril, then a member of the English Court of Appeal, later became a Lord of Appeal in Ordinary. The explanatory notes to the Israeli Bill acknowledged the influence of the 1921 Act and the Salmon

danger that the report will inhibit freedom of expression and proper enquiries by the media".[137]

G. Structure and formality without the constraints of litigation

As well as authority, it is sometimes said that the use of a judge brings "dignity" to the proceedings".[138] Sir Stephen Sedley comments that a judicial inquiry can bridge the gap between government and governed, between authority and liberty, in situations where those sides have pulled apart to an extent which could damage the body politic."[139] Its "public" status borrows one of the strengths of the legal system and helps to get away from the anarchy and subjectivity of public debate without being subject to the constrictions of litigation. Pressure for an inquiry is likely to be particularly strong where there is no possibility of recourse to litigation and no ready political response.

While Sedley's argument is attractive, the discretion now left to the judge as to the procedure to be adopted means it should not be pressed too far. Since 1982 the majority view in Britain is that the Salmon Commission's six cardinal principles for the protection of individuals introduced significant and often inappropriate features of adversarial proceedings to statutory inquiries, a view that has been reinforced by the expense and length of a number of recent inquiries. The Government's recent consultation paper states that it "strongly believes" that inquiries should be investigatory, and that "the introduction of adversarial elements" which are likely to

[137] Quoted by Frances Gibb in *The Times*, 29 January 2004, p. 17.
[138] Diana Woodhouse, "Matrix Churchill: A Case Study in Judicial Inquiries" 1997 50(1) Parliamentary Affairs 24, 25
[139] Sedley, "Public Inquiries: A Cure or a Disease" (1989) 52 MLR 469, 473.

increase costs and can cause delays "should be avoided wherever possible".[140] In this respect the government would not wish there to be a return to Salmon. I have noted that the discretion left to the judge as to the procedure to be adopted can leave people feeling they have been treated unfairly. The discretion is also problematic because it gives the process an ad hoc character which can detract from the qualities commended by Sir Stephen Sedley.

The way the discretion is exercised may reflect but also mask differences of view as to the nature of inquiries and the extent to which adversarial elements should be allowed to shape procedure. In this context it is interesting to note that the Saville Inquiry has in one respect taken what can be seen as a more adversarial stance. No Salmon letters have been sent to those who may be criticised. But those involved in the inquiry – I hesitate to call them parties – have been allowed to make accusations which, if there is an evidential basis for them, will be put to those who are so accused.[141] This is a variant of the procedure, described by Sir Louis Blom-Cooper QC as sending "Smoked Salmon" letters, which he refused to permit in his inquiry into complaints about Ashford Hospital.[142] This element to some extent loosens the control of those conducting the inquiry. It may simply be an example of procedural flexibility and reflect the nature of that particular inquiry. The fact is that there are adversaries before it: those sympathetic to the demonstrators, and those sympathetic to the position of the army and police.

There are, however, indications that some restriction on the existing discretion may now be favoured. For example, the government's consultation paper asks whether the

[140] DCA CP 12/04 "*Effective Inquiries",* para.82.

limited provision for procedural rules in inquiries dealing with technical evidence should be supplemented by statutory rules of procedure on the taking of evidence, participation and representation. It states that any procedural rules would need sufficient flexibility to allow the person conducting the inquiry to do so effectively, whatever its size, form and content.[143] Neither the Salmon Report nor the Council on Tribunal's 1996 advice are, however, mentioned in the Consultation Paper and it is to be hoped that the lessons of recent history will not be forgotten.

That recent history can be summarised as follows. The statutory inquiry into the Crown Agents which deliberated for 4 years and reported in 1982 stated that its adherence to the Salmon principles did nothing to shorten an inquiry and introduced elements of adversarial litigation into a process whose purpose was to dig deep to establish the facts and the truth, rather than a contest between two sides. They believed that Sir Cyril's Commission could not have had in mind an inquiry as "wide-ranging and complex" as theirs and the nature of their inquiry caused them to depart from some of the Salmon principles. Sir Louis Blom-Cooper QC's inquiry into mistreatment of patients detained at the Ashford Mental Hospital also considered that the process of sending out what are now generally known as "Salmon letters" to those against whom allegations have been made before they give evidence was cumbersome and not appropriate in an inquisitorial inquiry. The inquiry saw some positive virtue in not using such letters at all on the ground that everyone involved should regard

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[141] Accusations have been made against many persons, including former soldiers.
[142] (1992) Cm. 2028-1, page 9.
[143] DCA CP 12/04 paras 107-110. Sir Roy Beldam had reported in 2002 that rules "could potentially be of great assistance to inquiry chairmen" Annex C to CP 12/04, para. 18 and James Dingemans QC, Counsel to the Hutton Inquiry, is reported to believe that there could be many advantages in having an over-arching statute on inquiries, setting out what the legal powers of each inquiry would be but retaining the flexibility and the distinctions between statutory and non-statutory inquiries": Times Newspaper Law Supplement, 25 May 2004 p. 5. For a succinct statement of the basic requirement for a public inquiry, see the Cory Collusion Inquiry Reports HC 470-473 1 April 2004.

themselves as potentially vulnerable to criticism. The report considered that it might be unwise for an inquiry to formulate the precise nature of potential criticisms before it has fully digested the documentary material and heard evidence. Moreover, legal representatives were increasingly arguing that satisfying this requirement required the detail and precision appropriate for proceedings in court, which in fact distorted the purpose of "Salmon" letters. [144]

Although the procedural model favoured by the Salmon Royal Commission has been strongly criticised by many, it also has passionate defenders.[145] Given the criticisms, it was not surprising that not only was there no legislative implementation of the recommendations of the Royal Commission, but that the non-statutory inquiry became the fashionable and preferred tool, despite the fact that such inquiries had no power to compel the attendance of witnesses or to refer those obstructing them to the courts for contempt. Non-statutory inquiries were thought to afford greater flexibility and efficiency.[146] Non-co-operation can, however, be a problem. A member of the government actuary's department walked out of Lord Penrose's recent inquiry into the financial affairs of the Equitable Life Assurance Company.[147] Sir Louis Blom-Cooper QC's inquiry started without statutory powers but, following non-co-operation by the prison officers union, sought and obtained them. Mr Justice Keith opened his Inquiry into the murder of a young Asian offender beaten to death in his prison cell by his

[144] (1992) Cm. 2028-1, pp. 8- 9.
[145] In particular Lord Howe of Aberavon QC. See [1996] PL 445; 569 HL Deb., cols 1267-1273 (26 February 1996).
[146] See text above nn. 35-38 above. On the practical reasons for using a non-statutory inquiry, see n. 32 above.
[147] Times 16 March 2004 (Ian Rice)

racist cellmate by stating that if the inquiry was undermined he would seek statutory powers. The Times headline was "Judge may be 'helpless' in cell murder inquiry".[148]

The Scott inquiry abandoned some of the Salmon principles, including the need to inform witnesses before they gave evidence of allegations against them and the substance of evidential support for the allegations, and the opportunity to be examined by one's lawyers and for the lawyers to cross-examine others. Sir Richard Scott's substantial qualification of the Salmon principles was based on his view that it was inappropriate to take procedures devised for adversarial process to an inquiry because an inquiry was "inquisitorial" and there were no "adversarial parties" to it. Those to be criticised in the report were, however, given the opportunity of seeing drafts in advance of publication but after the evidence had been taken. This approach reflects the doubts of the Blom-Cooper inquiry and this procedure was used in both the Macpherson Inquiry and the Companies Act Inspection into the floatation of Mirror Group Newspapers. It was in substance supported by the Council on Tribunals. It is also supported by the call for flexibility in the government's consultation paper. It is, however, difficult to see how one can preserve flexibility while providing procedural rules . The Salmon principles were meant to be guidelines and to be applied flexibly, but departure from them in the Scott inquiry attracted sharp criticism.

H. Achievement of Closure: drawing a line

The capacity of a judicial inquiry to draw a line under a crisis depends on a number of factors. The first is the extent to which the authority, independence and impartiality of

[148] The Times 26 May 2004, p, 29.

the judge conducting it remains unimpaired. This in turn depends on the questions addressed in sections D and E above.

Unless the public accepts the findings and recommendations of a report, there is a risk that the issues that led to the inquiry will continue to fester. We have seen that in Britain on occasion a report has not been accepted by a significant section of the public. Sometimes this will be the result of a perception that the judge did not address the right questions. This may be because of the terms of reference. It may be because the report is perceived to be a vehicle behind which government ministers are sheltering at the expense of others.[149] A report may also not achieve finality if it furnishes the instruments or the factual material for parliamentary and political accountability, but the political system does not take up the baton, as it has been argued it did not in the case of the Devlin and Scott Reports.

I. Conclusion

Lord Howe, adapting the words of Dennis Healey, another former Foreign Secretary, has said that the risk is that the seriously misjudged shape of the Hutton inquiry following as it did on the Scott experience, may have done for public or judicial inquiries in Britain what the Boston Strangler did for doorstep selling in Boston. He saw that as a serious loss from the British Constitutional Armoury.[150]

Lord Howe's criticism of these two inquiries is overblown and the tone of his remarks unwarranted. Judges are not obliged to accept an invitation to conduct an inquiry, but,

[149] Diana Woodhouse (1997(50(1) Parliamentary Affairs 24 suggests this was so in the case of the report on Vehicle & General Insurance, HC 133 (1972). In the case of the Penrose Report on Equitable Life HC 290 (8 March 2004), the view that no compensation was payable because there was "a regulatory system failure" rather than "failure by the regulator or individuals" was seen as sheltering the FSA and the government: see *The Times* 16-17 March 2004.

as Lord Woolf has said, have voluntarily undertaken what is regarded as an important public service out of a sense of public duty.[151] It has been argued that there are real risks to the reputation of the individual judge and the judiciary for independence and impartiality and to their authority. The cumulative weight of the arguments suggests that judges should only be asked to conduct inquiries with a strong political flavour where, as Sir Cyril Salmon suggested, and the Israeli Commissions of Inquiries Act provides, the matter is of vital public importance, and where there is really no alternative. The alternative may lie in regular legal process in courts or a coroner's inquest. Where this is not so and an inquiry is needed, the many inquiries successfully conducted by legal practitioners, and others, including retired civil servants, and academics show there will often be a good alternative to a judge.[152]

If the government nevertheless proposes that a judge be used there should be some check that this is appropriate in the circumstances of the particular inquiry. While the initiative will naturally lie with government, perhaps with the participation of the legislature, it should not be for government alone to choose the judge who is to chair the inquiry or to determine its terms of reference. The Head of the Judiciary should either, as happens in Israel, appoint the judge who is to serve, or there should be a requirement that the Head of the Judiciary and the relevant government minister concur in the appointment. While the terms of reference are primarily for government, there should also be a real opportunity for the Head of the Judiciary and the individual judge to have some input into the terms of reference. Moreover, the "managerial" fashion for "one-person" inquiries needs rethinking, particularly in the case of

[150] The Times 5 February 2004.
[151] See text above n. 82 above.
[152] Lord Woolf is reported as stating that in the future American-style non-judicial inquiries may be a better way of proceeding: Mary Riddell, *The Observer* 26 June 2004, p. 24.

politically sensitive inquiries. On this it seems there are lessons to be learnt from the Israeli experience since "one person" inquiries are hardly used.

Another area in which Britain could usefully learn from the Israeli experience is the treatment of a report once it has been delivered. One check on the risk to judicial independence that arises from the rejection of a report might be for guidance to be given as to the circumstances in which the findings of fact and recommendations of an inquiry may legitimately be rejected. This could be reinforced by a duty to give reasons for such rejection. Findings of fact and personal recommendations differ from policy recommendations and should be treated differently. In the case of policy recommendations it is perfectly reasonable for a government to have a wide discretion as to whether they should be adopted. Even for policy recommendations, however, a duty to give reasons would be useful.

A common theme in Biblical stories dealing with the period before the conduct of trials passed from God to humans is characterised by Dan Friedmann in the following way. First, a disaster occurs. The people then approach a deity for assistance. The diety informs them the disaster has been inflicted as a punishment for wrongdoing; the wrongdoer is punished (sometimes by being stoned to death). Order and legitimacy are then restored to the world.[153] Judges are certainly far from divine; sometimes they are seen as barely human. But apart from that fundamental difference Friedmann's thematic characterisation has similarities to the idealised version of the story of a judicial inquiry. However, we all know that life is far from ideal. The reality has perhaps been best characterised by John Morris QC, a former Attorney-General.

[153] *To Kill and Take Possession: Law, Morality, and Society in Biblical Stories* (2002) 11.

Discussing the Scarman and MacPherson inquiries he said "[w]hen a judge enters the market place of public affairs outside his court and throws coconuts he is likely to have the coconuts thrown back at him. If one values the standing of the judiciary … the less they are used the better it will be."[154] Judges should only be used to conduct inquiries where there is a vital public interest in them doing so and if they are given appropriate protective clothing against coconuts and other missiles. The protective clothing needed is not anything that would stifle wide debate about and close examination of a report by government, the media, and the public. It is provided by creating the institutional framework of an appropriate system for appointing the judicial members of inquiries, and a more structured and measured approach by government and other public bodies affected by an inquiry to its findings of fact and personal and policy recommendations.

[154] Lord Morris of Aberavon QC 648 HL Deb. Col 883 (21 May 2003), discussing the Scarman and MacPherson inquiries.

THE STEPHEN LAWRENCE INQUIRY

REPORT OF AN INQUIRY
BY SIR WILLIAM MACPHERSON OF CLUNY

ADVISED BY

TOM COOK, THE RIGHT REVEREND DR JOHN SENTAMU, DR RICHARD STONE

Presented to Parliament by the Secretary of State
for the Home Department by Command of Her Majesty.

February 1999

Cm 4262-I

CHAPTER THREE

THE INQUIRY

3.1 On 31 July 1997 the Home Secretary announced in Parliament that the terms of reference of this Inquiry would be:-

> ***"To inquire into the matters arising from the death of Stephen Lawrence on 22 April 1993 to date, in order particularly to identify the lessons to be learned for the investigation and prosecution of racially motivated crimes."***

Soon afterwards HM Attorney General authorised the Inquiry:

> ***"to undertake in respect of any person who provides evidence to the Inquiry that no evidence he or she may give before the Inquiry, whether orally or by written statement, nor any written statement made preparatory to giving evidence nor any document produced by that person to the Inquiry will be used in evidence against him or her in any criminal proceedings, except in proceedings where he or she is charged with having given false evidence in the course of this Inquiry or with having conspired with or procured others to do so".***

3.2 The first preliminary hearing of the Inquiry took place at Woolwich on 8 October 1997. Then and thereafter full legal representation was allowed to those involved who merited representation and who applied for it. The names of Counsel and Solicitors are set out in the Appendices to this Report. We are grateful to all the teams of lawyers who took part in the Inquiry.

3.3 It had become obvious that all those parties required and deserved representation because the Inquiry would need to address specific issues, and criticism of the actions of many police officers would be expected. This became even more plain when the PCA Report was published in December 1997. That Report, in its short statutory form, and in the full text of the Kent inquiry, roundly and severely criticised many aspects of the MPS investigation, and specifically blamed individual officers.

3.4 **Accordingly a detailed and comprehensive list of Issues was prepared by the Inquiry's legal team, in close consultation with other represented parties. Those officers who might be called to address each Issue were named in the comprehensive document. There can have been no possible doubt in the minds of any witness that his or her own actions and part in the investigation would be closely and critically examined. Furthermore the possible impact of racism and collusion was foreshadowed in those Issues.**

3.5 All parties and witnesses were given every opportunity to see all potentially relevant documents which were disclosed to the Inquiry. It should be stressed that the Inquiry itself had few documents. All the vast documentation came from others. In particular the MPS, the PCA, Mr & Mrs Lawrence, the CPS and others helpfully provided the Inquiry with documents in their possession. The Inquiry expresses its gratitude for their co-operation. During the Inquiry we were particularly grateful to Detective Chief Inspector Ragna Tulloch and Police Constable Reg Perriss, who

assisted not only the Inquiry but all parties who sought further documents or information from the MPS.

3.6 The Inquiry was alert to the principles which govern the conduct of inquiries generally. In particular we heeded the recommendations of the Royal Commission on Tribunals of Inquiry 1966 (the Salmon Report), and the six principles laid down by Lord Salmon. As Lord Bingham said in Crampton and others v Secretary of State for Health (9 July 1993) *"...the rationale of the six cardinal principles is undoubtedly sound and anyone conducting an inquiry of this kind is well advised to have regard to them, (although) the Royal Commission Report itself has not been embodied in legislation and numerous inquiries have been conducted, and satisfactorily conducted, since 1966 without observing the letter of those principles"*.

3.7 In this case the Inquiry did send "Salmon" letters to virtually all witnesses before they came to give evidence. So that the gist of possible criticism was again transmitted to those involved. To their credit all the witnesses came to give evidence.

3.8 During the hearings complaint was made that the attack upon witnesses aimed particularly by Mr & Mrs Lawrence's legal team was wider and harder than had been foreshadowed. This matter was raised fully and formally and in public. The Inquiry required further notices to be given in this regard, before witnesses were called. In one instance a witness' evidence was interrupted, so that notice of additional allegations could be given. The witness was then recalled and agreed to further questioning.

3.9 Every witness was represented by leading and/or junior Counsel, and by his own or his professional body's solicitors. So that any suggestion of unfair treatment or surprise could have been and should have been raised during the hearings which lasted for 59 days, including the final submissions.

3.10 **The criticisms and allegations against the police and individual officers were certainly hard-hitting. In the circumstances, and bearing in mind the abject apologies offered by Assistant Commissioner Johnston and later by the Commissioner himself, this can have been no surprise to anybody, let alone the witnesses themselves.**

3.11 In considering the Inquiry's procedures we stress the concluding words of Sir Richard Scott, in his lecture to the Chancery Bar Association on 2 May 1995:- *"The golden rule is that there should be procedural flexibility, with procedures to achieve fairness tailored to suit the circumstances of each inquiry"*. We believe that our procedures did ensure fairness. It should be noted that the procedures were expressly or tacitly accepted by all the legal teams involved, throughout the preparatory months and the 59 days of our hearings.

3.12 Inquiries have many purposes. Some are concerned with establishing simply what happened and why. For example, the King's Cross Fire Inquiry and other railway accident inquiries have focused upon this purpose, the process of learning, and of establishing the facts. Some, such as the PCA inquiry in this case, focus upon discipline. Many inquiries, including this Inquiry, involve catharsis and close analysis of what may have gone wrong.

3.13 Our terms of reference required us to consider *"the matters arising from the death of Stephen Lawrence"*. The Inquiry came into existence because of explicit complaints and serious unease about the conduct by individual officers and the MPS itself of the investigation of Stephen Lawrence's murder.

3.14 It was obvious and publicly known that we would therefore have to decide whether criticisms of the investigation were made out, and whether individual officers and the team involved, or the MPS itself, should be blamed for the alleged failures of the investigation. It has also always been known that Mr & Mrs Lawrence's allegations included suggestions that the investigation had been flawed by racism and collusion. Hence full representation, and a procedure which was in the result adversarial rather than inquisitorial.

3.15 **This has led to complaints, publicly made, that the Inquiry has allowed unfair cross-examination, and that the Inquiry has been "stage managed". The latter complaint was never particularised and can be dismissed as unworthy. The former complaint came from the Commissioner, in a statement read publicly on 20 April 1998 which included the following passages. The full text is in the transcript for Day 13.**

> *"The Commissioner appreciates the need for thorough and fearless investigation, which may well include criticism of police officers, but he is concerned that the confrontational nature of cross-examination of some of the police officers has not assisted the search for truth.... such cross-examination may be appropriate in adversarial procedures but not to an inquisitorial hearing, where it may lead to witnesses failing to do themselves justice by adopting an unduly defensive attitude..... .*
>
> *More seriously the Commissioner is concerned about the damage which is being done to the relationship between the police and the black community. If police witnesses are constantly pilloried by a barrage of confrontational cross-examination the attempts by the MPS to rebuild that relationship, which was seriously harmed in the aftermath of Stephen's murder, could be set back significantly".*

3.16 **Cross-examination of many officers was undoubtedly robust and searching. But the harm to the relationship between the police and the black community was the result of police failures, and the answers to the questions rather than the nature of the questioning. It is of central importance that the Commissioner and his officers should recognise and accept this fact. Failure to do so can only reflect a lack of understanding of the essential problem and its depth, which would make progress difficult if not impossible.**

3.17 We hope and believe that the first part of the Inquiry has achieved catharsis. Our Report does focus upon errors and criticisms. This was inevitable, given the origins of the Inquiry. Neither catharsis nor identification of those errors might have been achieved without searching cross-examination. We do not believe that the Commissioner's complaint was justified.

HOUSE OF COMMONS

Justice Committee

Oral evidence: The Coroner Service: follow-up, HC 490

Tuesday 30 January 2024

Ordered by the House of Commons to be published on 30 January 2024.

Watch the meeting

Members present: Sir Robert Neill (Chair); Tahir Ali; James Daly; Rachel Hopkins; Dr Kieran Mullan; Edward Timpson.

Questions 1 - 70

Witnesses

I: His Honour Judge Thomas Teague KC; Derek Winter DL; and Her Honour Judge Alexia Durran.

what should be provided by the funding authority. That is the only note of warning I would sound. That is not in any way the fault of the CCSS, or a criticism of it.

Q19 **Dr Mullan:** You mentioned at the start the question of a level playing field and equality. You have described it as access to justice. Before we go on to that, could you outline succinctly why you think an attempt to avoid the inquisitorial nature of it is so important to the coronial process?

His Honour Judge Teague: I think it is absolutely essential. We have to keep a clear distinction in our minds. One of the problems in the past has been imprecise use of terminology, which has led to misunderstanding and an unnecessarily polarised debate. You hear people say that inquests are adversarial. Very often, they use the word "adversarial" in a sense that is very different from the sense in which I would use it. They may mean "contentious" or "controversial". There is no doubt that some inquests are controversial and contentious; we all know that, although I would say it is a clear minority. When I use the word "adversarial" I am talking about who controls the process, and that is why it is an important distinction. In adversarial proceedings, in the strict legal sense of the word, it is the parties who control the proceedings. The prosecution in a criminal case decides what charges to bring and what evidence to adduce; the defendant decides whether to give evidence and call witnesses, and does not have to do either. The same goes for civil proceedings, so the parties are in charge.

In inquisitorial proceedings it is the judge who is in charge. We talk about "the coroner's inquest" in a way you would never talk about "the judge's trial". The coroner is there not to adjudicate but investigate. It is a public judicial investigation, and the difference matters in all sorts of practical ways. I can think of one practical example straightaway. In adversarial proceedings where there is a burden and standard of proof, you manage cases very differently. If you want submissions on a point, you will say to the party who bears the burden of proof that they must provide their submissions by such and such a date, and then you say to the other parties that they have a further period of 14 days, or whatever, to consider what has been written and then reply. Inevitably, that builds in delay, but it cannot be avoided in adversarial proceedings.

My view is that in inquisitorial proceedings the correct approach is to case- manage much more aggressively. I do not apologise for using that word. Set short time limits and enforce them. I think the coroner should not be saying that the hospital trust will provide submissions by such and such a date, the family can have another 14 days, and the police force can have so much. They should say that all submissions should be provided in seven days, by 4 o'clock on Friday. In that way, you can drive forward the case and make clear that the coroner is in charge; it is an investigation. The danger, if you slip into adversarial habits, is that you cede control of the process to lawyers.

As is often said—it was said as long ago as 1982 by Lord Lane—there are no parties to an inquest; there are interested persons who assist the coroner to carry out a public investigation. There are no parties; there is no prosecution, defence or indictment. It is an investigation.

I do think that terminology matters for that reason. If we start to use language imprecisely, it can affect our thought processes and the way we deal with cases. That is why I say it is more consonant with the notion of an inquisitorial process to think in terms of access to justice and effective participation.

Q20 **Dr Mullan:** Maybe one of the challenges is that in a court process you are always seeking to be contentious and it operates in that way. I am not sure you can necessarily draw such a clear distinction with all coroner's inquests. I can think of constituency cases where the relative is seeking to achieve clear accountability by the healthcare provider. They would not see a huge difference; they would see the healthcare provider as seeking to defend their position as not having been negligent, and they would see their role as ensuring that the coroner has the facts and information that show the contrary. I think those 14 days in the example you have given would be very important in some circumstances for them to be able to go away as lay people and get an expert opinion. In the case I have referred to, the expert opinion that the family secured was very important and had a big impact on the process.

While I sympathise enormously with the general flow of how these things might work, do you not recognise that, in reality, there will be inquests where a public body is seeking to defend its conduct which inevitably perhaps have more in common with an adversarial process than an inquisitorial one?

His Honour Judge Teague: People misuse the process or seek to do so— very often large organisations intent on avoiding reputational damage—but it does not alter the nature of the process and the obligation of the coroner to keep control of it and not allow it to become a form of surrogate litigation. There are other channels for ventilating legitimate legal claims and so on.

I come back to what I said before. The focus of this ultimately must be the deceased and the investigation into the death of a person. The danger is that, if the coroner allows the process to be sidetracked in order to assist some parallel litigation that may be either threatened or in progress, paradoxically, the family gets sidelined because the focus shifts from the deceased perhaps to some extraneous dispute, in some cases not even involving the family, between, for example, a doctor and a hospital trust, or two different large organisations.

The focus procedurally always has to be on investigation. I quite acknowledge that, unfortunately, people sometimes try to exploit the process, but it is incumbent on coroners to remember that the apportionment of blame is no part of the process. This has been said by

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INVESTIGATION OF DEATHS BY CROWN OFFICE AND PROCURATOR FISCAL SERVICE (COPFS)

Role of COPFS

29. The Lord Advocate is the ministerial head of COPFS and is responsible for the prosecution of crime and the investigation of deaths in Scotland.

30. COPFS aspires to deliver a world leading public prosecution and deaths investigation service which secures justice for the people of Scotland. One of its strategic objectives[13] is that deaths which need further explanation are appropriately and promptly investigated. This includes all sudden, suspicious, unexpected and unexplained deaths and any deaths occurring in circumstances which give rise to serious public concern. The primary purpose of the investigation is to ascertain a cause of death, although there are a number of other aims of the investigation, including:

- To ensure any criminality is discovered and where appropriate, prosecuted;
- To allay public anxieties about particular deaths;
- To alert family members to any genetic causes of death, which may be avoidable; and
- To maintain accurate death statistics.

31. In other parts of the United Kingdom, the coroner investigates deaths and holds inquests. Under the law coroners have two main functions. First, they seek to explain the unexplained. If the death is not from natural causes, if it is unnatural, violent, of unknown cause or occurs in custody, coroners will investigate so that answers are found, for bereaved families and the wider public. Secondly, where appropriate, coroner's report to prevent future deaths.

32. While in some respects the purpose of an inquest by the coroner mirrors that of an FAI in Scotland, we found a number of fundamental differences that precludes any meaningful comparisons between the two systems:

- The coroner service is essentially a local service, run by individual local authorities;
- The type of investigation that can result in an inquest in the coroner's system is much wider and include all suicides and drug and alcohol related deaths and more recently, all deaths of residents in care homes or hospitals that are subject to Deprivation of Liberty Safeguards (DoLS), usually the elderly suffering from dementia. There are also understandable differences in scale; in 2014, for example, the coroner opened 25,889 inquests[14] compared to 34 FAIs held in Scotland;
- The role of the coroner differs from the procurator fiscal with the coroner presiding over both the investigation and the judicial proceedings;
- Unlike Scotland, a jury may sit with a coroner, if the coroner believes that: the deceased died in custody or state detention and the death was violent or unnatural or the cause of death is unknown and where the death resulted in an act or

[13] *COPFS Strategic Plan 2015-2018. http://www.crownoffice.gov.uk/images/Documents/Business_Strategy_Plans/Strategic_Plans/COPFS%20Strategic%20Plan%202015-2018%20.pdf*

[14] *Coroners Statistics 2014, England and Wales, Ministry of Justice Statistics bulletin. https://www.gov.uk/government/statistics/coroners-statistics-2014*

omission of a police officer, member of a service police force or that the death was caused by accident, poisoning or disease which must be reported to a government department or inspector; and

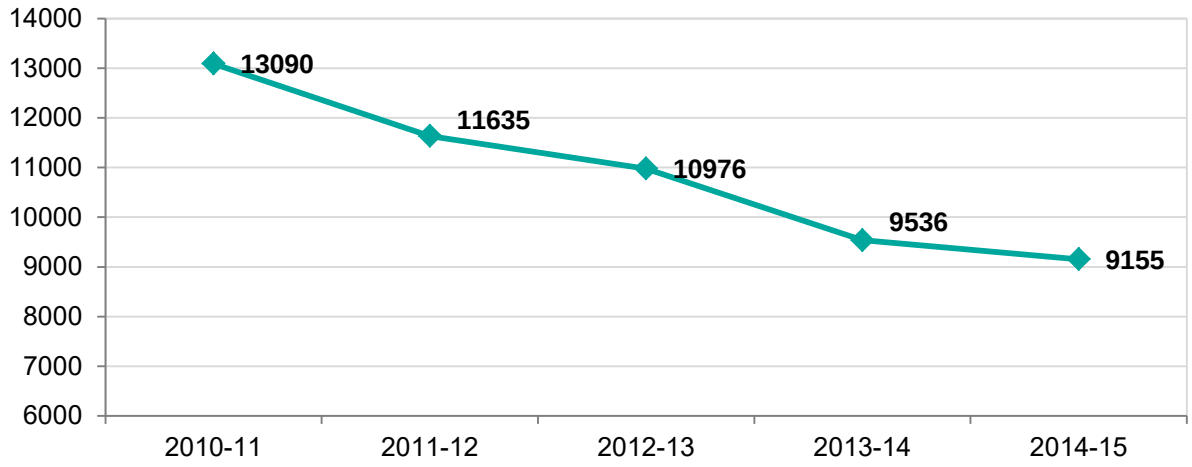
- The procedures differ with many inquests being opened and adjourned, for a variety of reasons, including allowing criminal investigations to take place.

Statistical Data

Death Reports Received

33. Deaths are most commonly reported to COPFS by hospital doctors, General Practitioners (GPs) and the police. Chart 1 illustrates that the number of death reports received by COPFS between 2010/11 to 2014/15 has decreased since 2010. In 2010, COPFS received 13,090 reports. This reduced to 9,155 in 2015, a decrease of 30%.

Chart 1 – Death Reports Received[15]



34. Once a death has been reported, COPFS has legal responsibility for the deceased's body, until a cause of death has been established. This is often provided by the procurator fiscal accepting a certificate issued by a doctor certifying the cause of death.[16] Such deaths are categorised as “routine deaths”.

35. If the cause of death cannot be certified or if a cause of death is believed to be known, but there are other concerns surrounding the death, further investigation may be required, such as: a post-mortem examination (also known as an autopsy), statements being obtained and liaison with nearest relatives and professionals. Such deaths are categorised as “deaths requiring investigation”.

[15] Source – COPFS MI Book 31/05/16.
[16] A certificate specifying the cause of death required to enable registration of a death with the Registrar of Births, Deaths and Marriages in Scotland.

36. Charts 2 and 3 show the number of routine deaths and deaths investigated by COPFS between 2010/11 to 2014/15.

Chart 2 – Routine Deaths[17]

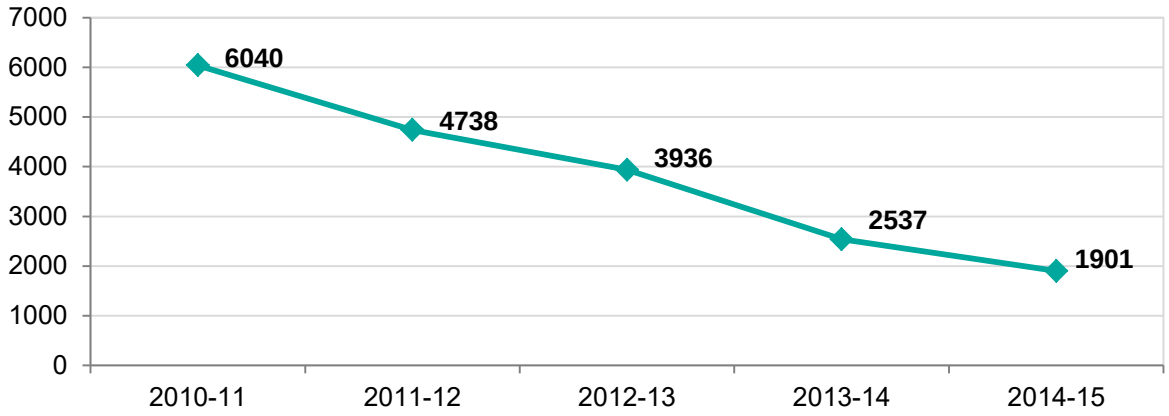
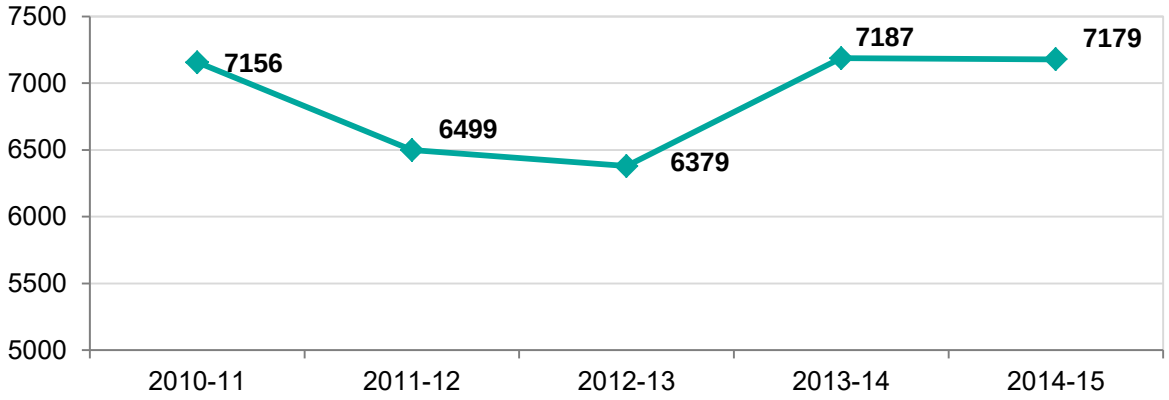


Chart 3 – Deaths Investigated[18]

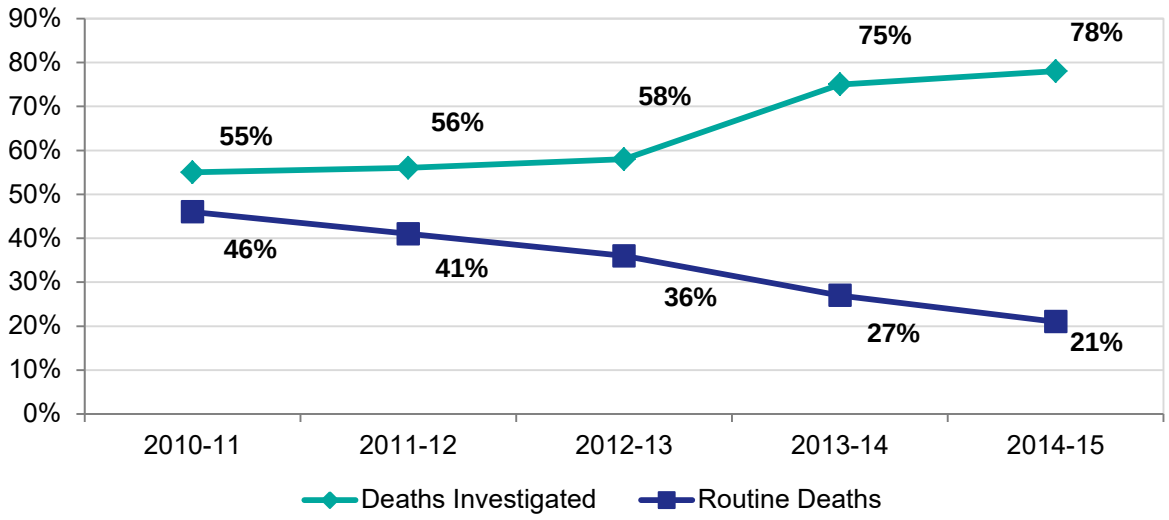


37. Chart 4 shows the number of routine deaths and deaths investigated as a percentage of death reports received. It illustrates a significant increase in the number of deaths investigated in 2013/14 and 2014/15. This reflects:

- An evolution in the public's attitude to death, with a greater expectation of being involved in all important decisions regarding relatives and, in obtaining more information on the circumstances of the death;
- The increasing complexity of such investigations with advances in medical science and more sophisticated means of detecting the cause of accidents; and
- A changing landscape with an increasing number of regulatory and scrutiny bodies that have a duty to investigate a wide spectrum of different types of deaths.

[17] Source – COPFS MI Book 31/05/16.
[18] Source – COPFS MI Book 31/05/16.

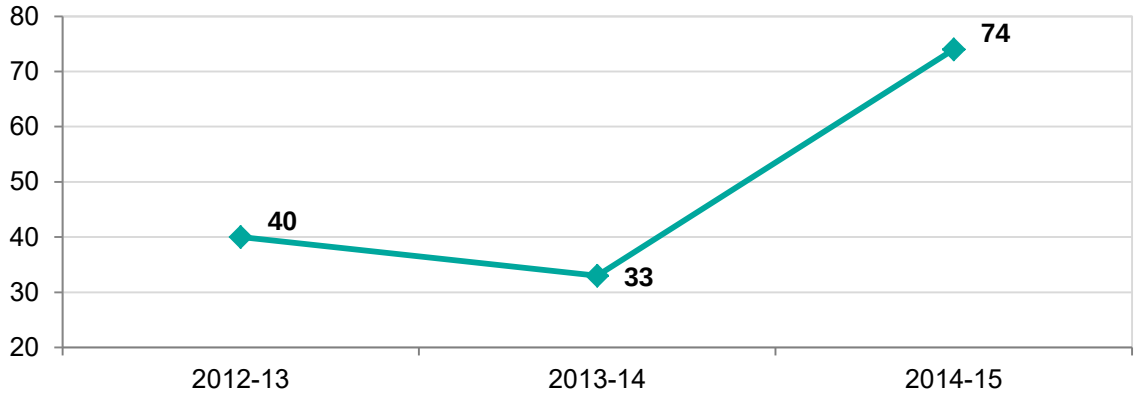
Chart 4 – Deaths Investigated/Routine Deaths as % of Reports Received[19]



FAIs

38. Many deaths requiring investigation do not result in an FAI. There were 147 FAIs[20] held between 2012/13 and 2014/15. Chart 5 illustrates the spread of FAIs over this period.

Chart 5 – FAIs [21]



39. Following a reduction in the number of FAIs in 2013/14, the number more than doubled in 2014/15. This corresponds with the sharp increase in deaths investigated in 2013/14. Overall, there has been an 85% increase in the number of FAIs over the three year period. Despite this increase, the number of FAIs is extremely low, representing 0.7% of all deaths investigated.[22]

[19] Source – COPFS MI Book 31/05/16. Note: The total does not always add up to 100% due to a delay in inputting target data.
[20] Some FAIs may involve multiple deaths.
[21] Source – SFIU spreadsheet 11/11/15 (based on first Preliminary Hearing date).
[22] Between 2012/13 and 2014/15.

Type of FAIs

40. Mandatory inquiries must be held when a death occurs as a result of a work-related accident or when the deceased was in legal custody. Discretionary FAIs are held at the discretion of the Lord Advocate if it is in the public interest and if there are lessons that can be learned to prevent deaths occurring in similar circumstances.

Mandatory FAIs

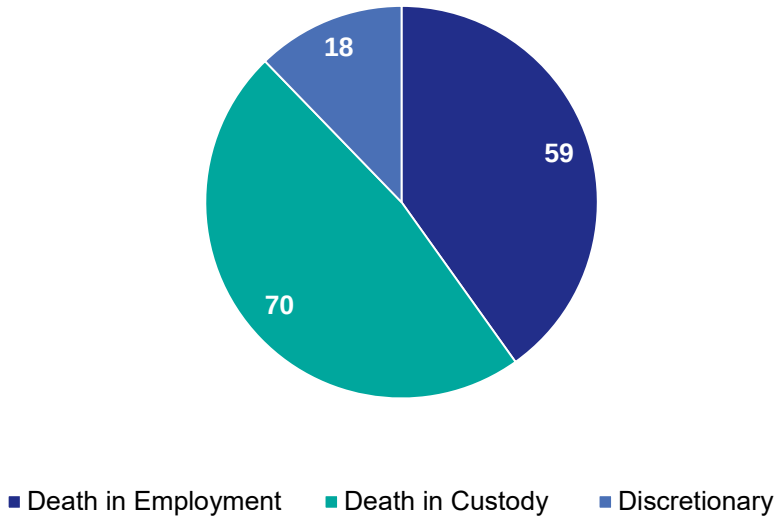
41. There were 129 mandatory FAIs held between 2012/13 and 2014/15; 31 were held in 2012/13, 30 in 2013/14 and 68 in 2014/15, representing a 119% increase over the three year period. Of the 129 mandatory FAIs, 59 concerned deaths that occurred in the course of employment and 70 concerned deaths that occurred while the deceased was in legal custody.

Discretionary FAIs

42. There were 18 discretionary FAIs held over the same period. There were nine discretionary FAIs in 2012/13, three in 2013/14 and six in 2014/15, representing a 33% decrease over the three year period.

43. Chart 6 provides a breakdown of the type of FAIs held.

Chart 6 – Type of FAI 2012 - 2015[23]



[23] Source – SFIU spreadsheet 11/11/15, based on first Preliminary Hearing date.

Standard of Proof
Ruling

Introduction

1. Whenever the panel of an inquiry is required to investigate and reach conclusions of fact the issue arises as to what standard of proof should be applied. Should the panel reach a conclusion of fact only when on the evidence it is sure that the fact is established (the criminal standard) or should it reach a conclusion of fact when satisfied that the evidence establishes the fact on the balance of probability (the civil standard), or should the panel apply some other or variable measure depending upon the factual issue under consideration?

2. In my Ruling "Costs of Legal Representation Awards" published on 16 December 2015 (which is posted on the Inquiry's website) I set new timetables and gave directions towards the hearing of preliminary legal issues. The timetable and directions set for consideration of the appropriate standard of proof are to be found at paragraph 36 of the Ruling.

Inquiry counsels' note

3. In accordance with those directions, on 16 December 2015 I received from the Inquiry's counsel team their Note on the Standard of Proof which, simultaneously, was despatched to the core participants. Although that Note is already posted on the Inquiry's website I shall for convenience attach a further copy to this Ruling (as Annex 1).

'Minded to' letter

4. On the following day, 17 December, I published a "minded to" letter (attached as Annex 2) in which I announced that, subject to further argument, I was minded to "apply to issues of fact that arise in the evidence given to the Inquiry a **flexible and variable standard of proof**" by which I meant and explained that the starting point would be the civil standard; however, where the context required, and depending upon the issue under consideration, I would express my state of certainty or uncertainty with such accuracy as I could.

5. My directions (paragraph 36(3) Costs Ruling) required that responses by core participants to the "minded to" letter should be served by 4 pm on Friday, 8 January 2016.

Responses from core participants

6. I have received written responses on behalf of the following core participants:

   The represented non-state, non-police core participants (Tamsin Allen of Bindmans)

   Metropolitan Police Service (Melanie Jones, Directorate of Legal Services)

   National Crime Agency (NCA Legal Department)

   Home Office (Government Legal Department)

   'N' Police Officers (Slater and Gordon)

   Peter Francis (Leigh Day)

   Each of these core participants either expressed agreement with the approach that I had provisionally favoured or expressed no wish to make contrary submissions.

7. I have received supplementary submissions dated 7 January 2016 from Imran Khan and Partners on behalf of Baroness Doreen Lawrence, The Monitoring Group and the Blacklist Support Group. They adopt the agreement expressed by Bindmans on behalf of the non-police, non-state core participants, but make the following assertions:

   (i) The Inquiry should require disclosure and examine the evidence with the same rigour that would apply to civil proceedings;

   (ii) The Inquiry should not apply a flexible and variable standard of proof so as to avoid taking a rigorous approach to disclosure and the examination of evidence;

   (iii) The core participants require the Chairman to give a "formal assurance" that the application of a flexible and variable standard of proof "will not prevent the core participants from making...rigorous enquiries, and requesting...full disclosures, as to allow the Inquiry to discharge its obligations..."

   I shall return to these submissions later in my Ruling.

Is an oral hearing necessary?

8. The direction given at paragraph 36(4) of the Costs Ruling, required the Inquiry, by 4 pm on Wednesday, 13 January 2016, to notify core participants whether an oral hearing on the issue of standard of proof is necessary.

9. I have decided that no oral hearing is necessary or appropriate. I am satisfied upon the written material provided to me by the Inquiry counsel team and the core

participants identified that the application of a flexible and variable standard is the correct approach to issues of fact that arise in the evidence.

Reasons

10. None of the core participants takes issue with counsels' note to the Inquiry; nor do they take issue with the reasoning of my 'minded to' letter. Counsel's note is, manifestly, a fair and accurate summary of the developing reasoning and practice of modern public inquiries whether instituted under the Inquiries Act 2005 or not. I accept it.

11. It is appropriate that in a public inquiry the starting point should be the civil standard of proof. However, depending upon the inquiry's terms of reference, the issue of fact under consideration and the context in which the issue arises, an inflexible application of any particular standard may have the effect of stifling the ultimate purpose of the inquiry which is, usually, to make recommendations in the public interest. In my view, this is just such an inquiry. I am required to investigate what has happened during 47 years of undercover policing. I will need to consider whether there has been misconduct or other failure of duty and, if so, in what areas and to what extent. Public acknowledgement of some misconduct and failure of management has already been made on behalf of the Metropolitan Police Service. In establishing the factual background against which the Inquiry will offer recommendations as to future conduct and management it seems to me likely to be more conducive to the public good if I am free to express my state of mind as to the existence (or non-existence) of a fact without being bound to any particular standard of proof. As the counsel team put it at paragraph 38 of their note, recent public inquiries have adopted "a flexible and variable approach to the standard of proof so as to enable a full and nuanced approach to the determination of facts".

12. I shall adopt the flexible and variable standard as the circumstances require but my starting point will always be the civil standard. I do not consider it necessary further to expand on the reasons given above and in my 'minded to' letter.

The nature of the Inquiry

13. I turn to the supplementary submissions made by Imran Khan and Partners. This is not litigation; it is an Inquiry whose purpose is to investigate and report in accordance with its terms of reference. The distinction was referred to in closing sentences of paragraph 24 of the Costs Ruling. Paragraph 8 of the terms of reference provides that the Inquiry will examine and review all documents as the Chairman shall judge appropriate; paragraph 9 provides that the Inquiry will receive such oral and written evidence as the Chairman shall judge appropriate. Section 17(3) of the Inquiries Act 2005 requires me to act with fairness and with regard to the need to avoid unnecessary cost. The approximate duration of the

Inquiry has been estimated at three years. The essential difference between litigation and a public inquiry is that in a public inquiry there are no parties who would in their pleadings define the issues to be resolved. The probable issues in this Inquiry are foreshadowed by its terms of reference. From time to time I shall have to make a judgement whether and to what extent a particular issue of fact will be explored by the inquiry. When doing so I shall have in mind both the importance of the issue in itself and its importance in the context of the Inquiry as a whole. The Inquiry will be manageable only if an appropriate sense of proportion is applied.

14. It seems to me that the "rigour" with which the Inquiry pursues its terms of reference is entirely unrelated to the issue as to what standard of proof should be adopted by the Inquiry. I am surprised that Messrs Imran Khan and Partners should have thought it appropriate to seek from the Chairman a formal assurance that he will not use the flexible and variable standard of proof to pursue an oblique motive of shutting down legitimate lines of enquiry. Such an assurance will not be given because it is unnecessary.

15. As to the scope of evidence-gathering by the Inquiry team and the core participants and of disclosure by the police, I do not intend at this stage to fetter my discretion under paragraphs 8 and 9 of the terms of reference. I shall make such decisions as and when required and will strive to act fairly and transparently in the process.

13 January 2016

Sir Christopher Pitchford
Chairman, Undercover Policing Inquiry

Annex 1

COUNSEL TO THE INQUIRY'S NOTE ON THE STANDARD OF PROOF

Introduction

1. This note examines and seeks to explain the legal context in which a decision falls to made by the Chairman of the Inquiry as to the approach which he should take to standard of proof when determining questions of fact during the course of the Undercover Policing Inquiry. In doing so it explores recent practice in other public inquiries, the majority of which have adopted a flexible approach to the standard of proof.

The Statutory Context

2. Neither The Inquiries Act 2005 ("the 2005 Act") nor the Inquiry Rules 2006 ("the Rules") specifies, or expressly refers to, the standard of proof which a public inquiry must apply when determining facts. Various provisions within the legislation do, however, inform the legal position in relation to the standard of proof to which facts may be determined.

Section 2 of the 2005 Act

3. The function of a statutory public inquiry is wholly different to that of either a civil or criminal court. Not only is the procedure of a public inquiry inquisitorial, unlike that of civil or criminal litigation which is adversarial, the panel of a public inquiry is specifically prohibited by s.2 of the 2005 Act from determining any person's civil or criminal liability. The statutory prohibition is stated in the following terms:

> *"2(1) An inquiry panel is not to rule on, and has no power to determine, any person's civil or criminal liability.*
>
> *"2(2) But an inquiry panel is not to be inhibited in the discharge of its functions by any likelihood of liability being inferred from facts that it determines or recommendations that it makes."*

4. The difference in function between a civil or criminal court on the one hand and a statutory public inquiry on the other means that the Inquiry is not required to adopt the standard of proof applicable in the civil courts or that which is applied in the criminal courts.

5. It is also clear from s.2(2) of the 2005 Act that a statutory public inquiry is not to be inhibited from making findings of fact to either the criminal or civil standards of proof merely because to do so might give rise to a likelihood of liability being inferred from facts so determined.

Section 17 of the 2005 Act

6. So long as he acts fairly, the Chairman is free to decide upon an approach to findings of fact which best suits discharging the Inquiry's terms of reference. The breadth of his discretion is conferred by s.17 of the 2005 Act which provides that:

> *"17(1) Subject to any provision of this Act or of rules under section 41, the procedure and conduct of an inquiry are to be such as the chairman of the inquiry may direct.*
>
> *"(2) In particular, the chairman may take evidence on oath, and for that purpose may administer oaths.*
>
> *"(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)." (emphasis added).*

Section 24 of the 2005 Act

7. The Chairman is under an obligation, imposed by s.24(1)(a) of the 2005 Act, to set out in his report the facts which he (as the inquiry panel in this Inquiry) determines.

8. S.24(1) contains a rider that the report may also contain anything else that the panel considers to be relevant to the terms of reference. As will be explained later in this note, this rider has been used in some statutory public inquiries to justify expressions of suspicion, falling short of findings of fact, where an inquiry panel has concluded that it suspects that something might have occurred.

9. S.24(1) of the 2005 Act provides that:

> *"The chairman of an inquiry must deliver a report to the Minister setting out–*
>
> *(a) the facts determined by the inquiry panel;*
>
> *(b)the recommendations of the panel (where the terms of reference required it to make recommendations).*
>
> *The report may also contain anything else that the panel considers to be relevant to the terms of reference (including any recommendations the panel sees fit to make despite not being required to do so by the terms of reference)."*
>
> *(emphasis added)*

The Approach Adopted in Recent Public Inquiries

10. There is now a line of decisions made by the chairs of previous public inquiries which have generally favoured what is sometimes referred to as the "flexible and variable" standard of proof. We explore them and the thinking which has underpinned them below before turning to examples of inquiries in which the flexible approach has not been adopted. A table summarising the approaches of recent public inquiries to the standard of proof is appended to this note.

The Shipman Inquiry: no single standard of proof

11. Dame Janet Smith inquired into the conduct of Dr Harold Shipman. She looked at almost 500 cases with a view to establishing whether Shipman might have killed the patient concerned. In some cases Dame Janet Smith was unable to reach a decision on the evidence. In other cases she concluded that Shipman probably was implicated and in certain cases she was sure that he had killed the patient. When considering standard of proof, Dame Janet Smith concluded that she was not constrained by any single standard of proof and was free to give nuanced conclusions which expressed the degree to which she was satisfied of particular conclusions. She summarised her approach to the standard of proof at paragraph 9.43 of her first report, making clear that her decisions would determine neither

criminal nor civil liability and emphasising the purpose of her fact finding inquiry, in these terms:

> *"In an inquiry such as this, there is no required standard of proof and no onus of proof. My objective in reaching decisions in the individual cases has been to provide an answer for the people who fear or suspect that Shipman might have killed their friend or relative. I have also sought to lay the foundation for Phase Two of the Inquiry. My decisions do not carry any sanctions. Shipman has been convicted of 15 cases of murder and sentenced appropriately. He will not be tried or punished in respect of any other deaths. Nor will my decisions result in the payment of compensation by Shipman. It is possible that relatives might recover damages from Shipman if they can show that Shipman has killed their loved one, but my decision that he has done so will not automatically result in an award of compensation against him. Accordingly, I have not felt constrained to reach my decisions in the individual cases by reference to any one standard of proof*
> (emphasis added)".

12. Dame Janet Smith was careful to explain in her report how the approach described in general terms in the quotation above had been applied in practice in the different scenarios which she had been required to consider. In relation to findings of unlawful killing she wrote, at paragraph 9.44:

> "*...In some cases, I have felt sure that Shipman has killed the patient. Where I have felt sure, I have said so. In some cases, I have concluded that Shipman has killed the patient but I have not been able to say that I am sure of it. In those cases, I have said that Shipman probably killed the patient. The evidence in those cases is not finely balanced; it is clearly weighted on the side of guilt and I have reached a positive conclusion. If it seemed to me that the evidence was too finely balanced, I have not reached a positive conclusion."*

13. In relation to the reverse of this position, namely that a death was natural, Dame Janet Smith decided that it was appropriate to express the mere possibility that Shipman was involved even where she thought it very likely that a death was natural. Thus, paragraph 9.46 states, insofar as is material:

> *"There are many cases in which I have been able to say that I am sure the death was natural and that Shipman was not in any way involved. There are also some in which I think it likely, or even very likely, that the death was natural and that Shipman was not involved. I have drawn the distinction between being sure and being not quite sure usually where there is some uncertainty in the evidence, which leaves open the possibility that Shipman was involved, even though my conclusion is that he was probably or almost certainly not ..."*
> (emphasis in original)

14. Where no decision was possible, Dame Janet Smith nevertheless considered that it was appropriate to distinguish those cases which she considered suspicious from those in which she was unable to form any view at all on the available evidence. At paragraphs 9.47 and 9.48 of her report, she stated:

> *"It was inevitable that there would be some cases in which I would not be able to reach a positive conclusion one way or the other. There are a number of cases where real suspicion arises that Shipman might have killed the patient and yet the evidence is not sufficiently clear for me to say that he probably did. In those cases, which I call 'suspicious cases', I have explained why my suspicions are aroused but I cannot give a positive decision either way. I regret that the families of such patients are left in a state of uncertainty.*
>
> *"There are also a number of cases in which there was insufficient evidence or evidence of such poor quality that I have been unable to form any view at all. I have not said that the death was natural or probably natural unless there was a proper evidential basis for that conclusion. In general, if there were no reason to think that a death is unnatural, one would assume it was natural. Unfortunately, where Shipman was involved, there is always a possibility that death might have been unnatural. Where, for example, all that is known is that Shipman certified the cause of death and indicated that he had seen the patient shortly before the death, I do not feel able to say that the death was probably natural. It might or might not have been".*

15. The approach taken in the Shipman Inquiry was particularly apposite to the specific task of that inquiry. However, it has been cited with approval and

followed by a number of subsequent inquiries: e.g. see paragraphs 9 & 10 of the Standard of Proof Ruling made by The Bloody Sunday Inquiry; paragraphs 1 & 28 of the Ruling on Standard of Proof made by the Baha Mousa Inquiry (which followed the approach in slightly modified form); and paragraphs 85 & 100 of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 1.

The Bloody Sunday Inquiry: endorsement of the flexible approach and rejection of a uniform standard of certainty

16. The Bloody Sunday Inquiry inquired into the shooting by British soldiers of civilians in Northern Ireland. A central focus of that Inquiry was whether or not the shootings were justified. The inquiry heard competing submissions on the standard of proof which it summarised in the following terms at paragraph 1 of its ruling:

> *"...On the one hand it was argued that the Tribunal should apply the criminal standard of proof before making any findings implying criminal conduct on the part of an individual (said to mean the balance of probabilities modified to take account of inherent improbability and likely consequences) before making any finding of serious misconduct falling short of criminality on the part of an individual. On the other hand it was argued that the Tribunal should not be obliged to apply these standards, provided it made clear in its Report the degree of confidence or certainty with which it reached its conclusions and gave its reasons for coming to those conclusions..."*

17. The Bloody Sunday Inquiry considered a number of authorities on the standard of proof to be applied by courts in adversarial litigation. It found them to be of little assistance in the context of a public inquiry because of the very different function of a public inquiry in comparison to adversarial litigation. At paragraph 8 of their ruling, the panel stated:

> *"In the context of the present Inquiry, there is no question of the Tribunal having any power to remove or diminish the rights, liberties or freedoms of anyone. It is not the function of an Inquiry of the present kind to determine rights and obligations of any nature. Its task, set by Parliament, is to inquire into and report upon the events on Sunday 30th January 1972 which led to loss of life in connection with the procession*

in Londonderry on that day, taking account of any new information relevant to events on that day. The Inquiry cannot be categorized as a trial of any description. Unlike the courts it cannot decide the guilt (or innocence) of any individual or make any order in its report. Our task is to investigate the events of Bloody Sunday, to do our best to discover what happened on that day and to report the results of our investigations. It accordingly follows that the considerations that led the courts in the cases cited to require proof to a very high standard before making orders that affected the rights, liberties and freedoms of individuals are no guide to the task entrusted to the Tribunal."

18. The Bloody Sunday Inquiry also considered case law relating to the standard of proof to be applied in coroners' inquests at paragraphs 11 to 17 of its Standard of Proof Ruling. It found these cases to be of little assistance, again because of the significant differences between a public inquiry and an inquest. It summarised its reasons for so finding at paragraphs 14-17 of its ruling, which stated:

> *"14. It is clear from the remarks of Lord Lane CJ cited by Watkins LJ in* ***R v West London Coroner, ex parte Gray (supra)*** *that a coroner's inquest is inquisitorial in nature and thus has this in common with the present Inquiry. However, there are other features that are quite different.*
>
> *"15. A coroner's inquest is limited in the verdicts that it can return, and where there is a jury it is obviously necessary for the jurors to be given clear and simple directions as to the degree of certainty with which they can reach particular verdicts. Unless there were different and specified degrees of certainty, it would be difficult if not impossible to reach a particular verdict, for example between unlawful killing and death by misadventure. Furthermore, as Woolf LJ pointed out in* ***R v Wolverhampton Coroner, ex parte McCurbin (supra*** *at page 724), before a change in the law in 1977 a jury could under Section 4(3) of the Coroner's Act 1887 return a verdict that named a person or persons as guilty of murder or manslaughter, which in his view still provided considerable assistance in considering the question of the standard of proof which was applicable, "since that section made clear the importance of the decision of the coroner's jury and the gravity of the issues which they had to determine which could result in a person*

being at that time arrested and in due course tried for murder or manslaughter". There are accordingly both practical and historical reasons for requiring a high standard of proof before making a finding of unlawful killing, reasons that do not apply to an Inquiry of the present kind, which does not have to select and give a particular verdict, but instead has to provide a report on the matters referred to it.

"16. It is also important to note that in the same case (at page 727) Woolf LJ made clear that in different proceedings there are different considerations which lead to what is the appropriate test which it is useful to apply, having regard to the role of the decision making body that has the task of coming to a conclusion on the facts. To our minds this is a clear indication that the Court in that case was not seeking to lay down any rule or principle applicable to all kinds of inquisitorial inquiry or which are apt in our consideration of the events of Bloody Sunday.

"In our view therefore the cases cited do not provide any support for the proposition that as a matter of principle we cannot make findings implying criminality unless we are satisfied to the criminal standard of proof or of serious misconduct unless we are satisfied to the enhanced civil standard" (emphasis added; citation of *ex parte* McCurbin corrected from ruling).

19. The Bloody Sunday Inquiry panel endorsed the analysis of the Supreme Court of Canada in *Canada (Attorney-General) v Canada (Commission of Inquiry on the Blood System) 1997 3 SCR 440* as to the status of the findings of a commission of inquiry. The decision, as summarised at paragraph 19 of the panel's ruling, again emphasised the difference between an inquiry and civil or criminal litigation:

> *"..the findings of a commission of inquiry relating to an investigation are simply findings of fact and statements of opinion reached by the commission at the end of the day; and though they may affect public opinion, they are not and cannot be findings of criminal or civil responsibility".*

20. The Bloody Sunday Inquiry panel rejected a submission that fairness required findings which implied criminal wrongdoing to be determined to the

criminal standard of proof. At paragraph 23 of its ruling the panel set out what it considered fairness required:

> *"In our view, provided the Tribunal makes clear the degree of confidence or certainty with which it reaches any conclusion as to facts and matters that may imply or suggest criminality or serious misconduct of any individual, provided that there is evidence and reasoning that logically supports the conclusion to the degree of confidence or certainty expressed, and provided of course that those concerned have been given a proper opportunity to deal with allegations made against them, we see in the context of this Inquiry no unfairness to anyone nor any good reason to limit our findings in the manner suggested..."*

21. The inquiry panel firmly rejected the submission that it ought not to reach conclusions on matters implying criminality or serious misconduct, unless it was sure beyond reasonable doubt. It went so far as to conclude that it was duty bound to take a different approach which required it to set out its reasoned conclusions and make clear the degree of confidence or certainty with which it had arrived at those conclusions. It expressed itself in the following way at paragraph 24 of its ruling:

> *"It was also submitted that there would be no point in reaching conclusions on matters implying criminality or serious misconduct, unless we were sure beyond a reasonable doubt. We do not understand this submission. We are asked to investigate and report on an event that took place some three decades ago, where on any view soldiers of the British Army shot and killed (and wounded) a number of civilians on the streets of a city in the United Kingdom and where the question whether or not they were justified in doing so has been the subject of such debate ever since that it led to the institution of this (the second) Inquiry some thirty years later. It seems to us that it would be quite wrong to confine ourselves in relation to this central part of the Inquiry to making findings where we were certain what happened. On the contrary, it is in our view our duty to set out fully in our Report our reasoned conclusions on the evidence we have obtained and the degree of confidence or certainty with which we have reached those conclusions. We are not asked to report only on these central matters on which the evidence makes us certain."* (emphasis added)

The Baha Mousa Inquiry: further application of the flexible approach and examination of the status of expressions of suspicion

22. The Baha Mousa Inquiry examined an instance of the very serious mistreatment of civilian detainees by British soldiers in Basra, Iraq in September 2003 which had led to the death of Baha Mousa and serious injury to other detainees. The inquiry panel in that inquiry comprised solely of the chairman, Sir William Gage. He expressed the provisional view that he should adopt a flexible approach indicating the level of satisfaction which he found established in relation to any significant finding of fact which warranted such an indication (i.e. the approach adopted both by the Shipman and Bloody Sunday inquiries). He heard submissions advocating a wide range of different approaches ranging from the application of the balance of probabilities across the board to complex systems applying different standards of proof to different categories of alleged conduct.

23. As was the case in the Bloody Sunday Inquiry, the Baha Mousa Inquiry's attention was drawn to a range of case law from both the coronial jurisdiction and civil courts. Sir William Gage explained at paragraph 17 of his ruling that these authorities did not help on the issue of whether he should adopt a uniform standard of proof across-the-board. That was because they were decisions in proceedings which did not equate to public inquiry proceedings.

24. Sir William Gage followed the Bloody Sunday Inquiry in endorsing Dame Janet Smith's flexible approach to the standard of proof, concluding that it was in the public interest to do so. He put it this way at paragraph 19 of his ruling:

> *"I must also be fair to the detainees who, on any view of the evidence I have so far heard, suffered serious and traumatic injuries following their arrest and detention in the TDF at Battlegroup Main between 14 and 16 September 2003. In addition, this is a Public Inquiry and it is in the public interest that my findings in the Report are expressed in such a way as can be readily understood as my judgment on what occurred, who was responsible and why I have made recommendations. In my opinion, this can best be achieved by adopting the flexible and variable standard of proof as applied in the Shipman Inquiry."* (emphasis added).

25. At the end of his ruling, in paragraph 28, Sir William Gage explained how he would apply the flexible approach in the relation to his task. He opted to adopt the civil standard of proof as a starting point but indicating where he was sure of a finding:

> *"For the reasons which I have endeavoured to explain I have concluded that it is right for me to approach my task by initially adopting the civil standard of proof in relation to findings of facts, but indicating where appropriate where I am sure of a finding. As I have said, I shall record the level of satisfaction which I find established in relation to any finding of fact. Thus, I shall state where necessary that I find a fact proved on the balance of probabilities or to a higher standard where appropriate. I do not think it will be necessary expressly to refer to expressions such as 'inherent improbabilities' or the 'bare' balance of probabilities".*

26. A specific issue arose during the course of argument as to whether in an inquiry under the 2005 Act the inquiry panel is permitted to express suspicion. Sir William Gage concluded that he was permitted to express a suspicion that an allegation was true but that to do so would not be a finding of fact but a permissible comment. The arguments and his conclusions are set out at paragraphs 24 – 26 of his Ruling on the Standard of Proof:

> *"24. During the course of oral argument I canvassed with all counsel whether or not I am entitled to make comments expressing suspicion or, some other such phrase, that an allegation is true. Mr Singh submitted that I am entitled to do so; others disagreed. Mr Beer submitted that I have no power to do so because my power is only to determine the facts (s.24(1)(a) of the 2005 Act).*
>
> *"25. I do not accept that I may not make such comments. In my opinion the terms of s.24(1)(a) do not restrict me from doing so. In any event, as Mr Singh pointed out, s.24(1) of the 2005 Act provides that "The report may also contain anything else that the panel considers relevant to the terms of reference". I do, however, accept and stress that by making a comment of that nature I would not be making a finding of fact. I further accept that the power to make such a comment should be exercised sparingly. Circumstances in which I will feel constrained to do so will, I believe, be comparatively rare.*

> *"26. In adopting this procedure for finding facts I do not see any unfairness arising to Core Participants from not knowing to what standard of proof allegations against them may be found proved. In preparing submissions on their behalf counsel representing them will no doubt properly seek to place their version of events in the best possible light, regardless of the variations in the standard of proof. As I have indicated, my starting point will be the civil standard. I shall not make findings of fact to a lower standard than on the balance of probabilities and I will make clear where appropriate that I am sure of a finding. This I conceive to be my duty and cannot lead to any unfairness. Equally, albeit sparingly and with fairness at the forefront of my mind, I may indicate, where appropriate, that reasonable suspicion remains in relation to an issue, but this would be a comment and not a finding of fact".*

The Al-Sweady Inquiry: further endorsement of the flexible and variable approach

27. Like the Baha Mousa Inquiry, the Al-Sweady Inquiry was concerned with investigating the alleged misconduct of British soldiers in Iraq. The chairman of the Al-Sweady Inquiry, Sir Thayne Forbes, set out his approach to fact finding in Chapter 5 of Volume 1 of the Al-Sweady Inquiry Report. He expressly adopted the same "flexible and variable" approach as that decided upon by Sir William Gage in the Baha Mousa Inquiry.

The Mid Staffordshire NHS Foundation Trust Public Inquiry: distillation of principles

28. Robert Francis QC, chairman of the Mid Staffordshire NHS Foundation Trust Public Inquiry, reviewed the rulings on standard of proof made in the Shipman Inquiry, the Bloody Sunday Inquiry and the Baha Mousa Inquiry before identifying the following five principles at paragraph 95 of Volume 1, Part 1 of his report. He expressed these principles in the following terms:

> *"Looking at the overall effect of how previous inquiries have approached the matter, together with the current Inquiries Act and Inquiry Rules, the following principles may be gleaned:*
>
> - *It is for the chairman of the inquiry to decide on the approach to be taken to findings of fact, criticism and recommendations as part of his role in determining the procedure of the inquiry.*

- *Even in inquiries which have to address allegations of extremely serious crimes, there is no place for the application of the criminal standard of proof.*

- *The context of the task set for the inquiry is important in deciding what the proper approach to making findings may be.*

- *An inquiry should not be inhibited from setting out its findings and opinions based on those findings by adherence to particular standards of proof.*

- *An inquiry is free to express its findings as it sees fit, provided that they are logically founded on the evidence, the basis of the finding is made clear, and a person adversely affected by a finding has had a fair opportunity to deal with it.*

29. Applying those principles to his terms of reference, Mr Francis determined to proceed as set out at paragraph 100 of the Introduction to Part 1 of his report which is a further example of an inquiry adopting a flexible approach to the standard of proof:

"Taking all these considerations into account, I have concluded that:

- *The Inquiry should make findings based on the evidence before it, taking into account the findings of the first inquiry. In all instances, the Inquiry's findings must be guided by what is fair.*

- *Much evidence of what happened has not been contradicted. Where such evidence is not contradicted the Inquiry is likely to accept it unless it is inherently improbable, in which case this will be made clear.*

- *Where there are issues in relation to what happened, all the evidence relevant to that issue will be considered and taken into account. No particular standard of proof will be applied, but the Inquiry will find the facts on the basis of the evidence that it has preferred. A common sense approach will be adopted whereby inherently improbable assertions will be regarded with more caution then inherently likely ones.*

- *Where it is decided in relation to an important event that it is only possible to say it may have occurred, this will be made clear. The narrative of the report will make clear what the inquiry has concluded occurred and will refer to evidence supporting that conclusion. As this is a report not a court judgment, a full account of the reasons for preferring the evidence cited will not always be given.*

- *Although there are no strict rules of evidence other than the overriding requirement of fairness, I will bear in mind that different weight may have to be afforded to different types of evidence.*

- *Criticisms of organisations and individuals may appear either in the course of a narrative account of what happened or separately. They may either be made explicitly or be implied. Where a criticism is made or implied, this will be the result of the Inquiry forming an adverse opinion arising out of the finding of fact. That opinion and the resulting criticism are a matter of judgment and not a matter for which proof is required. An explanation of the significance of criticisms in this report appears below"* (emphasis added).

The Robert Hamill Inquiry: choosing to adopt the balance of probabilities

30. The Robert Hamill Inquiry was tasked to inquire into the murder of an Irish catholic by a loyalist group. Following an oral hearing on 17 November 2009 the panel directed that the inquiry would apply the civil standard of proof. There is no ruling to explain why the panel decided to adopt that approach. It is evident from the transcript of the hearing that none of the interested parties sought to make submissions in support of any other approach.

The Leveson Inquiry, Part 1: choosing to adopt the balance of probabilities

31. The terms of reference for the Leveson Inquiry into press standards are divided into two distinct parts. Part 1 of that inquiry has taken place. Part 2 has not. The inquiry panel, Lord Justice Leveson (as he then was), set out his approach to the nature and standard of proof in Volume 1, Part A, Chapter 3, Section 3 of his Part 1 report. He decided to determine facts on

the balance of probabilities. The decision was specifically influenced by the general and forward looking nature of the task set by his Part 1 terms of reference and especially the ambit of the recommendations which he was required to make. Unlike the inquiries referred to above, these terms of reference did not require detailed factual investigation. Lord Justice Leveson summarised the nature of his task and the distinction between Parts 1 & 2 of his inquiry in these terms at paragraphs 3.2 and 3.3 of Part A, Volume 1 of his report:

> *"3.2. More important than the topics about which I am required to inquire are the subjects about which I am required to make recommendations. It is sufficient to repeat the Terms of Reference which are expressed in this way:*
>
> *'To make recommendations:*
>
> *(a) for a new more effective policy and regulatory regime which supports the integrity and freedom of the press, the plurality of the media, and its independence, including from Government, while encouraging the highest ethical and professional standards;*
>
> *(b) for how future concerns about press behaviour, media policy, regulation and cross-media ownership should be dealt with by all the relevant authorities, including Parliament, Government, the prosecuting authorities and the police;*
>
> *(c) the future conduct of relations between politicians and the press; and*
>
> *(d) the future conduct of relations between the police and the press.'*
>
> *"3.3 These issues are to be contrasted with those set out in Part 2 of the Terms of Reference, which are specifically directed to a far more fact focussed investigation of the conduct of News International and other newspaper organisations ('the extent of unlawful or improper conduct', 'the extent of corporate governance and management failures'), along with the police ('the extent to which the police received corrupt payments or other inducements, or were otherwise complicit in such misconduct or in suppressing its proper investigation') and politicians ('the role, if any, of politicians, public servants and others in*

> *relation to any failure to investigate wrongdoing at News International'). In Part 2, there is a requirement 'to consider the implications' of what is then found to have happened. In other words, Part 1 of this Inquiry is a qualitative exercise of sufficient breadth to determine the appropriate recommendations to make for the future. Part 2 is a quantitative exercise: how extensive have been the identified failures in News International, other press organisations, the police, the political class, public servants or others? On that basis, the implications (and any additional recommendations fall to be addressed. Part 2 requires a far greater and more detailed factual investigation than has Part 1: this is not surprising given that the Terms of Reference were split into two because of the ongoing police investigation and the lack of clarity as to where it might lead)."* (emphasis added).

The correct approach to determining facts on the balance of probabilities

32. Although there are limits to the assistance which can be derived from case law relating to adversarial or coronial proceedings, because of the unique nature of a public inquiry, there is one area in which case law from adversarial proceedings deserves mention. That is in relation to the correct approach to determining facts on the balance of probabilities. The leading case is now *In re S-B (Children) (Care Proceedings: Standard of Proof)* [2010] 1 AC 678, SC in which a panel of seven supreme court justices, in the context of care orders under s.31(2) of the Children Act 1989, confirmed and explained the case of *In Re B* in which Lord Hoffmann had held that the balance of probabilities did not involve a heightened standard of proof in cases where the allegations were serious. The core reasoning of the court is set out at paragraphs 10-14 of the judgement which are set out below:

> *"10. The House of Lords was invited to revisit the standard of proof of past facts in In re B (Children) (Care Proceedings: Standard of Proof) (CAFCASS intervening) [2009] AC 11, where the judge had been unable to decide whether the alleged abuse had taken place. The suggestion that it would be sufficient if there were a 'real possibility' that the child had been abused was unanimously rejected. The House also reaffirmed that the standard of proof of past facts was the simple balance of probabilities, no more and no less.*

"11. The problem had arisen, as Lord Hoffmann explained, because of dicta which suggested that the standard of proof might vary with the gravity of the misconduct alleged or even the seriousness of the consequences for the person concerned: para.5. He pointed out that the cases in which such statements were made fell into three categories. In the first were cases which the law classed as civil but in which the criminal standard was appropriate. Into this category came sex offender orders and anti-social behaviour orders: see B v Chief Constable of Avon and Somerset Constabulary [2001] 1 WLR 340 and R(McCann) v Crown Court at Manchester [2003] 1 AC 787. In the second were cases which were not about the standard of proof at all, but about the quality of evidence. If an event is inherently improbable, it may take better evidence to persuade the judge that it has happened than would be required if the event were a commonplace. This was what Lord Nicholls was discussing in In re H(Minors) [1996] AC 563, 586. Yet, despite the care that Lord Nicholls had taken to explain that having regard to the inherent probabilities did not mean that the standard of proof was higher, others had referred to a "heightened standard of proof" where the allegations were serious. In the third category, therefore, were cases in which the judges were simply confused about whether they were talking about the standard of proof or the role of inherent probabilities in deciding whether it had been discharged. Apart from cases in the first category, therefore, "the time has come to say, once and for all, that there is only one civil standard of proof and that is proof that the fact in issue more probably occurred than not": In re B [2009] AC 11, para 13.

"12. This did, of course, leave a role for inherent probabilities in considering whether it was more likely than not that an event had taken place. But, as Lord Hoffmann went on to point out, at para 15, there was no necessary connection between seriousness and inherent probability:

> *'It would be absurd to suggest that the tribunal must in all cases assume that serious conduct is unlikely to have occurred. In many cases, the other evidence will show that it was all too likely. If, for example, it is clear that a child was assaulted by one or other of two people, it would make no sense to start*

> *one's reasoning by saying that assaulting children is a serious matter and therefore neither of them is likely to have done so. The fact is that one of them did and the question for the tribunal is simply whether it is more probable that one rather than the other was the perpetrator.'*

"Baroness Hale of Richmond made the same point, at para 73:

> *'It may be unlikely that any person looking after a baby would take him by the wrist and swing him against the wall, causing multiple fractures and other injuries. But once the evidence is clear that that is indeed what has happened to the child, it ceases to be improbable. Someone looking after the child at the relevant time must have done it. The inherent improbability of the event has no relevance to deciding who that was. The simple balance of probabilities test should be applied.'*

"13. None of the parties in this case has invited the Supreme Court to depart from those observations nor have they supported the comment made in the Court of Appeal [2009] 3 FCR 663, para 14, that In re B 'was a sweeping departure from the earlier authorities in the House of Lords in relation to child abuse, most obviously the case of In re H'. All are agreed that In re B [2009] AC 11 reaffirmed the principles adopted in In re H [1996] AC 563 while rejecting the nostrum, "the more serious the allegation, the more cogent the evidence needed to prove it", which had become a commonplace but was a misinterpretation of what Lord Nicholls had in fact said.

"14. In re B [2009] AC 11 was not a new departure in any context. Lord Hoffmann was merely repeating with emphasis what he had said in Secretary of State for the Home Department v Rehman [2003] 1 AC 153, para 55. A differently constituted House of Lords applied the same approach in In re D (Secretary of State for Northern Ireland intervening) [2008] 1 WLR 1499."

33. In *in re D (Secretary of State for Northern Ireland intervening) [2008] 1 WLR 1499*, cited with approval in *In Re S-B*, Lord Carswell analysed, at paragraph 28, the way in which the seriousness of an allegation or the consequences

which might flow from it could be relevant to the civil standard of proof, notwithstanding that it was a finite and unvarying standard:

> *"…a possible source of confusion is the failure to bear in mind with sufficient clarity the fact that in some contexts a court or tribunal has to look at the facts more critically or more anxiously than in others before it can be satisfied to the requisite standard. The standard itself is, however, finite and unvarying. Situations which make such heightened examination necessary may be the inherent unlikelihood of the occurrence taking place (Lord Hoffmann's example of the animal seen in Regent's Park), the seriousness of the allegation to be proved or, in some cases, the consequences which could follow from acceptance of proof of the relevant fact. The seriousness of the allegation requires no elaboration: a tribunal of fact will look closely into the facts grounding an allegation of fraud before accepting that it has been established. The seriousness of consequences is another facet of the same proposition: if it is alleged that a bank manager has committed a minor peculation, that could entail very serious consequences for his career, so making it the less likely that he would risk doing such a thing. These are all matters of ordinary experience, requiring the application of good sense on the part of those who have to decide such issues. They do not require a different standard of proof or a specially cogent standard of evidence, merely appropriately careful consideration by the tribunal before it is satisfied of the matter which has to be established."*

34. Thus it is submitted that when determining whether an allegation is more likely than not to be true regard can properly be had to whether or not the disputed fact is inherently probable. However, it is to be remembered that the gravity of the allegation is not necessarily connected to its inherent probability.

Conclusions

35. The panel of a statutory public inquiry is not required to adopt any specific standard of proof so long as it acts fairly. The function of a statutory public inquiry is very different from that of a criminal court, a civil court or a coroner's court. Indeed, a statutory public inquiry is specifically prohibited from determining any person's civil or criminal liability. Consequently, the

case law relating to the standard of proof in those courts is of little assistance.

36. Uniform application of the criminal standard of proof is most unlikely to be appropriate even in inquiries which have to determine allegations of very grave conduct. However, this does not mean that the panel of an inquiry cannot express itself as being sure that something occurred if it chooses to adopt a flexible and variable approach to the standard of proof.

37. When deciding upon its approach to standard of proof an inquiry panel should have regard to the task which has been set through its terms of reference which should inform the decision. So long as he acts fairly, the Chairman is free to decide upon an approach to findings of fact which best suits discharging the Inquiry's terms of reference.

38. The majority of recent public inquiries have found it appropriate to adopt a flexible and variable approach to the standard of proof so as to enable a full and nuanced approach to the determination of facts. Of the two recent examples in which this approach was not followed and the civil standard was adopted, the Leveson Inquiry decision was made in the context of very different terms of reference for Part 1 of that inquiry. No fully reasoned decision was sought or given in the Robert Hamill Inquiry.

39. Expressions of suspicion are permissible. They are properly analysed not as findings of fact but as comment permitted under s.24(1) of the 2005 Act.

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16 December 2015

Recent Public Inquiries' consideration of standard of proof

Inquiry and date of decision on standard of proof	Links to relevant documents	Summary
Shipman First report published 19 July 2002	Report: http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/images/firstreport/narrative/pdf/vol1.pdf (Chapter 9, especially 9.40 – 9.48)	Set up under Tribunals of Inquiry (Evidence) Act 1921 Flexible and variable standard: cases in which the conclusion was that the Chairman was sure that something had happened; that it had probably happened; that it had probably not happened; that she was sure that it had not happened; also cases where it was not possible to reach a conclusion on the evidence.
Bloody Sunday Ruling dated 11 October 2004	Ruling: http://webarchive.nationalarchives.gov.uk/20101103103930/http://www.bloody-sunday-inquiry.org/rulings/tribunal/Archive/proof.pdf	Set up under Tribunals of Inquiry (Evidence) Act 1921 Flexible and variable standard following approach in Shipman. In particular, there is no support for the proposition that findings cannot be made implying criminality unless the Inquiry is satisfied to the criminal or "enhanced civil" standard.

Robert Hamill Directions dated 17 November 2009	Inquiry Chairman's directions, 17 November 2009: http://webarchive.nationalarchives.gov.uk/20140108104637/http://www.roberthamillinquiry.org/the-public-hearings/directions/ Transcript of directions hearing: http://webarchive.nationalarchives.gov.uk/20140108104637/http://www.roberthamillinquiry.org/the-public-hearings/transcripts/159/ (from page 28)	Set up under Police (Northern Ireland) Act 1998; converted to a 2005 Act inquiry on 29 March 2006 *"The Inquiry will apply the civil standard of proof to findings of fact as explained by the House of Lords in Doherty. This entails the general standard of proof being the balance of probabilities. The more serious the accusation, the more cogent the evidence must be before the panel will make the relevant finding of fact. There is no burden of proof."*
Baha Mousa Ruling dated 7 May 2010	Ruling: http://webarchive.nationalarchives.gov.uk/20120809191124/http://www.bahamousainquiry.org/linkedfiles/baha_mousa/key_documents/rulings/standardofproofruling7may2010.pdf	Set up under Inquiries Act 2005 Flexible and variable standard: Chairman decided to apply the civil standard of proof initially, but indicate where appropriate that he was sure of a finding. Considered that he could indicate suspicion (but that it would not be a finding of fact).
Azelle Rodney Protocol dated June 2011	Closing submissions: http://webarchive.nationalarchives.gov.uk/20150406091509/http://azellerodneyinquiry.independent.gov.uk/docs/ARI_Written_Closings_with_Submissions(6).pdf (pages 1 - 17) Burden and standard of proof protocol: http://webarchive.nationalarchives.gov.uk/20150406091509/http://azellerodneyinquiry.independent.gov.uk/docs/Burden_and_standard_of_proof__June_2011.pdf	Set up under Inquiries Act 2005 Flexible and variable standard – *"The Inquiry Chairman may express himself in terms of the degree of likelihood of something having happened."*

Leveson Inquiry report dated 29 November 2012	Report: http://webarchive.nationalarchives.gov.uk/20140212151345/http://www.official-documents.gov.uk/document/hc1213/hc07/0780/0780_i.pdf (Part A, chapter 3, section 3)	Set up under Inquiries Act 2005 It is the overall picture that is critical – the facts determined are those necessary to provide context for the recommendations. Worked examples may exemplify the problems, but it is not an inevitable inference that the culture, practices and ethics of the title affected is driven by the problem exemplified. In these circumstances the balance of probabilities is the appropriate standard.
Mid-Staffordshire NHS Foundation Trust Report dated 6 February 2013	http://webarchive.nationalarchives.gov.uk/20150423111725/http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%201.pdf (p 32 & seq.)	Set up under Inquiries Act 2005 Flexible and variable standard, following approach taken in Shipman, Bloody Sunday and Baha Mousa. No particular standard of proof will apply, but where it is only possible to say that an event may have occurred, this will be made clear.
Al-Sweady Inquiry report dated 17 December 2014	Inquiry Report: http://webarchive.nationalarchives.gov.uk/20150115114702/http://www.alsweadyinquiry.org/linkedfiles/alsweadyinquiry/theal-sweadyinquiryreport-volume1part1.pdf (para 1.29; Chapter 5) (Chapter 5 as separate pdf: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388255/43358_02e_Part_1_Chapter_05.pdf)	Set up under Inquiries Act 2005 *"Where I have been able to reach an appropriate conclusion on the evidence, I have stated clearly what it is and have also indicated the degree of confidence or certainty with which I have reached the conclusion in question."* -Report, Volume 1 Part 1, para 1.29 Analysis of the law and adoption of *"flexible and variable"* standard following approach taken in Baha Mousa and Shipman Inquiries – but taking the civil standard of proof as the basic starting point – Report, Volume 1 Part 1, Chapter 5

Annex 2
Chairman's 'minded to' letter

1. Subject to further argument, if any, I am minded to apply to issues of fact that arise in the evidence given to the Inquiry a **flexible and variable standard of proof**. By that I mean:

   (i) My starting point for most decisions of fact should be the civil standard, the balance of probabilities, but I should not be bound by it because:

   (ii) Depending upon what the issue is, it will be more useful if, having examined the evidence, I express my state of certainty or uncertainty upon it with such accuracy as I can.

2. It is not possible, in advance of the hearing of the evidence, to forecast the circumstances in which I will find it appropriate to depart from or enlarge upon the civil standard when expressing a "a determination of fact" (as to which see e.g. section 2 (2) and section 24(1)(a) of the Inquiries Act 2005) or to express in my report a comment upon an issue by a measure unrelated to standard of proof (as to which see section 24(1)(b) of the Inquiries Act 2005). I will need to make a judgement how best to express myself when I can see the issue of fact in its full Inquiry context. What matters is that the approach I adopt is transparent and properly explained.

3. The words used in the terms of reference demonstrate the investigatory nature of the Inquiry's task to ascertain or identify what happened during the 47 year period under review. Recollections are likely to be imperfect and contemporaneous documents may no longer be available. A fuller understanding of the essential history of undercover policing is likely to become available by the application of a flexible rather than an inflexible approach to the standard of proof.

4. I am also required to "assess the adequacy" of justification for undercover policing and of the statutory, policy and judicial regulation of undercover policing. Ultimately, I will "make recommendations" as to the future deployment of undercover officers. The essential quality of any assessment or recommendation is that it is explained by the range of findings I make. Provided that I express accurately the route that I have taken to my assessment and recommendations, the reader will be able to judge whether they are justified.

5. I agree with the opinion of the distinguished panel of the Bloody Sunday Inquiry at paragraph 23 of its ruling upon the issue of proof and the achievement of fairness in the resolution of allegations of misconduct (see paragraph 20 of the Inquiry counsel team's note).

6. In my opinion, the conclusions expressed by the Inquiry's counsel team at paragraphs 35 – 39 of their note are accurate.

17 December 2015

Sir Christopher Pitchford
Chairman, Undercover Policing Inquiry

Press release

Chair appointed for public inquiry into Nottingham attack

Former senior circuit judge, Her Honour (HH) Deborah Taylor, has been appointed by the Lord Chancellor to chair the statutory inquiry into the Nottingham attacks.

From: **Ministry of Justice (/government/organisations/ministry-of-justice)**, **Alex Davies-Jones MP (/government/people/alex-davies-jones)** and **The Rt Hon Shabana Mahmood MP (/government/people/shabana-mahmood)**

Published 22 April 2025

HH Deborah Taylor

- Her Honour Deborah Taylor to chair Nottingham inquiry
- Holistic review to provide recommendations to prevent similar incidents
- Full Terms of Reference to be published in due course

Barnaby Webber, Grace O’Malley-Kumar, both 19, and Ian Coates, 65, were tragically killed and three other survivors were seriously injured by Valdo Calocane in Nottingham in June 2023.

Speaking in the House of Commons today (April 22), the Lord Chancellor confirmed HH Deborah Taylor would undertake a thorough, independent assessment of the events that culminated in these brutal attacks, and provide recommendations to prevent similar incidents.

The statutory inquiry will have the power to examine all the agencies involved, including the Nottinghamshire Police and the Crown Prosecution Service; compel witnesses, and establish the facts. The Prime Minister has committed that the inquiry should report within two years.

The bereaved families and survivors of the attack were present in the public gallery during the Lord Chancellor's announcement.

Lord Chancellor Shabana Mahmood said:

> "The bereaved families and survivors of the Nottingham Attack, who have suffered so much, deserve to know how these horrific attacks were able to happen.
>
> "I am pleased to appoint Her Honour Deborah Taylor as the Chair of this inquiry. She brings deep experience to the role, and I know she will undertake a fearless and thorough examination of the facts."

The Chair, a retired senior circuit judge, has already engaged with survivors and victims' families, and taken views on the draft Terms of Reference, which will be laid in due course.

Minister for Victims and Violence Against Women and Girls (VAWG), Alex Davies-Jones, said:

> "My thoughts remain with the bereaved families and survivors of this terrible incident, who in the face of such tragedy, have consistently called for an Inquiry.
>
> "It is important for the bereaved families and survivors that this Inquiry reports without undue delay which is why the Prime Minister has committed the inquiry should report in two years."

Notes to editors:

- With the Chair in place and the inquiry being formally established today, it can begin preliminary work immediately. The final terms of reference will be published as soon as possible.
- There have been nine separate reviews into various elements of the Nottingham attacks including: Valdo Calocane's healthcare and the healthcare institution; actions by Nottinghamshire and Leicestershire Police; and decisions of the CPS. IOPC investigations into the actions of Nottinghamshire and Leicestershire police are ongoing.

- The Law Commission is undertaking a review into homicide law and will consider the partial defence of diminished responsibility.
- HH Deborah Taylor was a Senior Circuit Judge, Resident Judge at Southwark Crown Court and Recorder of Westminster until her retirement from the Judiciary in December 2022. In 2022 she was Treasurer of Inner Temple, where she advocated for greater diversity at the Bar.
- Deborah will continue in her role as Chair of the Criminal Legal Aid Advisory Board which she has held since July 2023

Published 22 April 2025

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Statements from families and legal team as Public Inquiry into 2023 Nottingham Attacks announced in Parliament

Dr Neil Hudgell
Executive Chairman

3 min read time
22 Apr 2025

Share on

Statement from the families of Barnaby Webber, Grace O'Malley-Kumar and Ian Coates

Failure, mistruths, incompetence and negligence, by multiple agencies, have faced our families for almost two years. We cannot put into adequate words the torture and trauma that all our families have endured as a result of the actions of Valdo Calocane.

There has been a shameful miscarriage of justice that currently permits him to serve no punishment for his crimes. He is the product of a system that has failed. Failed at every single level.

Countless opportunities to intervene and stop him were missed. Barney, Grace and Ian paid the ultimate price for this shameful level of incompetence, and that must not be in vain.

Following our long and painful fight for justice, we can have hope that today marks the beginning of uncovering the truth and addressing all that went so catastrophically wrong.

This Statutory Inquiry must dig deep and leave nothing unturned in seeking out the truth. Recognising the failings, holding those to account who failed, and also setting a direction through change in laws and practices to ensure public safety.

We have seen the draft Terms of Reference for the Inquiry, and proposed amendments to them which are being considered. We are hopeful that when finalised, they will ensure this Inquiry is able to get the answers to the questions we and many others have been asking.

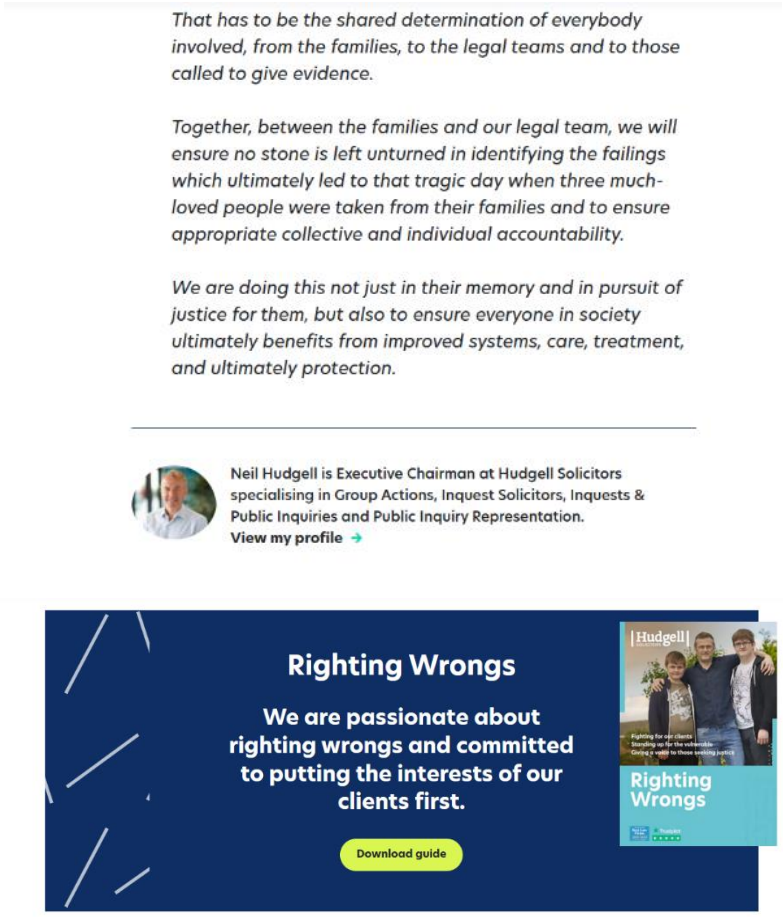
The truth will out. Wrongs will be righted. We will make sure of that. Whatever it takes, however we have to do it, and for as long as we must.

Unlike many, we have nothing to fear, nothing to hide or embellish.

We call for all involved, across all agencies who are called forward to finally do the right thing. Tell the truth, admit fault if they must, accept any professional redress and accountability should there be any, and allow this to be the moment that makes proper change for this country.

Statement of Neil Hudgell, of Hudgell Solicitors, lawyer for the families

> *Today is a watershed day for the families of Barney, Grace and Ian, as this Public Inquiry is being held only as a result of their determined pursuit of full transparency and accountability for the many, many failings of state organisations which have been identified since June 2023.*
>
> *Despite these many investigations however, true transparency and accountability has not yet been forthcoming.*
>
> *It is that which has made a Statutory Inquiry like this, which has wide-ranging powers and is able to compel people to give evidence and be questioned under oath, essential.*
>
> *Having had the opportunity to meet with the Chair, we are confident that transparency and accountability can now be achieved, and that this Inquiry can ensure lessons are learned, and lead to real change to prevent events like that in Nottingham in 2023 from happening again.*

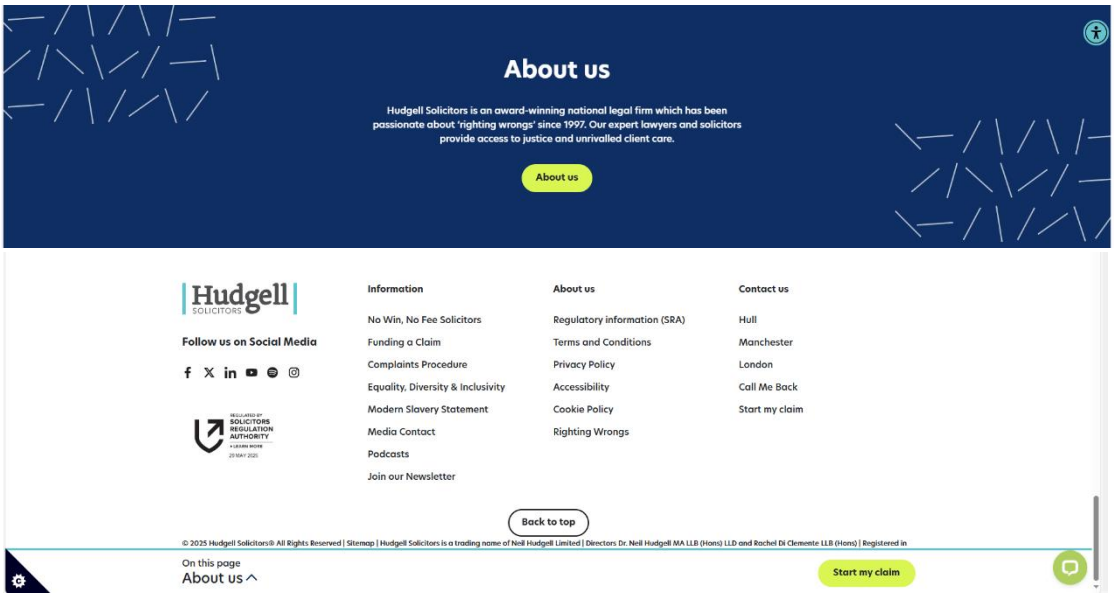


That has to be the shared determination of everybody involved, from the families, to the legal teams and to those called to give evidence.

Together, between the families and our legal team, we will ensure no stone is left unturned in identifying the failings which ultimately led to that tragic day when three much-loved people were taken from their families and to ensure appropriate collective and individual accountability.

We are doing this not just in their memory and in pursuit of justice for them, but also to ensure everyone in society ultimately benefits from improved systems, care, treatment, and ultimately protection.

Neil Hudgell is Executive Chairman at Hudgell Solicitors specialising in Group Actions, Inquest Solicitors, Inquests & Public Inquiries and Public Inquiry Representation.
View my profile →



Website: www.hudgellsolicitors.co.uk/news/company/statements-from-families-and-legal-team-as-public-inquiry-into-2023-nottingham-attacks-announced-in-parliament

Accessed: 29 May 2025

The Nottingham Inquiry

On 13 June 2023 Valdo Calocane, who suffered from paranoid schizophrenia and had previous interactions with health services and the police, killed three people and seriously injured three other people in Nottingham city centre.

On 22 April 2025, in a statement to the House of Commons, the Lord Chancellor and Secretary of State for Justice, the Rt Hon Shabana Mahmood MP, formally announced the Nottingham Inquiry and that it would be chaired by Her Honour Deborah Taylor.

On 22 May 2025, the Terms of Reference for the Inquiry were formally laid in Parliament.

Opening Statement by Her Honour Deborah Taylor

Nottingham Inquiry - Opening Statement by Her Honour Deborah Taylor

Read transcript

On 13 June 2023 in Nottingham, Valdo Calocane stabbed and killed Barney Webber, Grace O'Malley Kumar and Ian Coates, before driving into and seriously injuring Sharon Miller, Wayne Birkett and Marcin Gawronski, leaving them and their families with tragic and life- changing consequences.

Barney and Grace were talented, brave and loved young people torn away by dreadful violence on the threshold of their adult lives, and Ian was a hard working, kind and generous man, deprived by violent death of the enjoyment of his imminent retirement. Sharon and Wayne's lives have been changed immeasurably by the trauma they suffered.

Following these events crowds at vigils held in Nottingham showed the shock and sympathy of the community, and subsequently there has been widespread support for the families' campaign for this Inquiry, and for meaningful change to come out of this tragedy.

On 12 February 2025 the Prime Minister announced that there would be a Statutory Inquiry into the attacks in Nottingham, and on 2 April 2025 the Lord Chancellor announced my appointment as Chair of the Nottingham Inquiry.

Today the Inquiry website goes live and the full Terms of Reference published by the Lord Chancellor can be found on the website. The Terms of Reference follow the Lord Chancellor's consultation, and my consultation

with the families of the victims and with the survivors. In addition I have set out some questions which the Inquiry will address, and am grateful for suggestions made by the families and survivors in relation to these questions.

I now want to say something about the Inquiry, what has happened to date, and how we intend to proceed. The work of the Inquiry will fall under broadly two headings: firstly, what happened, when and why? Secondly, what can be done to prevent similar events happening again?

Much preliminary work has already been done. The Inquiry legal team have already started to gather documentary evidence from some organisations, and will continue to send detailed requests to others. Those approached have expressed a willingness to co-operate with and assist the Inquiry. In any event, because this is a Statutory Inquiry they are required to respond and provide evidence. Over the coming months the Inquiry team will analyse the documents, obtain statements, and instruct experts.

All evidence, written and oral, which will form part of the Inquiry will be heard in one set of hearings which are likely to run continuously, apart from a break for Easter, from late February to the end of May 2026. More accurate timings will be made available once it is determined how much oral evidence will be called.

As to what happened and why, in the three years prior to the attacks in Nottingham, Valdo Calocane had had received mental health treatment and had been diagnosed with paranoid schizophrenia. He had also come into contact with the police. His mother was in contact with health care providers as to his mental health. We will look at any concerns she raised and how her concerns were treated.

Following the attacks in Nottingham, a number of investigations were instigated, and reports produced which address, and acknowledge, failings in the operation of different health and criminal justice agencies in Valdo Calocane's treatment and the management of the risk he presented. But each of those investigations and reports cover one area only, and none address the whole picture, the full timeline of significant events, the knowledge and actions of each agency and those who worked for them, and the interaction between agencies.

This Inquiry will use the previous reports as a baseline to produce a comprehensive and thorough history and evaluation of actions taken and decisions made in the care and treatment provided to Valdo Calocane, the

assessment of his risk in the community, and his own and his family's interactions with all agencies, leading up to the 13 June

We will look at what happened in custody after his arrest. We will shine light on areas which have remained obscure, any which have not been addressed, as well as those which need to be looked at in more detail, and in the wider context.

As to what can be done to prevent similar events in the future, this Inquiry specifically concerns the attacks in Nottingham on 13 June 2023. Since the Inquiry has been announced, we have received requests for other cases of deaths caused by those receiving mental health treatment, both in Nottingham and in other parts of the country, to be included. Detailed investigation into those cases is outside the Terms of Reference and the Inquiry will not be considering any other case in depth.

However, the Inquiry will be making recommendations to prevent similar events happening in the future. Nobody should have to suffer what happened to Barney, Grace and Ian, to Sharon, Wayne and Marcin, and their families. The Nottingham attacks are not the only incident of homicide by mental health patients. I therefore want to make recommendations which are effective, evidence-based and of general application, and to do so, will be drawing on evidence about other similar cases

We will be approaching this aspect of the Inquiry in two ways: firstly, by obtaining expert evidence, guidance and policy materials, statistical and other historical data and evidence from agencies and others holding relevant information. We will look at current practice and standards, and whether and to what extent agencies work together and share information, and any changes which can be made in this respect to improve the care and outcomes for mental health patients, whilst balancing risk to the public.

Secondly, the Inquiry will be providing a means of capturing essential and relevant details about other similar cases in the form of a questionnaire available on the website to fill in online. So if you have been personally involved in or directly affected by a case in which there has been a homicide by a person undergoing or recently discharged from mental health treatment, and wish to contribute to the work of the Inquiry and the recommendations we make towards the prevention of further such cases, do please use this method to contact us. We are particularly interested in cases of homicide which have occurred over the last 10 years as best evidencing recent and current

practice in the treatment of mental health. In that way your experience can make a meaningful contribution to any recommendations for change.

Now the Terms of Reference are available and the Inquiry has formally started, we are keen to maintain momentum and proceed at pace. A venue for the hearings is being identified. More immediately, from today May 22 for a period of 6 weeks until July 3 there will be an opportunity for those who have a specific involvement and interest in this Inquiry to apply for Core Participant status. I will deal with those applications by the end of July at the latest. More information about Core Participant status is set out in the FAQs on the Nottingham Inquiry website, which aims to provide the answer to most of your questions.

The website will be kept up to date and will be the principal form of communication as to what is happening in the Inquiry. Any orders made in advance of the hearings will be made available on the website, and as the Inquiry progresses all important information, a timetable of evidence and then the evidence itself will be uploaded and publicly available.

As we approach the second anniversary of these terrible events I am sure our thoughts are with the bereaved families, and the survivors and their families who have suffered so grievously. I will be doing all I can to conduct this Inquiry thoroughly and fearlessly to uncover the full history of what occurred and why. Only then can the Inquiry identify lessons to be learned and necessary change aimed at preventing anybody else having to endure the unimaginable torment and grief of those involved in this case. That is the least they deserve. It will require will and commitment to make that happen, not only from the Inquiry team, but also from all those with contributions to make.

Let us ensure that we do.

Contribute to the Inquiry

If you are a **family member or otherwise directly affected** by a **fatal attack involving someone who was under the care of mental health services** please consider completing our **Inquiry Questionnaire**.

Complete the questionnaire

The Inquiry Team

Find out about the people working in the inquiry team (https://nottingham.independent-inquiry.uk/the-inquiry-team/), led by Her Honour Deborah Taylor.

Terms of Reference

The Inquiry's work is determined by its Terms of Reference. Read our Terms of Reference (https://nottingham.independent-inquiry.uk/terms-of-reference/).

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Press release

Secretary of State announces independent statutory inquiry into Omagh bomb

The Secretary of State for Northern Ireland the Rt Hon Chris Heaton-Harris MP has today announced that an independent statutory inquiry will be established into the preventability of the Omagh bombing in August 1998.

From: **Northern Ireland Office (/government/organisations/northern-ireland-office)** and **The Rt Hon Chris Heaton-Harris (/government/people/chris-heaton-harris)**

Published 2 February 2023

This was published under the 2022 to 2024 Sunak Conservative government

- Independent statutory inquiry to be be established into the preventability of the Omagh bombing

- The Real IRA claimed responsibility for the Omagh Bombing in 1998
- Inquiry will be held in response to a recent High Court judgment

The Secretary of State for Northern Ireland the Rt Hon Chris Heaton-Harris MP has today announced that an independent statutory inquiry will be established into the preventability of the Omagh bombing in August 1998.

This is in response to a High Court judgment that found there were specific issues that gave rise to plausible arguments that the bombing by the Real IRA could have been prevented.

The Real IRA claimed responsibility for the Omagh Bombing in 1998, and four members of the Real IRA were subsequently found liable for the bombing in civil proceedings held in Northern Ireland. This inquiry does nothing to counter these findings, which are clear in who was responsible for this awful atrocity.

The independent statutory inquiry will examine the four issues identified by the High Court; the handling and sharing of intelligence, the use of cell phone analysis, whether there was advance knowledge or reasonable means of knowledge of the bomb, and whether disruption operations could or should have been mounted, which may have helped prevent the Real IRA's attack.

It will have the full powers provided by the Inquiries Act 2005, including the ability to compel the production of all relevant materials and witnesses and take evidence under oath.

Limiting the inquiry to the specific findings of the High Court will ensure that the Government can comply with its international obligations under the European Convention on Human Rights. A final report will be published that will respond to each of the issues identified by the Court.

Work has begun to establish the independent statutory inquiry as soon as possible. The appointment of an inquiry Chairperson will be announced and the inquiry's terms of reference will also be published in due course.

Secretary of State for Northern Ireland, Rt Hon Chris Heaton-Harris MP said:

"The Omagh bomb was a horrific terrorist atrocity committed by the Real IRA, which caused untold damage to the families of those who were tragically killed and injured. Its impact was felt not just in Northern Ireland, but across the world.

"Having carefully considered the judgment of the High Court, I believe that an independent statutory inquiry is the most appropriate form of further investigation to address the grounds identified by the Court.

“I would like to thank the victims and survivors and all those affected by the Omagh bomb for their patience whilst I have reflected on the judgment and taken into account a range of sensitive, complex and technical factors.”

Published 2 February 2023

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Omagh Bombing Inquiry: Preliminary Hearing Transcript 30 July 2024

Tuesday, 30 July 2024

(10.00 am)

Opening statement by LORD TURNBULL

LORD TURNBULL: Good morning. I would like to welcome everyone to this, the first hearing of the independent public inquiry into the bombing which took place on Market Street here in this town on 15 August 1998.

I will be hearing evidence in the course of this Inquiry as to what occurred on that date. I shall also have the opportunity of hearing directly from some of those who suffered the sudden and shocking loss of their loved ones, their family members and their friends, or those who suffered injury themselves.

I would like to express my gratitude to all of those who are prepared to share their experiences of that day and to share an understanding of the grief, loss and harm which they have endured and to provide an insight into the lives of their loved ones.

That evidence will comprise an important part of the Inquiry's investigation. Even before I hear that evidence, though, what it is publicly known already allows me to appreciate something of the magnitude of the atrocity. I know that the pain of bereavement and the trauma caused by the bombing was felt far beyond the community of Omagh. Those who were killed were from

Northern Ireland, the Republic of Ireland, England and Spain.

I know that those killed and injured ranged in age from those yet to be even born through babies, infants, children, and young people with their whole lives ahead of them, men and women in their prime, and those who were looking forward to a time in which they could share in the experiences of their adult children and grandchildren.

I also know that the impact of this terrorist attack spread beyond the death and destruction brought to this community. The fact that such an outrageous attack took place only a few short months after the people of both Northern Ireland and the Republic of Ireland had voted so comprehensively in support of the Belfast Good Friday Agreement caused outrage and consternation across national boundaries and across continents.

Condemnation was expressed by the Prime Minister of the United Kingdom and the Taoiseach of the Republic of Ireland. Other world leaders, community leaders, religious leaders and political leaders all joined with them in expressing the unforgivable nature of what had occurred.

In keeping with the sentiments expressed Taoiseach

on that occasion, I am very pleased to note the support of the Government of Ireland for the work of this Inquiry. In that regard, I would like to extend my thanks to the Director General and the Deputy Political Director of the Ireland, United Kingdom~& Americas Division of the Department of Foreign Affairs within the Government of Ireland for kindly offering to attend here today.

Of course, almost 26 years have now passed since the events of that day. However, the contact which I and members of the Inquiry team have had with some of those who were directly affected by the bombing has made it plain to us that the trauma caused has been enduring and continues to have a most powerful impact.

31 lives were lost, and life-changing and other serious injuries, both physical and mental, were cruelly inflicted on many others.

It is right, therefore, that the interests and concerns of all of those who suffered the loss of loved ones and those who suffered injury should be at the heart of the work conducted by this Inquiry.

That statement is reflected in the approach which the Inquiry decided to take to the appointment of those bereaved and injured individuals who wished to be designated as Core Participants.

As part of our recognition of the importance of the Inquiry to those affected by the bombing, suitably qualified and experienced staff will be available to provide assistance when giving evidence or when attending at the Inquiry hearings. In keeping with this, the Inquiry will adopt a trauma-informed approach in all of its contact with family members and others affected.

But even with the legitimate interests of those affected by the bombing held closely in mind, the defining character of the Inquiry must be its independence. It is by guiding its own path and through the application of that quality of independence that the Inquiry will be able to engage in a credible fashion with the essence of its purpose, which is to establish whether there were reasonable steps which could have been taken by UK state authorities to prevent the bombing from occurring.

The Inquiry will undertake that task rigorously and fearlessly. It will not allow itself to be deflected from its purpose by the difficulties which may lie in its way on account of the passage of time, or the volume and complexity of materials it may be asked to consider.

The public nature of the Inquiry's work will

provide me with an opportunity to exhibit that commitment to persevere with determination.

Of course, some of the evidence and materials which the Inquiry will assess may be of particular sensitivity and it may be that, for reasons of national security, it becomes necessary to hear some of that evidence in private or in what are known as closed sessions.

If that is so, I will undertake to ensure that any evidence led in closed session is subject to the same level of rigorous scrutiny as that led in open proceedings. Insofar as it is possible to do so, I shall also ensure that any evidence heard in closed session is summarised or gisted, so that Core Participants and the public are aware of the central issues which the closed sessions are concerned with.

I have touched already on the need for the Inquiry's defining character to be its independence. The value which the Inquiry attaches to its independence means that it will not be amenable to influence from any Government or from any state agency.

I undertake to conduct my task of chairing the work of the Inquiry with an open mind. That, of course, means that I will assess the evidence which is heard

both fairly and reasonably. I will do so without any preformed view or impression as to whether the atrocity could or could not have been prevented. This is of prime importance given that so much has been written and reported about the bombing over the years which have passed.

There have also, of course, been a number of other investigations, inquiries and proceedings of one sort or another. Some of what has been written or reported has led to controversy, and various different and concerning claims have been advanced over the years.

This Inquiry will have the benefit of taking account of the work undertaken in some of the previous investigations and proceedings.

Nevertheless, it is important to emphasise the unique aspect of this Inquiry's jurisdiction and function. The work of this Inquiry will comprise the first occasion on which the question of whether the bombing could have been prevented will be explored and tested within the confines of an inquisitorial judicial process, which will have the ability to exercise powers of compulsion and recovery.

This exercise will be undertaken in an independent and focused manner by Counsel to the Inquiry, and it will, I am sure, benefit from the support and

co-operation of the highly experienced representatives of the Core Participants.

The combined benefits of the process which is engaged in under the Inquiries Act 2005 and the opportunity for Core Participants to assist the Inquiry in its work will, I believe, ensure that this Inquiry is able to credibly and comprehensively address its Terms of Reference.

Having said that, I do not underestimate the scale of the task which lies ahead. That is why I have sought to emphasise the importance of the role which the Core Participants have to play. The co-operation and active assistance of each Core Participant will be a prerequisite for the successful functioning of the Inquiry.

I am sure that there will be a combined will to see that the light which the evidence can still shine, all of these years later, remains sufficient to ensure that the truth becomes clear for all to observe.

Much of the work of the Inquiry will be undertaken by Mr Paul Greaney KC. He has agreed to accept the onerous and demanding task of Counsel to the Inquiry. His expertise and experience, as demonstrated in many similar proceedings to these, makes him a most valuable resource for me to depend upon.

Today he appears with Mr John Rafferty from the Inquiry counsel team.

In a moment I shall invite Mr Greaney to give an update on the work of the Inquiry and the plans for the coming months. In recognition of the enduring loss caused by the atrocity which this Inquiry is tasked with examining, I shall invite him to identify by name each of those who lost their lives. Once he has done so, I shall then invite all present to reflect on the individual and combined tragedy of so much loss by joining me in a minute's silence.

Once Mr Greaney has completed his submissions, I will invite each of the Core Participant representatives to introduce themselves, to identify the family group or other party for whom they appear, and to present any short submissions or observations which they may wish to offer.

Mr Greaney.

Opening remarks by MR GREANEY

MR GREANEY: Sir, thank you.

These are the names of those killed in the bombing.

James Barker.

Fernando Blasco Baselga.

Geraldine Breslin.

1 Deborah-Anne Cartwright.

2 Gareth Conway.

3 Breda Devine.

4 Oran Doherty.

5 Aidan Gallagher.

6 Esther Gibson.

7 Mary Grimes.

8 Olive Hawkes.

9 Julia Hughes.

10 Brenda Logue.

11 Jolene Marlow.

12 Ann McCombe.

13 Brian McCrory.

14 Samantha McFarland.

15 Sean McGrath.

16 Sean McLaughlin.

17 Avril Monaghan, and her unborn twins.

18 Maura Monaghan.

19 Alan Radford.

20 Rocio Abad Ramos.

21 Elizabeth Rush.

22 Veda Short.

23 Philomena Skelton.

24 Brian White.

25 Frederick White.

Lorraine Wilson.

Sir, we will now observe one minute's silence, as you indicated, and we invite those who are able to stand to do so during that period.

(Pause for the minute's silence)

MR GREANEY: Sir, that concludes the minute's silence.

In what I say next, immediately next, I will make reference to the circumstances of the bombing, and so I will pause for a moment to allow anyone who wishes to leave the room or to switch off the live feed to do so.

(Pause)

Sir, those we have just named and remembered were killed as a result of events here in Omagh on Saturday, 15 August 1998. That afternoon, the centre of Omagh was busy with shoppers, with workers and tourists.

At 2.00 pm that day, dissident republican terrorists drove a stolen Vauxhall Cavalier into the town. At 2.20 pm they parked the car up on Market Street and they walked away. The vehicle contained a massive bomb.

Shortly after 3.00 pm the device was detonated and those we have named, men, women and children, and unborn children, were killed by the explosion. Hundreds were injured and countless lives were changed forever.

What was done that day in Omagh caused the biggest

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News

Covid Public Inquiry

Published: **14 December 2021 17:30**
Topic: Coronavirus (COVID-19) in Scotland

Chair appointed and terms of reference published.

The terms of reference and a chair for the public inquiry into the handling of Coronavirus (COVID-19) in Scotland have been announced today.

In a statement to Parliament, Deputy First Minister John Swinney confirmed that the Hon. Lady Poole QC, Senator of the College of Justice of Scotland, will chair the inquiry.

Mr Swinney also published the terms of reference for the inquiry covering 12 areas of investigation, each covering a strategic element of the handling of the pandemic, to identify lessons to be learned and recommendations as soon as practicable.

The terms of reference were informed by public engagement and are subject to a period of reflection by the chair, who will be able to suggest adjustments, which may include taking the remit of the UK-wide COVID-19 inquiry into account.

The period covered by the inquiry will be from 1 January 2020 to 31 December 2022, but it will also consider pandemic planning undertaken prior to this.

The chair will now begin the process of appointing staff so the inquiry can begin considering evidence without delay.

Mr Swinney said:

“Today, I am announcing the establishment of a statutory inquiry under the Inquiries Act to examine the handling of the COVID-19 pandemic in Scotland.

“I am grateful to everyone who has shared their views on what the inquiry should look into, in particular bereaved families and those who have lost friends and colleagues. Their input has been key in developing the inquiry’s terms of reference.

“From my own and the First Minister’s interactions with Lady Poole, I am in no doubt that she has the necessary leadership skills, integrity and deep technical knowledge to undertake this inquiry. Her expertise in administrative and human rights law is exactly in line with our expectations of a human rights-based approach to the inquiry.

“We are committed to working with the UK Government to develop the approach to the UK-wide inquiry and expect the chair of the Scottish public inquiry to coordinate with the chair of the UK-wide inquiry.”

Lady Poole said:

"I am honoured to chair this independent public inquiry examining the strategic response to the COVID-19 pandemic in Scotland. We have all been affected by this pandemic. There has been a major impact on every aspect of all our lives. The death of so many as a result of COVID-19 is a tragedy, and others have suffered in many different ways.

“The inquiry will work independently to establish the facts in an open and transparent way in order to determine what lessons can be learned for the future. There is a great deal to be done in a short space of time. I will continue to give considerable thought as to how best to conduct the inquiry to ensure it fully achieves its aims, including a careful and thorough examination of the terms of reference.

“My immediate focus will be on getting the right people in place to support me and establishing the necessary systems, processes and information flows needed to allow the inquiry to function efficiently and deliver as quickly as possible. Work has already begun on this.

“It is too early to be any more specific about how the inquiry will carry out its functions, other than to say that the arrangements for providing both written and oral evidence will be set out in due course once the initial establishment phase is completed. A bespoke website will be created, to provide information and publish updates as the inquiry progresses.

“I look forward to collaborating with my counterpart on the UK COVID-19 inquiry once that inquiry is established."

Background

Lady Poole biography (judiciary.scot)

COVID-19 Inquiry Terms of Reference - gov.scot (www.gov.scot)

Covid Public Inquiry: Deputy First Minister statement - 14 December 2021 - gov.scot (www.gov.scot)

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Scottish politics

Bereaved Angus man launches stinging attack on judge whose resignation leaves Covid inquiry in turmoil

by Rachel Amery
October 6 2022, 6:00am

October 6 2022, 6:00am

Share

Alan Wightman with a photograph of his mum Helen, who died after being infected with coronavirus

A Forfar man has criticised senior judge Lady Poole whose shock decision to quit as chair of the Scottish Covid inquiry left the process in chaos.

Alan Wightman said the outgoing inquiry chief had lacked “empathy” and was making little progress.

His mum Helen died in May 2020 after contracting coronavirus in her care home in Leven, Fife.

Since then, he has led the Scottish Covid-19 Bereaved Families for Justice group and been a key voice in getting an independent inquiry set up in Scotland.

But the inquiry stalled after Lady Poole announced she was stepping down, citing personal reasons, shortly before it emerged four other lawyers had resigned.

'We suffered the greatest loss'

Helen Wightman, who is from Methil, had been staying in Scoonie House in Leven for a number of months when the coronavirus pandemic started in March 2020.

She started to feel unwell on April 20 and passed away on May 6.

She was one of four residents at the care home to die after being infected with the virus.

Her son Mr Wightman, who lived in Forfar at the time of her death, said: "From our perspective Lady Poole has been lacking in any empathy with the bereaved families.

Helen Wightman

"She had one 'tick box', perfunctory meeting with some of us in January and we have had nothing since, despite being promised to be front and centre.

“Lady Poole didn’t seem to understand that.

“The bereaved suffered the greatest loss during the pandemic.”

He added Baroness Hallett, who is heading up the UK-wide Covid inquiry, has met Scottish families and they felt “listened to and shown empathy” by her.

Mr Wightman added: “By contrast nothing has happened in Scotland and now Lady Poole has gone.

“I don’t know where that leaves the inquiry – is it dead in the water?”

He said it is a “good thing” she has left the inquiry, and questioned: “Why did it take so long for others to realise she was not up to the job?

“We had that sussed out back in January.”

One and only meeting was ‘disastrous’

Aamer Anwar, the solicitor representing the Scottish Covid-19 Bereaved Families for Justice, was told about the resignations by a civil servant only hours before it was made public.

He said he was on his way to London at the time to attend a meeting of the UK-wide Covid inquiry.

Mr Anwar added: “My clients are dismayed and worried.

Aamer Anwar, solicitor representing Scottish Covid-19 Bereaved Families for Justice

"The writing appeared to be on the wall when there was little to no contact with the families I represent in the last 10 months.

"We had one meeting which was disastrous."

He said he also has concerns the resignations in Scotland will also cause delays to the UK-wide inquiry.

Mr Wightman added: "I really don't want this to impact on the UK inquiry and everything Baroness Hallett has done to make it a success – I don't want Scotland to screw that up for her."

Swinney promises answers

Scottish Labour's deputy leader, Jackie Baillie, raised the resignations in Holyrood and demanded to know how bereaved families will be treated.

She also said the Scottish Government must detail when the inquiry will get back up and running, what the revised costs of the inquiry now are, and what is being done to secure a replacement for Lady Poole.

Covid-19 Recovery Secretary John Swinney told her the bereaved families "will be at the heart of this process" and must have their concerns properly aired and answered.

However he said he was not able to answer her other questions without breaking the Independent Inquiries Act.

He said Lady Poole told him on September 30 that she had resigned and that four other lawyers had resigned the day before.

Lady Anna Poole QC has stepped down as chair of Scotland's Covid inquiry.

Mr Swinney said he "considered carefully" whether to share this information and concluded it was an "exclusive matter" for the inquiry chair.

Lady Poole's resignation was then made public on October 3 but at that point no public statement was made on the other four resignations.

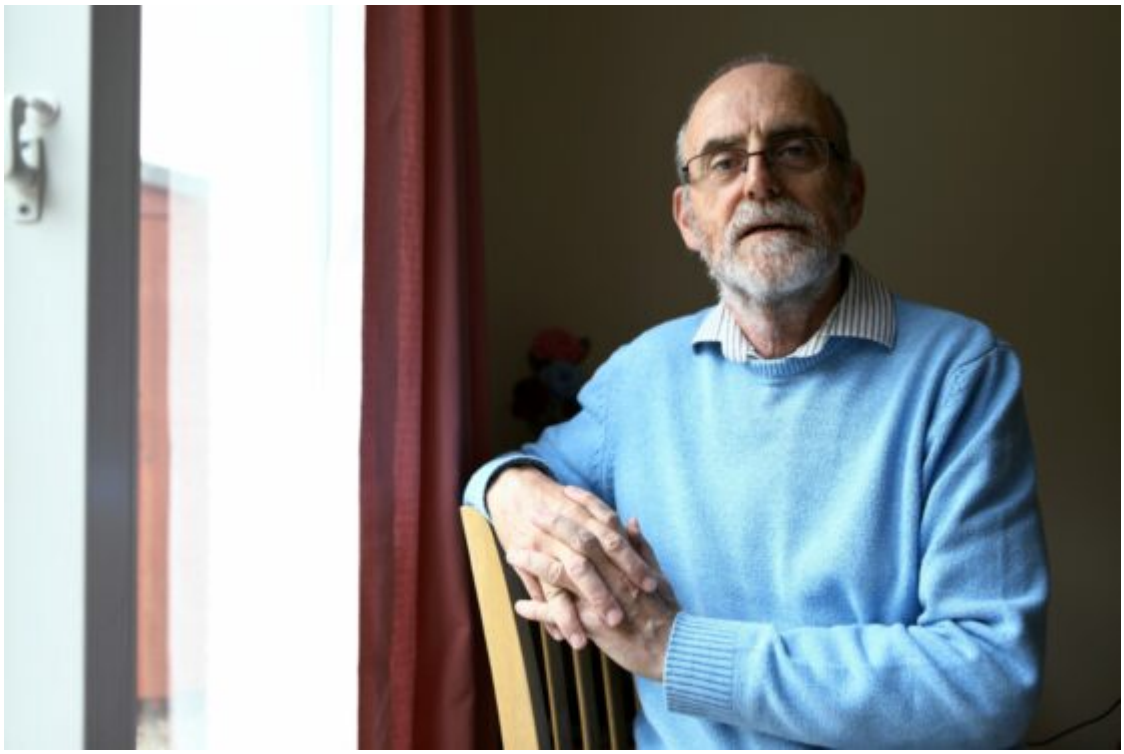
Ms Baillie has since branded Mr Swinney's response "arrogant and dismissive" and "an insult to those worrying about the progress of this vital inquiry".

Replacement needs 'experience and clout'

The Scottish Government said work to appoint a new chair is "being progressed at pace".

Mr Wightman said her replacement needs to be someone with "experience and clout" and someone who puts the bereaved families "front and centre".

He said: "It's OK if it takes a bit longer to get the right person – I don't want a hurried appointment just to fill the post, I want it to be a good appointment.



Alan Wightman.

"It is a mess, but with the right will and attention, it is a mess that can be fixed and brought back on track."

We contacted the Scottish Covid-19 Inquiry to ask why the resignations happened and why the public were not informed until almost a week later.

We also asked if there are implications for openness and transparency, and for reaction to Mr Wightman and Mr Anwar's criticism of Lady Poole.

The inquiry team declined to comment.

More from Scottish politics

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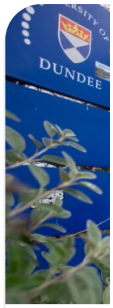

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Lord Brailsford appointed Chair of the Inquiry

Following his appointment, effective 28 October 2022, Lord Brailsford said: “I am honoured to have been appointed as the independent Chair of the Scottish COVID-19 Inquiry. The pandemic impacted everyone across the country to some degree. There is barely a family, business or organisation that wasn’t affected in some way.

"This Inquiry seeks to find out whether anything could, or even should, have been done differently and what lessons can be learned for the future.

“The public are rightly looking for answers and no more so than the loved ones of the nearly 16,000 people in Scotland who died during this pandemic. I am immensely aware of

amended to require the Inquiry to "demonstrate how a human rights-based approach by the Inquiry has contributed to the Inquiry's findings in facts and recommendations".

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Inquiry Chair meets bereaved families and relatives of care home residents

Lord Brailsford, Chair of the Scottish COVID-19 Inquiry, has undertaken an initial series of meetings with bereaved families and relatives of care home residents in Scotland.

The discussions have allowed Lord Brailsford to provide an update on the Inquiry's progress and learn more about their experiences during the pandemic in Scotland, and how they and their relatives were impacted by the lockdowns and other restrictions, such as those in residential care settings.

Lord Brailsford said: "I am extremely grateful for the opportunity to meet bereaved families and the relatives of care home residents, and very much appreciate them sharing with me their harrowing accounts of the losses they have suffered. I have learned a great deal and their experiences will be at the heart of the Inquiry's investigations."

SCOTTISH COVID-19 INQUIRY

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Scottish Covid-19 Inquiry

Day 1PH1

August 28, 2023

Opus 2 - Official Court Reporters

Phone: 020 4518 8448
Email: transcripts@opus2.com
Website: https://www.opus2.com

Monday, 28 August 2023

(10.00 am)

(Proceedings delayed)

(10.05 am)

Health and Social Care Preliminary Hearing

THE CHAIR: Good morning. I am Lord Brailsford, Chair to the Inquiry, and I'd like to thank you all for attending our first public hearing. I am honoured to have been entrusted with such an important undertaking on behalf of the people of Scotland.

Let's adjust this mike a little bit.

Today I'm here to share with you the approach I intend to take to the task I've been set, which is to establish the facts of and to learn lessons from the strategic response to the COVID-19 pandemic in Scotland between 1 January 2020 and 31 December 2022, the period covered by this Inquiry.

Before we begin, however, I would like to address bereaved families, care home relatives and all of those of you here today and watching online who were impacted by the pandemic and who are looking to this Inquiry for answers. We all hold at the forefront of our minds the very difficult and distressing experiences so many have had. In particular we remember those who have lost their lives and those who were separated from their

families, key workers who did all they could to alleviate suffering and the many people who are still affected by COVID-19 and the pandemic.

I wish to express my sincere condolences and those of the Inquiry team to those of you who lost relatives and friends to COVID-19.

I would now like to invite you to watch a short film as we reflect on the impact of the pandemic on the people of Scotland. This film is intended as formal and lasting recognition of the suffering caused by the COVID-19 pandemic. You may find some of the images and words in this film distressing and you may prefer not to watch. I will pause for a few moments for anyone to leave the hearing room or suspend the live-stream if you are watching online. I should tell you that the film lasts a little over 11 minutes. So we'll pause for a moment or two. It doesn't appear as if anyone wants to leave so could the film please start.

(Video played)

Now, I'm sure the film has brought back many memories for all of us in this room and those watching online. I can tell you it will be published on our website and can be viewed throughout the lifetime of the Inquiry.

The purpose of this preliminary hearing today is to

provide you with an update on the work undertaken by the Inquiry to date and to set out our plans for hearings this autumn and the relevant processes and protocols. What we will discuss today relates only to our health and social care hearings. Further information about our approach to future sets of hearings will be set out at a later date.

This preliminary hearing and the Inquiry itself is not a court. We are not here to determine criminal or civil responsibility; we are here to examine what happened in Scotland in a non-adversarial manner, working with core participants and gathering and analysing the experiences of people across the country. While you do not need to be a core participant to engage with the Inquiry, these organisations have some additional rights. We have 37 core participants to this Inquiry, many of whom are with us in the room today. They play a central role, working with the Inquiry to fulfil its terms of reference and ensure our terms are met.

When I was appointed Chair of this Inquiry by the then Deputy First Minister in October 2022, I was under no illusion as to the importance and magnitude of the Inquiry's work. The COVID-19 pandemic presented the most severe health crisis in living memory. It affected

everyone. More than 17,700 people have died in Scotland with COVID-19 listed as one of the causes on their death certificate, many without being able to say goodbye to their loved ones, and thousands of people are still living with the consequences, including those with long COVID and others whose mental health has suffered because of the pandemic. Care home residents and many of those required to shield because of underlying health conditions had long periods with no contact with their families and friends. Some people were unable to receive the medical treatment they urgently required. Young people's education was disrupted and educational opportunities were missed. Businesses faced financial hardship, some of them failed and jobs were lost. Health and social care workers faced huge pressures as they sought to save the lives of critically ill patients and keep us all safe. They, along with teachers, police officers and thousands of other emergency and key workers, risked their lives in the course of duty. Politicians, local government leaders, NHS boards and others found themselves in an unprecedented situation and were required to respond to a virus that was spreading rapidly and mutating. They had to make decisions at pace that impacted upon the entire population. They shouldered this responsibility for

many months.

I will conduct a robust investigation without fear or favour that will arrive at the facts, identify any lessons that need be learned and make recommendations to Scottish ministers so we are better prepared in the event of any future pandemic. I will not take sides and I will act with fairness towards all parties involved in the Inquiry process.

I'd now like to invite Mr Stuart Gale KC to make some opening remarks.

MR GALE: Thank you, my Lord.

Good morning, everybody. Can I also thank everyone present here in Murrayfield and also watching us online for joining us today in what is the first preliminary hearing of this Inquiry and indeed a very important milestone in the Inquiry. As some of you may know, I am Stuart Gale King's Counsel and, together with my colleague, Laura-Anne van der Westhuizen King's Counsel, we are the co-lead counsel to this Inquiry.

Our responsibilities, so far as the investigative work of the Inquiry and indeed the presentation of the evidence, are divided between us and our respective teams. You will be aware perhaps from the Inquiry's website that we have structured our investigative work into four portfolios. My team and I are responsible for

Portfolio 1, which is the public sector response, and Portfolio 3, which is of specific significance today. That is the provision of health and social care services. Ms van der Westhuizen and her team are responsible for Portfolio 2, which is the financial and welfare support to businesses and individuals, and Portfolio 4, which is education, certification and impact on children and young people.

My counsel team comprises advocates Alan Caskie, who is here with us today, and Faryma Bahrami. Ms van der Westhuizen's team comprises advocates David Turner and Mary Ellen Stewart. In addition our counsel teams have further counsel input from advocates Chris Stephens, Dennis Edwards, Graham Dunlop and Sarah Trainer. Each counsel team works with a dedicated team of solicitors and paralegals and support staff. Various specific investigative streams have been and will continue to be allocated to various members of the counsel and solicitors' teams.

In these introductory remarks from me I would like to reflect, if I may, on some of the matters touched on by Lord Brailsford in his opening remarks. At the very outset Lord Brailsford mentioned the honour that his appointment represents and the appreciation of the nature and extent of the undertaking which lies before

him. None of us associated with this Inquiry is under any misapprehension as to the scale of the task before us. It is immense and to a certain extent it is daunting. Speaking personally and on behalf of the whole counsel team, we are all honoured by the fact that Lord Brailsford has placed his trust in our abilities to perform the roles of Counsel to the Inquiry. Our role in the Inquiry is to be independent and to perform our duties to the best of our professional abilities, and we do that, as Lord Brailsford has said in the general context of the Inquiry, without fear or favour. All of us intend to carry out our duties in that way.

Both Lord Brailsford and I have had the honour of meeting members of both the Scottish Covid Bereaved and Care Home Relatives Scotland. In those meetings we heard distressing accounts of the loss of loved ones, the circumstances experienced both before and after that loss and the impact of being separated from loved ones, particularly in circumstances where that loved one had a compromised understanding of the reasons for that separation or isolation. To all those relatives and indeed to those individuals, whether in care homes or in other settings, the counsel team through me conveys their deepest condolences and sympathies.

Most of us have experienced personal loss, whether

it be of a loved one, a family member, a dear friend. The circumstances attending such loss are inevitably difficult to deal with. To try to have to cope with the circumstances of loss in the overall context of the restrictions imposed by outside authorities, all in the context of a pandemic, are completely unparalleled.

In addition to those who tragically died during the pandemic and those who had to deal with the impact of the pandemic and its restrictions in visiting loved ones in care homes and other settings, we, as a counsel team, are mindful also of the impact that the pandemic had on workers in the healthcare sector in particular and those impacts are relevant to our investigations. Indeed, if I may be permitted to make a personal observation, having watched now for I think the third or fourth time the film that we've just seen, there was a quotation from a nurse in that film, and she said this:

"Feeling we were failing everyone bore down hard on us as nurses. Our best was rarely good enough."

That was then followed by a photograph of a trainee advanced critical care practitioner in full PPE with bloodshot eyes. That was a particularly moving reminder of the impact that caring for people during the pandemic had on those in the caring professions.

Lord Brailsford has said that the role of this

Inquiry is to establish the facts of and learn lessons from the strategic decisions taken in response to COVID-19. Establishing the facts and the critical examination of those facts will lead to recommendations, the intention of which will be to provide an informed basis for an approach to dealing with another pandemic, should one occur.

As a counsel team, we are committed to the establishment of those facts and to a critical examination so that lessons can be learned. We will not hold back in examining and stating anything we consider to have been mistakes in the strategic decision-making process. Some chairs of previous inquiries have been sceptical of the success that inquiries have achieved in providing the basis for different approaches to similar circumstances. If I can give one example, Dame Janet Smith, who chaired the Shipman Inquiry, said this:

"If the success of public inquiries is judged in terms of changes in regulations and legislation, then we cannot often claim to have achieved that."

Now, we are aware of that critical approach and we are determined that this Inquiry will be a success in providing recommendations to decision-makers so that they are better prepared in the event of a future

pandemic.

In saying all this, we are mindful as an inquiry that COVID-19 remains in Scotland as well as in the UK more widely an issue. The National Records of Scotland for the week to 13 August of this year disclose that 17 deaths were recorded during that time in which COVID-19 was mentioned and that there have been also recent media reports of new variants emerging and new mutations. More recently Professor Jason Leitch, the National Clinical Director, stated in an interview last week that 200 people were admitted to hospital with the virus in the previous week. Also, over the weekend, we have been aware of further press reports regarding the closure of certain hospital wards due to the presence of COVID and again also of further mutations.

It seems reasonable to assume that COVID-19 is not behind us and we therefore take extremely seriously our obligation to identify the lessons to be learned from the pandemic that we have just been through.

Can I now pass back to Lord Brailsford to provide an update on the progress of the Inquiry so far?

THE CHAIR: Thank you very much indeed, Mr Gale.

Now, in this section we will provide updates in a number of areas, including staffing and premises, planning and structure of the Inquiry, the approach the

Inquiry will take in terms of human rights, being person-centred and trauma-informed, connections with the UK Inquiry and with the Crown Office and Procurator Fiscal Service and gathering evidence. I should say that between myself and Mr Gale we will share the informing you about these various heads, under these various heads.

So I will start with staffing. Over the last few months the Inquiry has undertaken a number of recruitment exercises to further expand the team to conduct the investigation. That process is advanced, with new team members now in post or joining soon. In July I welcomed Mr Ian Duddy to the Inquiry as Chief Executive and you heard very briefly from Mr Duddy earlier this morning. As chief executive, Mr Duddy is the Inquiry's most senior official and will be responsible and accountable for the administration and management of the Inquiry. He brings to the Inquiry more than 20 years' experience in leadership, advocacy and human rights, having served as a senior diplomat, a UK ambassador and former Chair of the Scottish Human Rights Commission. I am confident that Mr Duddy's extensive leadership experience will ensure the Inquiry continues to proceed apace. He will also be instrumental in assisting me in upholding my commitment

to conducting a robust, independent investigation and adopting a human-rights-based approach in arriving at its findings and recommendations.

As some of those present today will be aware, the secondment of Ms Joanna Bain, the Inquiry's interim solicitor, will end on Thursday, 31 August, three days' time. I would like to thank Ms Bain for her significant contribution to the Inquiry to date and wish her well with all her future endeavours.

I am happy to announce her successor as interim solicitor is Mr Gordon McNicoll, who is sitting on my left, although he's probably quite hidden from you, I fear. Mr McNicoll is an experienced solicitor who brings with him experience of working on other independent public inquiries. Mr McNicoll has already taken up post and is with us here today, as I've already said. Recruitment for the permanent appointment to this post is ongoing. I will ensure core participants are informed once this recruitment exercise has concluded.

If I now turn to premises. We have been working in our offices at Waverley Gate at the end of Princes Street for most of this year. The space the Inquiry team is using currently will become our hearing suite and we will move to another office space within the same building. The refurbishment works to make the

hearing space suitable and accessible will be completed in summer 2024. We are therefore planning to use other buildings for our hearings scheduled before then. We will use the Land Court space at George House in central Edinburgh for our first impact hearings in October and Mr Gale will say more about this shortly.

We recognise that those giving evidence may wish to have family members or friends close by and that we may not be able to accommodate everyone in the hearing room at George House. We are putting the needs of families and the bereaved very much at the forefront of our consideration of suitable spaces to hold hearings. Therefore we are hiring additional space close to George House where the proceedings will be live-streamed and families and friends can watch and have access to refreshments. We will have a hearings and witness support team in place for those hearings and will ensure that appropriate emotional support is available to those who need it, both in the hearing space and in the additional room where the live-stream will be shown.

A named support officer will be available for those giving evidence prior to their attendance on the day. The support officer will ensure those giving evidence know what to expect when they attend, have the opportunity to visit the hearing space beforehand and

receive support on the day. The support officer can also provide signposting to organisations that may be able to help to provide bespoke or ongoing support if that is required. This forms part of our person-centred and trauma-informed approach, and I will say a little more about that later today.

I would now like to pass back to Mr Gale to tell you something about the planning and designing of the structure of the Inquiry.

MR GALE: Thank you again, my Lord.

I would like now to share with you information about the structure and approach that we propose to take with our investigations and hearings. Again this is in the context of the health and social care hearings that are upcoming. The Inquiry is adopting a thematic approach. The themes are health and social care; education and young people; and finance, business and welfare. For each of these themes the Inquiry will look at the impact of the pandemic first, then the implementation of measures and, finally, key decision-making.

Our approach seeks to bring the experiences of people in Scotland to the forefront of the Inquiry's investigations and the presentation of evidence, ensuring that the human impact of the pandemic is captured first. This is a deliberate choice on our part

and I consider it right at this stage that I should explain a little more detail about the reasoning behind that choice.

Last year the counsel team gave advice to his Lordship as to how we saw the order of consideration in this Inquiry. In giving that advice, our view was that impacts were likely to have been contingent upon the decisions that were implemented. In essence, decisions have consequences. The fact and existence of decisions and their implementation gave rise to the impacts. It was our view that it would not be possible to consider decision-making without first considering the impacts. As further consideration was given to that approach, we became more satisfied that consideration of impacts should precede consideration of implementation and decision-making. In simple terms, we considered that, in order to properly consider the quality and nature of the decisions made and the way in which they were implemented, the Inquiry first needs to consider the impact of those decisions in the real world.

The counsel team made this recommendation to Lord Brailsford and, after discussion with him, he accepted the recommendation. Thereafter the approach was further refined. In particular, it was decided that the examination of impacts should begin with the impacts

in the health and social care setting and that we should conduct detailed examination of those impacts. I should emphasise that the counsel team was not persuaded by the suggestion that impacts did not require detailed consideration on the basis that those impacts were obvious.

I can perhaps give an example of the subtlety of certain impacts that would not, in my view, be regarded as obvious. Recently I have seen one witness statement where the individual who gave it had certain vulnerabilities and they indicated that some of the advice created in their mind a level of fear which had an adverse impact on their confidence and affected their coping mechanisms that they had come to rely on in dealing with their vulnerabilities.

There were a number of reasons we made a positive decision to commence our impact hearings with those in the health and social care setting. As Lord Brailsford will explain, the Inquiry has adopted a trauma-informed and human-rights-based approach to our investigations and our hearings. With that in mind, we considered it appropriate that in our evidential public hearings we begin without delay consideration of those people who wish to engage with the Inquiry and who have suffered loss and/or trauma of separation from loved ones. We

are also minded that much of the evidence from such witnesses will depend on personal recollections without the aid of extensive contemporaneous written records and, with that in mind, we feel that we should bring this evidence to the fore.

A further consideration that we have in mind is that, while our principal role is information-gathering, we appreciate that for many involved in public inquiries, providing a public statement, whether that is simply the statement or one which is then expanded upon at an oral hearing, is a cathartic experience and we are anxious to provide that opportunity.

It is right now that I give an indication of our programme of impact hearings in the health and social care setting.

The Chair has to strike a balance between the need to report as quickly as practicable so that lessons can be learned and ensuring that the Inquiry conducts a robust, open and independent investigation which gets to the truth and makes recommendations grounded in evidence and informed by the experiences of the people of Scotland. In addition he has a statutory duty to act fairly and with regard to the need to avoid unnecessary cost.

By necessity this means the Inquiry will not be able

to hear from everybody who wishes to give a formal witness statement or provide formal oral evidence at a hearing. To do so would lead to unacceptable delay in terms of reporting on findings and making recommendations. However, we will invite a number of organisations and individuals to appear as witnesses at our impact hearings. Those organisations and individuals will also provide signed witness statements which will be published on the Inquiry website and will form the basis for counsels' questioning of witnesses.

The impact hearings will begin on Tuesday, 24 October of this year. Weekly sitings will be from Tuesday to Friday of each week. The hearing will start at 10.00 am, continue through to about 11.30 for a mid-morning break and resume thereafter until 1 o'clock. We will then resume after lunch at 2 o'clock and continue until 4 o'clock or thereby, with a short mid-afternoon break. There will be flexibility in these timings and particularly about the finishing time if it is necessary to complete the evidence of a witness.

It is my intention that we begin with what we are terming "representative" statements on impacts. These will be from representatives of organisations speaking to the sorts of impacts that people associated with their organisations experienced. The organisations will

include those which were established during or just after the pandemic as well as from organisations which were established before the pandemic and continued to operate during it. In this regard the Inquiry has been in contact with a number of charitable organisations as well as other organisations established to assist with those having particular needs. The decision to take such evidence was instigated after certain members of the counsel team, including myself, held meetings with a number of organisations and they provided anecdotal information in respect of groups that they had supported during the pandemic. We anticipate that those representative hearings will probably take two weeks.

From the third week of hearings I expect to commence hearing from members of Care Home Relatives Scotland and Scottish Covid Bereaved and we are grateful as a counsel team and as an inquiry generally to Mr McGuire, Mr Anwar and their teams for facilitating engagement with members of the client groups that they represent. Further, we are grateful to members of those groups who have already provided witness statements and to those who are making time to engage with the Inquiry team to allow further statements to be taken.

As has been made clear, not all members of those groups will be called to give oral evidence and the

decision as to who gives oral evidence will be one for me and my team, but I can assure you that we will try to ensure that a broad range of impacts arising from this tragic situation are presented in oral evidence and I would wish to emphasise that all statements given by members of those groups -- and this applies to all groups and all others who provide statements -- will be considered and account will be taken of them.

It had originally been my intention in these initial hearings to only take evidence from those who suffered bereavement in the care home setting. On further reflection it seemed to me that to do so would be an unnecessary division and, mindful of the distress giving evidence of bereavement will inevitably cause, I have concluded that witnesses from these groups will give evidence of deaths of loved ones experienced in all settings.

I do not intend to place a limit on the length of time that witnesses from either group or indeed any other witnesses will take and, as with the scheduling of all witnesses to the Inquiry, there is no case of preference or prioritisation being given. The Inquiry intends to complete this first tranche of impact hearings at the conclusion of the week ending Friday, 8 December. We want to finish before the festive period

as we appreciate that, for many people who have been impacted by the pandemic, this will have been and will continue to be a very difficult period.

Therefore we will continue our engagement with the Care Home Relatives Scotland and the Scottish Covid Bereaved and their legal representatives, beginning as it has already and will continue, with a view to completing the witness—statement—taking process, and I should say that last week we were very grateful to have been provided by Mr Anwar and his team a total of 66 statements from members of the Scottish Covid Bereaved group and we are in the process of examining those statements, reviewing them, analysing them and, if necessary, seeking further clarification in certain areas.

For those individuals who are asked to provide oral evidence at the impact hearing, the Inquiry team will explore their availability in order to inform scheduling of the witness timetable. This is all with the ambition of having called all relevant witnesses in this area by 8 December, subject obviously to availability.

The Inquiry obviously has an idea of the number of witnesses who are likely to give evidence —— we have a very clear idea of that —— in these groups and also in the representative organisations that I've referred to.

It seems to us that, given the anticipated numbers of witnesses, it is quite possible that the witnesses from these groups will occupy the entire period to 8 December. Thereafter we will continue with our investigations, and I should say that our investigations do not stop during the presentation of evidence. Our investigations are ongoing, as they have been now for many, many months. We will continue with our investigations but we will not hold further public hearings until February 2024 so that we do not overlap with the UK Inquiry's Module 2A hearings, which are on Scottish matters and which will be held in Scotland.

From February we expect to run until Easter, continuing with public hearings on health and social care impacts. The reason we are not being specific at this stage about the exact number of weeks or the witnesses at this point is that we are mindful that many of the witnesses we call will have suffered bereavement or loss and we wish again to make a trauma—informed approach to all these hearings, not rushing witnesses to get through to a fixed timetable.

Our intention for the remainder of 2024 is to hold hearings on the impacts on education and young people and, after that, on the impacts, both human and economic, on finance, business and welfare. These

obviously, as I've said earlier, fall within the portfolios that are headed by my colleague, Laura—Anne van der Westhuizen. We will then return to health and social care and hold hearings on implementation, hearing from those who took decisions to put into practice the legislation and guidance in the health and social care sector over the period that we are investigating.

Can I ask Lord Brailsford now to expand on the approach of trauma—informed and human rights?

THE CHAIR: Thank you again, Mr Gale.

Now, the trauma—informed approach we are taking with respect to health and social care impact hearings will be embedded in all the Inquiry's work. While our purpose and terms of reference are set by Scottish ministers, it is for me, as Chair of the Inquiry, to set out how we will engage with others, how we will organise ourselves and how we will deliver these outcomes. I want to ensure that every person and organisation engaging with the Inquiry feels they have been treated fairly and feels that they have been heard. I know that many of the people the Inquiry will be engaging with have suffered loss of different kinds. Everyone working in the Inquiry has had training in trauma awareness. Those colleagues working in direct

contact with individuals who have been bereaved or suffered other losses have had specific, more in—depth training so they are equipped with the skills they need to conduct their tasks. While it is not the role of a public inquiry to provide counselling, we will provide emotional support at hearings through our own team and, where appropriate, through partner agencies.

When reporting at the end of the Inquiry, I am required "to demonstrate how a human rights—based approach by the Inquiry has contributed to the Inquiry's findings in facts and recommendations". This means taking a human—rights—based approach from the beginning. I want to set out here how I intend to do that.

A human—rights—based approach goes beyond a series of specific actions. I view it as the philosophy of the Inquiry and embedded in our approach to how we conduct our work in accordance with the terms of reference. We will apply this philosophy when scrutinising the extent to which decision—makers and those implementing measures set out in legislation and guidance had regard to human rights considerations. When investigating the 12 areas in our terms of reference, we will consider ways in which the strategic handling of the pandemic may have had an adverse effect on the exercise of human rights. As measures varied over time, we will consider

developments of legislation, guidance and policies individually and cumulatively and the extent to which regard was given to human rights and equalities duties.

It is important to remember that my role is not to determine if rights have been breached in individual cases or circumstances. However, when the Inquiry makes findings about lessons learned, where I determine it is relevant, I will consider and comment on any adverse effects on the exercise of human rights or equality issues.

On the issue of equalities and any disparities or unequal impacts, I am bound in the terms of reference to consider these as I deem appropriate and necessary. A statement of how we will embed a human-rights-based approach in our work will be published on our website in advance of our October hearings.

I would like now to turn to our relationship with the UK Inquiry. I recognise that people living in Scotland may be affected by and indeed interested in the investigations of both the Scottish COVID-19 Inquiry and the UK Covid-19 Inquiry. The response to the COVID-19 pandemic involved both Scottish and UK authorities. This Inquiry will only investigate areas within the devolved competence of the Scottish Parliament. However, as Chair, I recognise the importance of it

being clear to people which Inquiry is responsible for looking at particular issues and both inquiries have an obligation in our terms of reference to take steps to minimise any duplication of evidence gathering, investigation and reporting.

I have had several discussions with Baroness Heather Hallett, Chair of the UK Covid-19 Inquiry, about how our two inquiries might work together to share information and maximise value for money to the public purse. In February of this year, we signed a memorandum of understanding which formalises our agreement. This commits us to providing clear information to the public about how each inquiry will conduct its investigation in Scotland to enhance public understanding of its work, including both public engagement exercises, Let's Be Heard and Every Story Matters.

Officials and solicitors meet regularly and share information and planning where possible on areas which are within both our terms of reference. While we do not share evidence directly with each other, we endeavour to minimise the burden on material providers by sharing our requests for information so that, where such requests meet each other's needs, these are identical and require one search rather than two. Earlier in the summer we held a meeting for organisations which are core

participants in both inquiries. This was found useful by all parties and is something we would be pleased to arrange again at suitable points in time.

Where possible we will organise our timetabling of hearings to ensure we do not hold public hearings at the same time as each other. However, we are mindful of our own responsibilities in conducting our separate independent inquiries. I need to consider the interests of those who are not part of the UK Inquiry and who deserve to see this Inquiry's progress in a reasonable timescale. It will not be possible or desirable therefore to avoid having public hearings which overlap at times.

After the festive period, when the UK is holding its Module 2A hearing, which is specifically about Scottish matters, we will pause our own hearings. However, neither inquiry can guarantee there will not be overlapping hearing schedules at other times, when the focus of the UK Inquiry hearings is not Scotland-specific. Our particular meetings with our UK Inquiry counterparts will assist us in planning this and both inquiries will be flexible in responding to situations where the same witness or witnesses may be scheduled for a particular set of hearings.

I now ask Mr Gale to again represent to you in

relation to the relationship with the Crown Office.

MR GALE: Thank you, my Lord.

In the same way in which we and the UK Inquiry respect each other's independence, we and the Crown Office and Procurator Fiscal Service respect the distinct and independent roles each has. The Inquiry is aware of the investigations being carried out by Crown Office into deaths which occurred in care and nursing homes and other settings during the pandemic and the importance of avoiding, wherever we can, the possibility that work carried out by the Inquiry prejudices those investigations or any subsequent proceedings. The Inquiry and the Crown Office have already established an ongoing dialogue relating to these matters and will continue a channel of communication concerning their respective work and the Inquiry will discuss with all legal representatives of core participants and others in the event that we consider that it may be appropriate or necessary to defer participation in the Inquiry to a later date.

THE CHAIR: Thank you again, Mr Gale.

Now, an update on evidence gathering. Using my powers under the Inquiries Act 2005, I have required public bodies, including the Scottish Government, to produce documents relevant to the Inquiry's

investigations. We estimate that during the course of this Inquiry we will review and analyse millions of such documents, with the aim of producing a factual record of the key strategic elements of the handling of the pandemic.

Rule 8 and Section 21 notices are the two avenues at the Inquiry's disposal to pursue to recover documents and evidence from individuals and organisations. A Section 21 notice gives the Chair of the Inquiry the power to compel an individual or organisation to hand over documents and evidence to the Inquiry. In contrast, a Rule 8 request is for the voluntary provision of records and evidence. The Inquiry has published a full list of the recipients of Rule 8 and Section 21 recipients on our website.

When embarking on its evidence-gathering process, the Inquiry was mindful that information relevant to its investigations may include communications shared via WhatsApp and other private messaging applications. To ensure that such material is not lost or destroyed, in August 2022 the Inquiry issued "Do not destroy" letters to organisations and individuals which may hold information relevant to the Inquiry's investigations. Those letters, which made specific reference to WhatsApp and text messages, emails and other communications,

require such information to be preserved and retained so it is available to the Inquiry as and when required.

The Inquiry is examining all the material that has been provided to it by Scottish Government and other parties. As this process continues, I will decide whether any further calls for evidence are required. Where documents and requests for information are required by these hearings, we will endeavour to engage as early as possible with document-holders to understand demands on organisations and co-ordinate requests for evidence where practicable.

While I do not have power to make any findings of criminal or civil liability, I will continue to use my powers as Chair to the Inquiry to obtain evidence and to compel the production of documents and the appearance of witnesses. I will not tolerate any attempt to obstruct or hinder the work of this Inquiry.

Can I now ask Mr Gale to tell you something about Let's Be Heard?

MR GALE: Thank you again.

Earlier it was mentioned today that you do not have to be a core participant to engage with the Inquiry. For most people in Scotland, the principal channel for sharing your experiences with us is through our listening project, Let's Be Heard. It aims to give

a voice to as many people in Scotland as possible. Let's Be Heard allows people to tell us about their experiences in the pandemic, how these affected them and any lessons that they believe should be learned or could be learned from those experiences. We are gathering and analysing the thousands of experiences the people of Scotland have kindly shared with us through Let's Be Heard.

Provision of information to Let's Be Heard is a formal submission to the Inquiry, therefore project staff are working closely with the Inquiry's legal teams in engaging with both organisations and individuals. In addition to facilitating the identification of potential witnesses, the experiences gathered through Let's Be Heard will help guide the Inquiry's investigations and inform its reports and recommendations.

I can perhaps just reiterate that the quotations that you saw on the film that was played this morning were, in the main, obtained from representations and communications received by Let's Be Heard.

The process that we are undertaking will include identifying any disproportionate or unequal impacts on particular groups or communities. The legal team review the evidence received by Let's Be Heard and may follow

up with individuals to ask if they would provide a further statement to the Inquiry.

In addition to our online platform and paper forms, Let's Be Heard has created a bespoke Engagement Guide to encourage organisations to engage with their members in a way that best suits them. Let's Be Heard asks to attend events where invited and offers financial support to help meet accessibility needs. Let's Be Heard is also designed with accessibility in mind, but we understand that some may face further barriers in participation. We encourage people to contact Let's Be Heard if they have any queries or require any additional materials, any translations, languages or formats, so that they can find a way for people to engage with Let's Be Heard.

A dedicated team of researchers and analysts has been recruited to the Inquiry to analyse these responses and Let's Be Heard will publish a series of reports based on key findings of the experiences shared by the public in Scotland. The reports will provide insights into the issues, impacts and recurring or emerging themes.

So far Let's Be Heard has received 2,800 responses from individuals and groups and will continue its national engagement approach until the end of this year.

I'm grateful to the team for providing detailed information with regards to the geographic spread of the responses into Let's Be Heard. It is pleasing that Let's Be Heard has received individual responses from people in every local authority area in Scotland. Based on a preliminary analysis of submissions, it is perhaps, however, unsurprising that almost a quarter of all responses have come from the City of Glasgow and the City of Edinburgh areas. Certain areas that we have heard less from include, for example, West Lothian, North Lanarkshire and Fife, and I would welcome as many people as possible from those areas and indeed across Scotland broadly to engage with Let's Be Heard. Frankly, we all have an experience that can be conveyed to us.

Both Let's Be Heard and the counsel team are eager to ensure that we hear from ethnic minority groups in Scotland and I would use this platform to ask that members of such groups engage with the Inquiry, either directly or through Let's Be Heard, in order that we are informed of the impact of the pandemic on members of such groups and their suggestions of any lessons to be learned so that they can be incorporated into our investigations and final recommendations.

Let's Be Heard will undertake a more targeted

approach this winter and beyond, which will include more specific engagement and research, such as focus groups and workshops, as requested by the Inquiry's investigative teams, in order that we can fulfil any information gaps and provide a more detailed information base.

Aligned to this, I wonder if I could refer briefly to academic research that the Inquiry has instructed and undertaken. So we have been able to call on independent academic research of the highest quality.

When the Inquiry was established in December 2021, it commissioned introductory scoping research from academics considered to be leading authorities in their respective fields to provide context for the Inquiry's investigative portfolios. This research has been crucial in helping direct our investigations and covers many, but not all, of the areas within the Inquiry's terms of reference and from a multitude of perspectives.

In keeping with the transparent way in which we are working, these scoping research reports were published on our website in June 2022 and included research from academic institutions including the Universities of Dundee, Edinburgh, Edinburgh Napier, Glasgow, Highlands and Islands and Birmingham.

These reports covered the period up to April 2022.

We issued a second call for academic research in January of this year to extend the scope of research to cover the entire period of the Inquiry, that is up until 31 December 2022. As well as additional areas identified as important, we are preparing to publish these additional reports on our website in the coming weeks and months.

I have found the high-quality research which has been produced to date to be extremely instructive as we conduct our investigations and prepare for our public hearings and I'm very grateful to all the academics involved for their continued invaluable input into our work.

This research is one of many sources of evidence of the Inquiry which we will consider before we report, and it follows, therefore, that the content of the research we have received and will receive in future should not in any way be seen to pre-empt the eventual conclusions and recommendations that we will make.

Could I also say some words about the science and epidemiology? As COVID-19 spread across the world, we all found ourselves in unchartered territory. Decisions regarding Scotland's response to the emerging pandemic were taken against the backdrop of evolving science regarding the nature and transmission of COVID-19 and

the race to develop and then roll out effective vaccines.

In July of this year Dr Ashley Croft provided a report and a presentation on the epidemiology of COVID-19. We will be hearing from other epidemiologists and public health experts as we continue our investigations. In addition, we will be analysing academic research and materials published by a wide range of sources, including those commissioned by the UK Inquiry, where relevant to our terms of reference.

None of the findings of these expert reports and academic research papers is binding on the Inquiry, which will reach its own conclusions on all matters within the terms of reference. We will also be examining the science which informed the alternative strategic approaches taken by countries around the world to managing the pandemic. We will explore what factors influenced the contrasting approaches taken by countries such as New Zealand and Sweden and how these compare to the decisions taken in Scotland.

Now back to Lord Brailsford on the matter of reporting.

THE CHAIR: Although I think we will have a pause. Thank you very much, Mr Gale.

That has been a relatively large amount of

information and I appreciate you've all been very patient over the course of almost an hour and a half and I also don't forget, of course, that much of this for many of you has been quite emotional. So we'll have a break now of about 15 minutes or thereby, which should have us back —— my computer has conveniently switched itself off, as these things do at the moment, so I'm not sure of the exact time. I think it's about 11.20 —— so around about 25 to or 20 to 12. Thank you very much. We'll pause for a moment.

(11.21 am)

(A short break)

(11.48 am)

THE CHAIR: Welcome back.

Now, I think I said just before the break that I would turn now to reporting. It's not possible for me to say at this stage how long the Inquiry will take to reach its final conclusions, but we will, of course, report as quickly as we can whilst ensuring we conduct a robust, thorough, independent investigation which establishes the facts and identifies any lessons that need to be learned so that Scotland is better prepared for the future.

As the work of the Inquiry progresses, it is my intention to publish interim reports as and when

I consider it to be appropriate to make sure interested parties are kept informed. Again, I can't say how many we will have. It will very much depend on when it seems appropriate to do that.

I turn now to specific protocols which are probably of primary interest to those that will be —— solicitors who will be responsible for looking after the affairs of their clients in a practical sense. So I'm going to deal with protocols and orders, firstly restriction orders.

A number of questions have been put to the Inquiry in advance of today's proceedings relative to anonymity, disclosure and use of identifying information. As Chair, I have been clear that I consider it important that this Inquiry carries out its work in as open and transparent a manner as is possible and that its proceedings are conducted in public. However, I appreciate that there will be circumstances where it would not be appropriate to do so and that it will be necessary and in the public interest to keep some of the evidence provided to the Inquiry private.

One of the powers available to me as Chair is the power to make an order known as a "restriction order", which restricts the disclosure or publication of specific information. These orders remain in force

unless and until I decide they should be changed or cancelled and usually remain in force at least until the Inquiry has ended but often beyond that.

I made one of these restriction orders on 5 May this year, known as "Restriction Order 1 —— Health and Social Care". The effect of that order is to impose restrictions on the publication or disclosure of evidence or documents produced by or provided to the Inquiry pertaining to health and social care in the Inquiry's investigation of matters covered by Terms of Reference (g), (h) and (i) and, where appropriate, Terms of Reference (c), (d), (e) and (f). It is important to note that this order applies equally to the Inquiry itself as it does to core participants.

The Inquiry is very grateful to individuals who are coming forward to provide witness evidence and is acutely conscious of the need to ensure sensitive information is given appropriate protection. In terms of how Restriction Order 1 works in practice, it first creates a category of protected persons who will benefit from the protections set out in the order. Those are: persons who apply to give evidence to the Inquiry in respect of the Inquiry's impact hearings on health and social care; that person's family members; persons and/or their family members who were in receipt of care

in a residential care setting or hospital or in receipt of health and social care in the community alongside the witness; the name of the residential care setting, hospital or other care setting; the name of individual carers, whether paid or unpaid, and healthcare providers; a person who was a key worker, although this is subject to certain exceptions.

Restriction Order 1 prohibits the disclosure or publication of information that can enable a protected person to be identified unless I give my express written permission to the contrary. What this means in practice is that careful consideration will be given before documentation is disclosed by the Inquiry in unredacted form to ensure that the information falling within the terms of the restriction order is kept private.

There are exceptions to the restriction order; for example, where we receive evidence which includes allegations of criminality, the Inquiry may disclose the identities of a protected person to Police Scotland. Therefore, I would encourage all core participants to ensure their legal representatives have reviewed Restriction Order 1. It can be found on the Inquiry's website.

I also want to remind core participants of the terms of section 36 of the Inquiries Act 2005. This provides

that where a person fails to comply with or breaches a restriction order made by the Inquiry, I may refer the matter to the Court of Session. Any breach of the restriction order will not be treated lightly and I request in the strongest terms that all legal representatives and core participants ensure they are familiar with its terms.

I would like to say something now about anonymity. I am aware that there may be circumstances where individuals may wish to provide evidence to the Inquiry but may be concerned about any personal or professional implications of them doing so. Therefore I wanted to address today the matter of whether an individual can provide a statement to the Inquiry anonymously.

I consider that anonymity for those providing evidence to the Inquiry will only be granted if the reasons why it is required have been properly justified. This would be done on a case-by-case basis and would involve the individual or their legal representative setting out in writing why it is needed and who should be covered by it, and that will enable me to make a decision on that matter.

Criticism. Some core participants have raised questions with me about whether they will have the opportunity to respond to any criticisms made about them

by witnesses to the Inquiry. I would like to highlight section 10, subsections (a), (b) and (c) of Restriction Order 1, which enables the Inquiry to disclose the identity of protected persons to individual carers or healthcare providers or residential care settings or hospitals or other care settings and their representatives in the interests of fairness. In practice, what this means is that, where significant or explicit criticism of individuals or organisations is made, the Inquiry can disclose this to them in the interests of fairness.

As with our approach to granting requests for anonymity, the Inquiry will take decisions about whether to disclose such information on a case-by-case basis. In the event that an unexpected criticism is made during the course of a hearing, the live-stream will be on a delay, which will give the Inquiry time to prevent that information from being released into the public domain. The terms of the restriction order will apply to all those in attendance at the hearing. While organisations are entitled to respond to criticisms made of them, the Inquiry cannot guarantee the opportunity to respond before a witness gives evidence nor will the Inquiry give a right of reply.

Organisations will have opportunity during the

course of the implementation hearings to provide statements in which they can comment on the evidence presented to date. The Inquiry is an inquisitorial process, not an adversarial one, therefore, depending on the severity of the criticism and the implications this might have for an organisation, I may decide that details of the criticism will not be disclosed to the wider core participant group.

I have also been asked to clarify whether the Inquiry will investigate and rule on every criticism and complaint. It is not the role of the Inquiry and therefore we will not do so.

Now, leave to appear. Whilst this does not apply to preliminary hearings such as the one we are having today, there will be a general rule at all substantive hearings that any core participant who wishes to appear at this Inquiry's hearings will be required to be granted leave to appear. I think I may have said "leave to appeal" by mistake at the outset of this. I apologise for that. It's leave to appear.

Those granted leave to appear at any hearing in the Inquiry will be given copies of documents to be referred to at the hearing prior to those being made available to the public in advance of the hearing taking place, be able to request Counsel to the Inquiry to ask certain

questions of witnesses, be able to ask questions of witnesses direct with the permission of the Chair and be able to make opening submissions at the hearing where the Chair directs that such submissions are required.

Making a closing statement at any hearing where the Chair directs the making of such statements is not contingent on the core participant or its or their recognised legal representative having had leave to attend the hearing to which the closing statement relates. Those granted leave to appear will be notified of the number of representatives they can have present in the hearing room during the hearing in question.

I would remind core participants that the requirement to obtain leave to appear applies separately to each substantive hearing date held by the Inquiry, so leave to appear at one hearing does not confer leave to appear for any subsequent hearing. I encourage core participants and their legal representatives to familiarise themselves with the terms of the Inquiry's leave to appear protocol, which can be found on our website.

Opening statements. In relation to the October 2023 impact hearing, I can confirm that opening statements will be sought from core participants who have been granted leave to appear. I will issue a direction on

opening statements in due course which will set out my position on this matter.

Expenses. I recognise that the question of the payment of expenses has been raised in advance of this hearing. As Chair, I have a legal duty to minimise expense to the public purse. The Inquiry's current policy of not paying travel expenses to people voluntarily attending a hearing in person is consistent with those of other public inquiries. The Inquiry does, however, pay legal expenses for core participants and others, where eligible, to ensure they have appropriate legal representation throughout the course of the Inquiry's work. We will shortly publish our policy with regards to the payment of expenses for witnesses who will be asked to attend future hearings.

People who are unable to attend the Inquiry's preliminary hearing and future hearings are invited to watch them via dedicated live-streams on the Inquiry's YouTube channel, which will also be recorded and available to watch any time on demand.

The questioning of witnesses. In advance of our first substantive hearings, I wanted to take some time to set out this Inquiry's position regarding the questioning of witnesses. Rule 9 of the Inquiries (Scotland) Rules 2007 enables core participants to apply

to examine a witness. Witnesses may be asked to give evidence in the form of a written or oral statement and may also be asked to appear at an inquiry. I will issue a procedural direction in the coming weeks which will set out further details on the process for core participants making an application to pose questions. My intention is for Inquiry counsel to ask any questions that have been posed by core participants, subject to them being granted permission by Inquiry counsel, rather than have witnesses examined by the representatives of core participants. I would expect that application process to be preceded by an informal approach to Counsel to the Inquiry to explore whether they are prepared to put a question or line during examination.

Confidentiality undertakings. I wish to highlight that confidentiality undertakings were sent to core participants on 24 August 2023. I remind all core participants and their representatives that documentation will only be disclosed to individuals who have signed such an undertaking.

Evidence and witnesses. For our October hearings, core participants who have status in respect of sections (g), (h) and (i) of the Inquiry's terms of reference and leave to appear will receive bundles containing witness statements and documentary productions in respect of

this tranche of hearings prior to these being available to the public and in advance of the commencement of the October 2023 impact hearing. The Inquiry team is working towards an initial tranche of disclosure in respect of bundles at the end of September 2023. Documents will be shared with core participants using our document management system, Relativity.

The Inquiry is in the course of gathering evidence from a variety of sources in preparation for the first set of hearings. As I highlighted earlier in the session, in the context of the impact hearing specifically, written statements are being sought from members of core participant groups and relevant external organisations, in addition to which we are conducting detailed analysis of the submissions made to Let's Be Heard.

Core participants will not be entitled to comment on draft witness statements of others. The only circumstances where someone may comment on a draft witness statement is the witness to whom the draft pertains. Inquiry counsel will then take a view on who ought to be called to appear in person to give oral testimony. As a general statement, witnesses who are called to give oral evidence will, at the start of their evidence, be invited by Counsel to the Inquiry to

confirm that they will adopt the written statement as their evidence.

The Inquiry team will identify and call witnesses to give evidence. We will, of course, communicate to core participants when their own members are expected to be called but it is not our intention to publish a witness list for impact hearings. However, we will provide on a weekly basis a list of those with leave to appear in that period. Because of the nature of impact hearings, there may require to be changes to the intended witness schedule. Witnesses may be asked to give evidence in the form of a written or oral statement and may also be asked to appear at an Inquiry hearing. Counsel to the Inquiry will identify and call witnesses to give evidence.

Witnesses who speak to key and distinct impacts will be invited to give oral evidence. Evidence will be led by a cross-section of witnesses who are able to speak to key and divergent impacts experienced by individuals.

Can I turn to access to medical records? Specific questions have been asked in advance of this hearing about whether the Inquiry plans to routinely consider the medical records of individuals who have been asked to give evidence. Given the Inquiry's remit, it is not our function to ascertain causation of anyone being in

hospital, therefore it is unlikely. They will only be requested as and when required. Where the Inquiry does require access to a patient's medical records, it will issue a notice under Section 21 of the Inquiries Act 2005 requiring their production. The Inquiry may involve medically qualified persons in considering patient records if it considers it necessary.

I will make decisions on what records may be relevant and I will consider this on a case-by-case basis, bearing in mind what is necessary, proportionate, reasonable and relevant to fulfil the Inquiry's terms of reference. Not everything that is collected will be disclosed to core participants or placed into the public domain. This will also be considered on a case-by-case basis.

As you know, core participants were asked to pre-submit questions in advance of this preliminary hearing so I'd like to take some time to speak to the points raised. I believe most of these questions will have been covered in the course of today's proceedings already. However, there were a number of specific questions raised that I will now address.

Evidence. I have received a number of questions regarding what types of evidence the Inquiry will consider during the course of our health and social care

hearings. We will not publish evidence proposals for the impact hearings. I may consider doing so for the implementation hearings and decision-making hearings. Proceedings for these hearings will be shared nearer the time.

One question specifically mentioned evidence relating to population triage and DNACPR (do not attempt cardio-pulmonary resuscitation decisions), decision-making in hospital and social care settings. This is an area where we have already collected evidence and will consider further during the course of our investigations.

Front-line workers. I have been asked to confirm if workers and workplaces will be considered in the impact hearings. The Inquiry will of course hear evidence from front-line workers. This will likely take place in the next tranche of hearings early next year. Staff will be approached directly rather than through their employers. The Inquiry is in its evidence-gathering stage and is focusing on the impacts felt in relation to health and social care. The terms of reference in focus at present are: (g), in care and nursing homes, the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, infection prevention and control, and inspections; (h), the

provision of healthcare services and social care support, including the management and support of staff and the recognition, involvement and support of unpaid carers; (i), the delivery of end-of-life care and the use of DNACPR, again do not attempt cardio-pulmonary resuscitation decisions.

There will of course be staff who do not fall naturally within the themes. We are actively considering this and do not wish for anyone to fall between the cracks. We will provide further information in the course of our investigations.

Long COVID. I've been asked how the Inquiry will address the issue of long COVID. As many of you will be aware, following a legal opinion from the advocate and junior counsel to this Inquiry, Mr David Turner, I determined that certain matters relating to long COVID fall within the Inquiry's remit. This was because the existence and effects of long COVID are relevant to the handling of the pandemic in Scotland and those affected by long COVID will be relevant to the scope of the Inquiry. Mr Turner's full opinion can be found on the Inquiry's website for those with an interest.

The Inquiry is in its evidence-gathering stage and is focusing on the impacts felt in relation to health and social care. The terms of reference in focus are --

I have already stated these, so I won't repeat them again. They are (g), (h) and (i), which I read out just a moment or two ago.

Evidence will be sought in respect of long COVID, particularly in respect of ToR (h).

One question specifically mentioned evidence relating to population triage, and again I think I've covered this, so I don't need to repeat that this is an area which we've collected evidence in and will consider further during the course of investigation.

Some core participants have also asked for opportunities for their members to provide evidence to me as Chair which would not be made public. I would invite all these core participants with an interest to make a formal request to Counsel to the Inquiry and, if a request is approved, this will be arranged by the Inquiry policy and external relations team.

Disproportionate impacts. One question asked what the Scottish COVID-19 Inquiry is going to do to specifically address the issue of race in the first hearings. On the issue of equalities and any disparities or unequal impacts, I am bound in the terms of reference to consider these as I deem appropriate and necessary. In preparing for the hearings, we have been gathering evidence from organisations representing those

with protected characteristics and other disadvantaged groups where it is relevant to each of the 12 areas included in the terms of reference, including consideration of any disproportionate and intersectional impact.

Dr Croft's report. I have received a number of questions concerning the status of the report and evidence provided by Dr Ashley Croft to the Inquiry regarding the epidemiology of COVID-19. To set the report in context, prior to commencing hearings we considered it appropriate to explore the scientific position at the relevant time. We instructed Dr Croft to provide an account of this.

Dr Croft is a public health physician and epidemiologist who has undertaken and published research on a wide range of public health issues, including issues relating to COVID-19. Dr Croft's report was commissioned to form the basis for future discussion in the Inquiry and to provide some scientific context for the work that will follow. His report will sit alongside other existing academic research the Inquiry has received and will receive in future, covering specific areas in more detail.

The contents of Dr Croft's report, as with any expert commissioned by the Inquiry, should not be seen

to pre-empt the eventual conclusions and recommendations I will eventually make. The views expressed in Dr Croft's report are his own professionally informed opinions and were provided by the Inquiry to inform core participants, interested parties and members of the public and to form the basis for future discussion in the Inquiry.

As is the case with all commissioned advice and research, I will consider all relevant material. I will assess it and give it the weight I consider to be appropriate, taking into account all the relevant circumstances.

I have also been asked to provide further details on the timeframe for core participants to have the opportunity to respond to Dr Croft's report and his presentation in Dundee last month.

Core participants will of course have an opportunity to apply to the Inquiry for questions they may wish to be put to Dr Croft with regard to his presentation. This will necessarily take place at a date later in the lifetime of the Inquiry to enable core participants to consider the conclusions presented in Dr Croft's report in the context of the additional evidence presented in the course of the Inquiry's work. Careful consideration is being given to scheduling and core participants will

be given appropriate notice ahead of any session to enable them to prepare questions which will be submitted to Inquiry counsel for consideration.

I also think it is important to address some of the questions asked regarding why this Inquiry has taken a different approach to the UK Inquiry with regards to the use of an expert presentation. As with all statutory inquiries, it is for the Chair to determine the structure of investigation and hearings. In line with our memorandum of understanding, we have opted not to duplicate costs in commissioning a very similar exercise to that undertaken by the UK Inquiry.

Where the UK Inquiry has commissioned expert reports, such as that produced by Professor Heymann, these are available to us. As is the case with all commissioned advice and research both by the UK Inquiry and this Inquiry, I will consider all the relevant material and give it the weight I deem appropriate, considering all the circumstances.

Evidence from expert witnesses. Questions have also been raised about whether I plan to instruct any additional expert witnesses during the course of proceedings. As I have previously discussed, the Inquiry is an inquisitorial process and, in the course of progressing work to fulfil its terms of reference,

I will decide whether and which experts I wish to instruct. Where an expert is brought to a hearing, I wish to reassure core participants that they will have an opportunity to apply to ask questions to the expert. Any documentary evidence relied upon at the hearing will also be disclosed to core participants with leave to appear prior to the hearing.

The Inquiry has already conducted some round-table meetings with experts and key organisations to help gather the evidence we hope to capture. The Portfolio 4 team, led by Ms Van der Westhuizen KC, commenced round-tables with Colleges Scotland on 24 August and will continue through the week of 28 August. Similar round-tables have been set up with Universities Scotland. Where the Inquiry considers round-tables to be most effective, it will consider using them.

I understand some core participants have also asked whether the Inquiry may be willing to fund the instruction of experts by core participants to assist with their preparation for hearings. There will be no blanket permission or denial of such a request at this stage. If a core participant strongly felt that it would not be possible for them to prepare fully without the input, in an advisory rather than investigatory capacity, to help them understand technical evidence

advanced, the Inquiry will consider that request with regard to its overarching duties and, in particular, with regard to proportionality and fairness. Any request for funding for such expert input will need to be considered in context.

In principle, if a strong case were to be made and I consider it appropriate to do so, the Inquiry could grant such a request. It may be, for example, that multiple core participants are asked to jointly instruct an expert to ensure proportionality or some other limitation or expectation may be placed on parties seeking to secure such funding. This, however, I stress, will need to be considered in context and on a case-to-case basis.

While we would not envisage that such expert input would be required, for example in the context of the impact hearings, it may be that this is a justifiable request with regard to particular aspects of the Inquiry's work in due course, and I will turn my mind to such requests as and when they are made.

Funding -- bear with me. I think I said already this computer closes down from time to time so I need to refresh it.

Funding. In terms of what legal fees can be claimed for preparatory work for public hearings, the initial

interim award and accompanying documents set out a range of activities for which funding can be made available and we are currently working to confirm the final scheme for the award of legal expenses. We hope to have that ready and published to all legal representatives by early October. Until the work to put in place structures for the final award has been concluded, fees submitted will be assessed with reference to the interim award scheme.

In terms of whether work charged to the UK Inquiry for work done with regard to their terms of reference, we cannot provide assurances that that work will necessarily be funded with regard to this Inquiry. Specifically, we cannot take the view it would necessarily be fair to double-fund for work already done. Any claim for legal expenses will need to be tied to the ongoing work of the Scottish Inquiry at a given time and will be considered on its merits by the Inquiry. We will, however, consider how best to reflect these issues in the ongoing work on what will be the final funding award.

Operation of the hearings. A number of the questions we have received related to the practical operation of our hearings in relation to the publication of transcripts and the option for remote participation.

The proceedings will be live-streamed and, as such, can be viewed by as many people as want to access them. In terms of individual requests for participation in hearings without attending in person, we are considering the needs of individuals on a case-by-case basis, with a view to facilitating remote access where appropriate to do so. We are presently considering requests from people who wish to participate in hearings but cannot do so by attending in person. The Inquiry will produce a transcript of each hearing which will be made available on the website as soon as practicable.

Now, that concludes, rather more expeditiously than we had necessarily thought, the introductory remarks and the answers to some of the questions which have been posed by myself and by Mr Gale. We're slightly ahead of schedule. I'm told that lunch isn't available for another seven minutes -- I checked -- and I apologise for such expedition.

I think, however, the sensible thing to do is, bearing in mind that luncheon is not available until 12.30, we'll give you an hour from 12.30 and, instead of starting again with any questions that may remain at 2 o'clock, we'll start at 1.30. There's always the prospect we might finish earlier than the anticipated time, which I'm sure no one would object to. So thank

you very much for listening this morning. I appreciate it's been a lengthy session.

I'm sorry, I apologise. I've been reminded I should have told you that anyone who wishes to ask a question at the afternoon session, could they please do so at the reception -- is that correct? -- at the reception, please. Thank you very much indeed.

(12.25 pm)

(The short adjournment)

(1.39 pm)

THE CHAIR: Good afternoon, ladies and gentlemen. Over the luncheon adjournment I have been provided with information that two persons have additional questions. What I'm going to do is ask them in turn to come up and give me their question from the lectern here so they can address you.

So the questions and the persons that want to ask questions are Mr Aamer Anwar, who is the solicitor for Scottish Covid Bereaved, and Ms Amber Galbraith, who is the lead counsel, I assume, for Care Home Relatives Scotland. So Mr Anwar first, if you would, please.

MR ANWAR: I'm obliged, your Lordship. If this fails, it's because the wifi connection is awful and for the next set of hearings it will be checked out before we go into the hearing process.

As your Lordship said, I am the lead solicitor for the Scottish Covid Bereaved and I have a handful of questions for your Lordship and your senior counsel. The public quite rightly are looking for answers and no more so than the loved ones of the nearly 16,450 people in Scotland who died from the pandemic.

The Inquiry has claimed repeatedly and has so again today that it is human-rights based, so the question, having spoken to my clients earlier on and prior to this, is -- the question that the Scottish Covid Bereaved and many others -- core participants I've spoken to are asking is: why can they not be given precise dates of hearings? It starts on Tuesday, 24 October, which happens to be the same date that the preliminary hearing into Module 2A is taking place in London for the UK Inquiry, and that impacts on Scotland, and when after that will this hearing actually sit? We have been provided by the UK Inquiry dates of hearings of up to six months in advance into 2024, yet the Scottish Inquiry is still unable to provide precise details of when from 24 October onwards the Inquiry will actually sit.

We understand that you have a memorandum of understanding with the UK Inquiry and the Scottish Covid Bereaved welcome that. We know that

Module 2 impacts on Scotland and we have dates of 30 October to 1 November, 1 November to 9 November, 20 November to 30 November and 1 December to 7 December when Module 2 is sitting in London. So one wonders how exactly is it not clashing. I appreciate and we have said to our clients that there will be an overlap in dates in hearings, but clarity and preciseness is important, not just to the bereaved, but also to their representatives, who have to organise their diaries and be able to make sure that counsel, solicitors, are available to fully represent and adequately represent their clients.

Both our clients and their representatives have the right to know in advance. The bereaved have said it is deeply traumatising for them to even be here today. They have this hanging over them, and to not even know when they have family commitments, when they have work commitments -- many of the families we represent are suffering from financial crisis but also from the crisis that they lost their loved ones, and the idea that they should drop everything a few days in advance or a week in advance or two weeks in advance is simply unacceptable and, I repeat, it traumatises those who want to speak and who want a right -- that have a right to clarity and they want to be front and centre.

There are also 37 core participants and so far we have heard very little about the other core participants. I am conscious of the fact that there is myself and somebody else asking questions today, but we have only so far heard about the care homes and the Scottish Covid Bereaved. I know that many of my clients also happen to be front-line workers, they happen to be members of trade unions, they are people involved in the care homes, and many of the core participants want to know when will they be involved, when will they be spoken to. All of those issues interact with each other, and that is essential that this Inquiry, that is human-rights based -- and these families and the bereaved and front-line workers and trade unions and the refugees and the minorities, the minority ethnic communities, are front and centre of this Inquiry, then that should most definitely be addressed and not left up in the air because again that retraumatises. Again, there is a concern.

There is a concern from what has been said today that it would appear that no politicians, no ministers and no senior civil servants will give evidence until 2025. We have already heard from a former Prime Minister, we've heard from the former Chancellor of the Exchequer, we have heard from the former First

Minister in the London Inquiry and we know whether individuals are being called back for October, November and December.

Another matter that arises, as I understand, is that no core participants out of the 37 core participants have received any disclosure of worth for evidence. For comparison, we received disclosure from the UK Inquiry almost six months in advance of the hearing so we could be ready. We were disclosed a total of 35,370 documents, totalling around 385,436 pages. However, when it comes to the Scottish Inquiry, we have to date received only one report, of which the main part of the report is 127 pages, from an expert that our clients do not accept as an expert.

We understand that you and senior counsel will decide who gives evidence. Where is the clarity on the participation of core participants in that process? How is that human-rights based? Will we have any involvement or is it simply the case that it will be your Lordship and senior counsel that will decide who gives evidence in the impact hearing?

I am one of those who, I remember at the start of the UK Inquiry, explained to our clients and accepted the fact that it would be impossible for all bereaved to come to an inquiry to give evidence, but what happened

in the UK Inquiry was that the statements were taken, they were provided to the Inquiry and out of that it was selected core individuals who would come forward and give evidence. I am concerned when it is said there is no time limit on giving evidence that we have —— I don't like to call it "tradition", but in this country where inquiries trundle on for years.

Your interim solicitor of course was involved in the Trams Inquiry, which is still yet to report and has spent £13 million. This Inquiry, we sought an FOI in terms of clarification of the costs. £8 million have been spent on this Inquiry. We have not received any answers of breakdown in costs, but there is a real concern that this will break the record of the Iraq Chilcot Inquiry, which the Trams Inquiry had in terms of that.

The families do not want haste at the expense of it being robust and independent and transparent but they do have a right to know exactly what is happening with regard to cost, expenditure, even in terms of the general day—to—day of an inquiry hearing, how people are treated, whether it is trauma—based, whether counsellors are available, et cetera.

The final question, my Lord, is: why is there such secrecy around experts? How can we prepare if we do not

know in advance? Dr Croft, as far as we're concerned —— and that's the only so—called expert we can go by —— but as far as the Scottish Covid Bereaved were concerned, his evidence was disastrous and we do not want to repeat that.

However, we are entitled, if it's a human—rights—based Inquiry and it is operating —— it has a gold—plated standard which to look at, to know who the experts are in advance in order that we may instruct and seek permission and seek leave to instruct our own experts to advise on that, not to be told four weeks in advance. This is far too important and we need to have that clarified.

I'm obliged.

THE CHAIR: Thank you. I'll just wait until you're back in your seat.

Well, as you fairly said at the beginning, there are a number of questions embedded in that speech and I think in fairness quite a lot of the points that you have raised have been covered in what I've already said today. However, I will highlight certain matters. I'm also going to call on Mr Gale to address certain of those issues because he's the person that is directly concerned.

The first one concerned timings, and you indicated

that you had, I think you said, notice of specific dates of hearings from the UK Inquiry six months in advance, but unless my arithmetic is very wrong, Mr Gale gave you this morning a clear indication of what his intention was in relation to adducing evidence in a period which is I think a little in excess of six months.

It is in what Mr Gale said earlier this morning, but I think in fairness and to be absolutely clear, I'm going to ask Mr Gale again to explain his plan for the hearings between now and Easter, which I think is at the beginning of April next year.

Mr Gale.

MR GALE: Thank you, my Lord.

Yes, as I said earlier, the plan is to commence impact hearings on 24 October and I indicated that they would be each day, a four—day week and run through to 8 December. Initially we are going to hear from representative witnesses —— and a quite deliberate decision has been taken on that —— and thereafter we will hear from Care Home Relatives and the Covid Bereaved group, and the intention is that there will be witnesses through that period up until 8 December.

If there are more witnesses than we can accommodate in that period, we will have further hearings in relation to those witnesses. We are not prescriptive in

cutting off witnesses as at 8 December, and I hope I made that clear.

Thereafter, into the new year, we have a period when we will not be sitting due to the presence here of the UK Inquiry and thereafter we will resume our hearings in February and run through to Easter. During that time we will hear from other impacted witnesses and groups, and that will include —— as I think was made clear at an earlier hearing and also at an earlier meeting that I had with some of the parties —— that will include, for example, those who were employed within the care and health sectors. We will also hear from witnesses and their impacts who were in the refugee community. We will also hear from witnesses who were in prison. We have dedicated teams looking at each of these areas, and they are just some. We will also be looking specifically at hospitals and we will be looking at care in the community. So we have the intention of obtaining as much information on impacts in as many settings as we can conceivably accommodate. So that is our plan.

As I say, we have a number of dedicated teams. When I say "dedicated teams", I use that word in two senses. They are very dedicated to what they're doing and they are specific in relation to what they are doing. They are looking —— for example, there is a dedicated team

looking to those who were impacted by the use of "do not resuscitate" notices. We already have a number of witnesses who are within that category, we have statements from them, we have material from them, we have liaised with hospice groups, we have liaised with groups providing palliative and end-of-life care. So I would like to reassure Mr Anwar that all of these matters are in hand, are well in hand and prepared. We are utilising the statement that his firm gave us last week in relation to the witnesses within his client group and we will be in touch with him and, through him, his clients to advise as to when his clients will be giving evidence.

THE CHAIR: Thank you, Mr Gale.

Now, there's a number of other points ancillary to that that arose in the questions from Mr Anwar. The first one is in relation to hearings on the same dates as the UK Inquiry has intimated it is having hearings. As I said earlier this morning, there is a memorandum of understanding between the two inquiries and that memorandum of understanding encompasses trying, where possible, to avoid having hearings on the same dates or certainly hearings concerning the same subjects on the same dates.

In relation to that, it is not an absolute

undertaking not to have hearings on the same dates although we will use our best endeavours to avoid having hearings on the same dates. My understanding is that the hearings of the UK Inquiry in the months of October, November and December do not directly relate to Scottish matters, and that was a factor we took into account.

Now, I immediately acknowledge that there may be dates when representatives who are participants in both inquiries might feel a need to be at the UK Inquiry even if it's not dealing specifically with Scottish matters. If there are such dates, then we would be willing, on representations being made to us by the participant involved, to consider whether we can do anything about that. But as a matter of generality, my understanding is the UK Inquiry is not dealing with Scottish matters. Obviously, we are accommodating the UK Inquiry by not sitting when it is dealing with Scottish matters in January of next year. That's the first point.

The second point is in relation to the question or the issue of why our focus in this case. One of the reasons we're having hearings when we're having hearings in October is because we are taking a people-centred approach. We are putting individuals, people, in all their capacities, workers, bereaved and so forth and so on, at the heart of our Inquiry. As Mr Gale said when

he was addressing you this morning, there were good, cogent reasons for trying to prioritise this evidence. Memories get stale is the obvious one. We were anxious to hear individuals at the first opportunity. That is why we put impact hearings first. If we delayed impact hearings, these people, these individuals, would not be heard until well into next year. We took, and I may say still take, the view that that is undesirable if we want to be person-focused and adopt a human rights approach. So that is another reason why we are proceeding in October.

You make the point absolutely correctly that politicians and others have already given evidence in the UK Inquiry. Again this comes back to the priorities and the focus that we have chosen to adopt in this Inquiry. We will hear from politicians during the implementation and decision-making hearings, when these come later, but we thought that frankly it was more important to hear from the individuals as soon as possible rather than hearing from persons who were taking decisions, important though that obviously is.

Let me see, what else did you raise? Disclosure, yes. I again acknowledge that there are times when disclosure should be made well in advance of any hearings. You have been provided, you told me, with

many thousands -- I can't remember the exact figure. Forgive me -- but many thousands of documents, at considerable periods of time, months in advance of hearings of the UK Inquiry. Well, I've already said that the UK Inquiry has been run in a different way from us and was hearing evidence of those involved in decision-making and implementation at an earlier stage, at the beginning of their Inquiry, and since those persons are those that would require documents or would be involved in relation to documents that were produced, I can well see the need for you having lots of notice of that. When we come to implementation hearings, I can assure you that we will give adequate time and you will get, I've no doubt, fairly voluminous volumes of production of documents well in advance.

The hearings that we're going to have between now and Easter of next year are of a different category. They are, obviously, primarily of individuals as witnesses and therefore the documents which we will disclose to you will be in the majority witness statements from those persons. It's Mr Gale's ambition, which again he's stated this morning and which I can assure you is being adhered to, that he will try and give you a month's notice of those things and, in the exercise of our professional judgment, for documents of

the sort that we're going to use in the implementation hearings, that is sufficient. You will get a greater degree of notice when we come to implementation at a later stage.

I think —— is there anything I've forgotten? No. I think that is my answer to your questions. If there is anything that I've missed, please feel free to communicate this and we will supplement anything I've said.

ATTENDANT AT HEARING: (inaudible).

THE CHAIR: Yes. Can I just —— I didn't quite hear you. There was some coughing at the side. Clarification of the costs?

ATTENDANT AT HEARING: (inaudible).

THE CHAIR: Well, I think that's actually again relatively straightforward. We have to set up a public inquiry. A public inquiry is of necessity an expensive process. We had to engage staff. I may say the staff continued to grow and to some extent continues to grow and we have to pay for staff. We had to acquire premises, which I may say was a very time—consuming and difficult job and has not been without its difficulties. We had to engage academics to perform research who require to be paid. We had to set up Let's Be Heard, which is a very wide—ranging process which continues to operate. It's

been operating since the —— well, it's been set up since the inception of the Inquiry and is operating and will continue to operate for many months yet. All those things cost a great deal of money and that is why we have expended to date something in the region of £8 million.

I do not, I may say, consider the £8 million to be at all excessive, having regard to the scale of the organisation and operation that we've set up.

Yes. Thank you, Mr Anwar.

Ms Galbraith.

MS GALBRAITH: Chair, thank you for the opportunity to ask questions on behalf of Care Home Relatives Scotland and PAMIS. There are five key questions I would like to ask which each relate to different issues. The Chair may prefer if I pause after each question to allow for an answer on each specific point.

The first question relates to the practical operation of restriction orders and anonymity. It's considered this remains a little unclear and in that respect the Inquiry is asked whether consideration could be given to providing a protocol or written policy regarding the practicalities.

Four particular issues arise that I would like to highlight in that regard. The first is where a person

falls within the definition of those protected in terms of a restriction order. Will this prevent information that could lead to their identification being passed to other core participants as opposed to being disseminated to the wider public or would there have to be an application for anonymity? The second point is: when can an individual apply for anonymity? Thirdly, if anonymity is refused, can an individual withdraw their evidence? And lastly, if the Inquiry consider a statement contains criticism, will the identity of the critic be given to the organisation or individual being criticised and will the critic be told about that and given the opportunity to withdraw that criticism?

THE CHAIR: Right. I think probably the answer is that we can provide you with some written protocol in relation to that. So far as the four specific sub—heads are concerned, I don't think I would be confident in answering the first question off the top of my head and I think I'd prefer to have that answered in writing. I think I may apply that to the other three heads as well, although I'm prepared to answer those. When can an application apply for anonymity? I think "any time" is the answer to that, but we'll confirm that in writing. Can it be withdrawn? "Yes", I think is the answer to that. And will —— if there is a complaint,

will the identity of the complainer be revealed? I think the answer to that is probably "No". But could you please treat these as provisional answers and we will respond in writing?

MS GALBRAITH: Thank you, Chair.

The second question is in relation to the timeline. The indication is that in October there will firstly be evidence from representatives of organisations. Can it be clarified whether this is only for a care home or social care organisations or is the term being used in a wider context, such that it might cover those I represent?

THE CHAIR: Right. I think I'll ask Mr Gale to answer that.

MR GALE: Yes. The position in relation to representative organisations, as I said, will be wider than simply Care Home and I think I indicated there would be various charitable organisations that we are approaching. So I won't give a particular example but we have been in touch with numerous charitable organisations who advised groups with specific needs in the care sector and the health sector to give an indication of the sorts of impacts that they were experiencing or their members were experiencing, so it will be wider than care homes.

MS GALBRAITH: Thank you.

The third question is: what opportunities will there

be to use creative or multi—media means to hear evidence of those with profound and multiple learning disability?
THE CHAIR: Again, I think I can be quite straightforward. We will cater to the best of our abilities to enable persons in the categories you indicate to give their evidence —— we've given quite a lot of thought to that and I'm confident that we'll be able to satisfy the demand.
Could I ask you and to any other core participants to whom this affects to give us as much notice in advance of witnesses in those categories so that we can make sure that we take the appropriate and adequate means to facilitate the giving of their evidence.
MS GALBRAITH: The fourth question relates to what was said earlier about the use of medical records. Can it be clarified what approach will be taken to records from care homes or perhaps social work records if the same would apply?
THE CHAIR: Yes, I don't think we anticipate requiring to recover medical records in relation to persons in care homes, but again I'll ask Mr Gale to say a bit more about that. So far as social work records are concerned, again, I'm not sure if the requirement is going to arise on many occasions, but let's see what Mr Gale thinks.

MR GALE: Where circumstances disclosed in a witness statement require us in our view to obtain some more clarification about circumstances of a particular witness or about whom a witness is speaking, then we may wish to obtain more specific records. An obvious situation that we may be faced with is a date on which a particular resident contracted COVID and we may need to obtain records relating to that so that we can set in context what restrictions were being placed on the visiting of that relative, and so those are circumstances where we would consider doing it.
I must emphasise, however, that we are not and will not be in the business of obtaining widespread records in relation to individual care home residents. Those are beyond —— what is strictly necessary would be all that we would be requiring and we would not be wanting, for example, to know why somebody was put into a care home three years ago. We would only want to know whether there was information relating to the care of that resident and the interaction of the resident's relatives with the care home at the material time of the pandemic.
THE CHAIR: I think I'd simply add to that, Ms Galbraith, that Mr Gale made clear, when speaking earlier this morning, that we are not concerned, obviously, within

the terms of the remit of causation, of any person being in a care home or hospital and therefore our approach in the event that we require to recover records will be the most restrictive possible.
MS GALBRAITH: Thank you. The last point is: can a reassurance be given that the first tranche of evidence will not only consider the issue of deaths due to COVID in health and care settings but will deal with wider issues of the impact of restrictions on individuals and their families, even where there was no death, and will also consider the impact on care home residents of all ages, not simply the elderly?
THE CHAIR: Yes, I think we're both absolutely clear the answer to that is in the affirmative.
MS GALBRAITH: Thank you.
THE CHAIR: Thank you.
Very good. Well, I think that answers the supplementary questions that have been proposed, so that formally brings an end to the day's hearing. I would like to say, however, again —— repeat my thanks to all of those that have attended today. We appreciate particularly to the relatives of victims of this that this has been a trying and stressful day and we're all the more appreciative for your appearance today. Thank you, and thank everyone else for their participation and

help and we look forward to their support going forward. Thank you all very much.
(2.11 pm)
(The preliminary hearing concluded)

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News story

Home Secretary statement on Southport: 20 January 2025

Statement from Home Secretary Yvette Cooper on Southport.

From: **Home Office (/government/organisations/home-office)** and **The Rt Hon Yvette Cooper MP (/government/people/yvette-cooper)**

Published 20 January 2025

Home Secretary, Yvette Cooper, said:

> “All our thoughts today must be with the families of little Bebe King, Elsie Dot Stancombe and Alice Da Silva Aguiar, and all those who were harmed by this truly horrendous, barbaric and cowardly attack. Three innocent little girls who went to a summer dance club lost their lives in the most devastating way, other children faced terrible injuries, and they and all the parents and families have had to endure the most unimaginable trauma and grief.
>
> “My thoughts are also with the entire community in Southport, which has shown such strength and courage in the face of the unspeakable act of violence visited on their town. I also want to take the opportunity to thank all the police, first responders, hospital staff and prosecutors who

have worked in incredibly difficult circumstances from the day of the attack to support the families and bring this case to today's trial.

"It is important that justice has been served today. But nothing will ever take away the trauma and loss endured by the children and families and we will ensure that they continue to receive the support and care they need in the coming weeks, months and years.

"The Crown Prosecution Service (CPS) has been clear that important information about the perpetrator's past could not be made public before today to avoid jeopardising the legal proceedings or prejudicing the possible jury trial, in line with the normal rules of the British justice systems. Nothing has been more important than securing justice for the families.

"But now that there has been a guilty plea, it is essential that the families and the people of Southport can get answers about how this terrible attack could take place and about why this happened to their children.

"The responsibility for these terrible murders and the barbaric attack lies with Axel Rudakubana. The CPS has described him as "a young man with a sickening and sustained interest in death and violence" who has "shown no sign of remorse."

"But the families and the people of Southport also need answers about what happened leading up to this attack. The perpetrator was in contact with a range of different state agencies throughout his teenage years. He was referred 3 times to the Prevent programme between December 2019 and April 2021 aged 13 and 14. He also had contact with the police, the courts, the Youth Justice system, social services and mental health services. Yet between them, those agencies failed to identify the terrible risk and danger to others that he posed.

"This terrible case comes against a backdrop over a series of years in which growing numbers of teenagers have been referred to Prevent, investigated by counter-terror police, or referred to other agencies amid concerns around serious violence and extremism. We need to face up to why this has been happening and what needs to change.

"Although, in line with CPS advice to preserve the integrity of the prosecution, we were constrained in what we were able to say at the time, the Home Office commissioned an urgent Prevent Learning Review during the summer into the 3 referrals that took place and why they were closed. We will publish further details this week, alongside new reforms to the Prevent programme. But we also need more independent answers on both Prevent and all the other agencies that came into contact with this extremely violent teenager as well as answers on how he came to be so dangerous, including through a public

inquiry that can get to the truth about what happened and what needs to change.

“This horrendous attack will leave a lasting impact on our country. We will all remember Alice, Bebe and Elsie, and we will always stand with the families and the community who are living with the pain of their loss. In our efforts to answer the questions that remain about this case, the need to see justice done for the victims and their families will remain at the forefront of our minds.”

Published 20 January 2025

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News story

Inquiry into the Southport attack begins today

The Home Secretary announces the first phase of the Southport Inquiry starts today and appoints Rt Hon Sir Adrian Fulford as chair.

From: **Home Office (/government/organisations/home-office)** and **The Rt Hon Yvette Cooper MP (/government/people/yvette-cooper)**

Published 7 April 2025

The Home Secretary, Yvette Cooper has announced that the first phase of the Southport Inquiry will start today.

The Home Secretary previously announced in January 2025 that an inquiry would be launched following the conviction of the perpetrator of the 2024 Southport attack, to examine what went wrong in this horrific case and how services should respond to fixated youth violence.

Sir Adrian Fulford has been appointed as the chair following consultation with the victims and families of those killed or affected by the attacks and plans to travel to meet them as a first priority.

This follows the Prime Minister's commitment to leave no stone unturned in uncovering how this attack happened and to not let any institution of the state deflect from their failure.

Home Secretary, Yvette Cooper said:

> "The brutal murder of three young girls: Bebe, Elsie and Alice in Southport was an unimaginable tragedy – we owe it to their families, and all those affected on that terrible day to quickly understand what went wrong, answer difficult questions and do everything in our power to prevent something like this from happening again.
>
> "The Southport Inquiry will provide insights into any failings that allowed a young man with a previous history of violence, to commit this horrendous attack.
>
> "Sir Adrian Fulford will bring a wealth of legal and criminal justice expertise to this role, and I am pleased he has agreed to chair the inquiry."

The inquiry will be statutory. This follows representations made by families and victims of the attack and means the Inquiry has all the necessary legal powers to receive evidence and hear witness testimony effectively.

It will take place in 2 phases. The first will thoroughly investigate the circumstances surrounding the attack and the events leading up to it. This will include examining an overall timeline of the perpetrator's history and interactions with various public bodies including criminal justice, education, social care, and healthcare, as well as decision-making and information-sharing by local services and agencies.

The second is expected to examine the wider issues of children and young people being drawn into extreme violence.

Sir Adrian Fulford will bring an impartial and extensive legal background, particularly on issues relating to policing and the criminal justice system.

He is a retired Lord Justice of Appeal and former judge of the International Criminal Court 2003 to 2012. Previously, he was the Vice-President of the Court of Appeal (Criminal Division) in 2019 and was the first Investigatory Powers Commissioner between 2017 to 2019.

Published 7 April 2025

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Monday, 9 September 2024

(11.00 am)

Opening statement by THE CHAIR

THE CHAIR: Well, good morning everybody. I'm Baroness Lampard and, with this statement, I'm opening the hearings of the Independent Statutory Inquiry into the deaths of mental health inpatients in Essex. I want to welcome everyone here today at the Civic Centre and those watching over the live feed.

The purpose of this Inquiry is, according to my terms of reference, to "investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trusts in Essex" over the 24-year period between the start of 2000 and the end of 2023.

This is the first Public Inquiry set up in the UK to investigate mental healthcare. We'll be investigating matters of the gravest public concern and significance. The Inquiry is not considering one single event, one set of circumstances or one individual. Instead, we're investigating alleged failings in mental healthcare on a scale that is deeply shocking.

As you may be aware, during the Inquiry's non-statutory phase, when it was called "The Essex Mental Health Independent Inquiry", the Inquiry was informed of approximately 2,000 deaths being in scope.

This information was provided to the Inquiry by relevant mental healthcare providers.

Following publication of the Terms of Reference for the Lampard Inquiry, I requested that Essex Partnership University Trust, known as "EPUT", as well as other relevant providers, submit updated figures of the number of deaths in scope in line with the Inquiry's definition of "inpatient death".

Data quality and retention issues over the 24-year period, as well as varying interpretations of the terms of reference, have meant that this process has taken longer than anticipated. The Inquiry is working with all providers to obtain figures which are as accurate as possible. I have and will continue to reject information and data from providers which I do not consider to be an appropriate or reliable standard.

It's worth noting that the Lampard Inquiry's Terms of Reference, including our definition of "inpatient death", are broader than those of the non-statutory Inquiry, with the timeframe having been extended by a further three years. In addition, the Lampard Terms of Reference include, for example, private sector providers of NHS care and those who were assessed but not admitted to inpatient care. The Essex Mental Health Independent Inquiry did not include such deaths in

scope.

I do not at this stage have a number of deaths in scope to share with you. The tragedy is that we may never have a definitive number of deaths that fall within the Inquiry's remit. The Inquiry is committed to publishing a figure of the number of deaths as soon as we have finished analysing and interrogating the information provided to us. I will release the figure when I feel confident that it is the most accurate representation of the number of deaths in scope that can be achieved.

This number is likely only ever to be approximate and I find it shocking that we may never be able to say for sure how many people died within the remit of this Inquiry. What I can tell you now is that the number of deaths in scope will be significantly in excess of the 2,000 that were being considered by the Inquiry during its non-statutory phase.

I wish to express my deepest sympathy for the loss and heartbreak experienced by families and friends of those who have died while an inpatient in a mental health facility in Essex and also to current and former patients who have experienced harm or unnecessary suffering when in inpatient facilities in Essex.

I invite us to pause for one minute of silence in

respect of those who died.

(One minute of silence observed)

The purpose of these initial hearings is to hear opening statements from the core participants involved in the Inquiry. I will listen with interest to what they have to say and their suggestions for working with the Inquiry to achieve its objectives. I've read with care the statements they have already provided.

Significantly, the purpose is also to hear about those who have died. Each death represents a tragedy. I am profoundly grateful to have the opportunity to learn more about these individuals from their families and friends and to commemorate them. I will also be hearing deeply personal and difficult accounts of the impact of the events which are the focus of this Inquiry on families and friends.

I want to thank all those who have contributed written accounts, photographs, videos and other forms of commemoration as well as those who are coming to speak at the hearing. It will be crucial to my understanding and the understanding of all of us involved in the Inquiry of the true impact of the deaths and harms which have occurred.

There will be a further opportunity for families, friends and former patients to provide commemorative and

impact evidence in the hearings conducted remotely in November and I urge anyone who thinks they might want to do that to get in touch with the Inquiry team.

The Essex Mental Health Independent Inquiry was launched in 2021 with Dr Geraldine Strathdee as its chair. I am grateful for the important work that she undertook in that role. In June 2023 the former Secretary of State for Health and Social Care, Steve Barclay, announced that the Inquiry would be converted to statutory status under the 2005 Inquiries Act, with new powers to compel individuals and organisations to provide it with evidence and with serious repercussions if they failed to do so. Dr Strathdee stood down as chair in this time.

In September 2023, I was asked by Mr Barclay to take on the role of chairing this Inquiry and I was formally appointed as chair on 26 October 2023. The following day the Department of Health and Social Care issued a formal notice of conversion, confirming the Inquiry's statutory status. The Inquiry then relaunched as the Lampard Inquiry on 1 November 2023.

When the non-statutory Inquiry was first launched, Dr Strathdee made a commitment to put families and former patients at the heart of our work. I firmly

stand by that commitment. I will ensure that the experience of family, friends, patients and former patients remains central to the Inquiry's work.

My key concern is properly and fully to understand all the issues I'm required to address and to make meaningful recommendations. This is to ensure that any necessary improvements in mental health care are made here in Essex but also nationally and to do this within a reasonable period of time. There is urgency to my task. A number of the issues that have been identified remain of current concern and I need to address those quickly.

This Inquiry was not established on the back of a single incident. Instead it was the accumulation of a number of tragic deaths which have led to a series of investigations, key reports from regulators and other relevant bodies and awareness-raising by parliamentarians.

In my statement of approach to the Terms of Reference, I referred to the courage, resilience and strength that the families have demonstrated in these most tragic of circumstances, including in bringing to light some of the matters I will be looking into. I again acknowledge the instrumental role of the families in the creation of this independent statutory

Inquiry. Without their dedicated and tireless campaigning, it is unlikely that we would be here today. I am grateful to have met with a number of families to hear about their experiences, their concerns and, most importantly, about the person they lost.

I think it's important that I should say a little about my own background. After spending a number of years practising as a barrister, I gained an in-depth understanding of our health systems through holding various senior non-executive roles within the National Health Service. During my career, I have led independent reviews into matters of serious public concern. These include being appointed by the Department of Health and Social Care to oversee its investigations into the allegations of sexual abuse by the late broadcaster Jimmy Savile, taking place in NHS hospitals.

I have had a role considering deaths in a closed setting as interim chair of the Independent Advisory Panel On Deaths in Custody. I also conducted independent reviews of allegations of the mistreatment of detainees at Yarl's Wood Immigration Removal Centre and then later at the Brook House Immigration Removal Centre. This led, in 2019, to my being appointed by the then Home Secretary to conduct a review of the Borders,

Immigration and Citizenship Service. I therefore have significant experience of the conduct of major investigations and reviews. I intend to apply that experience to my work as chair of this Inquiry.

The role of chair comes with deep responsibility and is one I've not stepped into lightly. I and my Inquiry team will be investigating matters of grave importance relating to life and death, which are of course the most serious issues that we can find ourselves dealing with. I will ensure that this Inquiry is fair, objective, thorough, rigorous and balanced. It's important to stress that I am independent. As chair, I will act without fear or favour and without interference from government, health bodies or others to get to the truth. You have my full commitment to establishing the key facts and issues at the heart of this Inquiry, to probe, to examine the evidence critically and to ask the difficult questions.

This Inquiry is not a trial in court. It's not about finding guilt, although wrongdoing is likely to be uncovered. I do not have the power to make findings of criminal or civil liability. Instead, this, like other inquiries, is a process independent of Government and politicians, stakeholders and all interested parties, with the key aim of getting to the truth.

I must approach the Inquiry proportionately and efficiently and deliver my findings and recommendations in as swift a manner as possible. People have waited too long for answers and, as I've already said, we need to make sure that matters that need remedying are put right urgently to limit any further unnecessary suffering.

I'm not going to be opening up and determining cause of death in every single case. In many cases the cause of death has already been determined by legal processes. In others the passing of time and lack of evidence make it impossible to do so. In any event, this Inquiry is concerned with and has been set up to identify the systemic issues that have given rise to the deaths and serious harm we're concerned with. This Inquiry will uncover what went wrong, but, in doing so, I also want to investigate what went right, what good practice looks like and how things can be improved. Indeed I accept that there were many dedicated members of staff on the wards during the time in question who were carrying out their work to the highest standards. The importance of this Inquiry is to learn lessons of general application so that we can ensure that the identified failings are never able to happen again, in Essex or beyond, in mental health facilities across the country.

The Secretary of State for Health set the Inquiry's Terms of Reference in their current form in April this year. They outline the matters this Inquiry will investigate. You can find them on the Inquiry's website along with an explanatory note which indicates how I propose to interpret them.

The Inquiry is investigating "the circumstances surrounding the deaths of mental health inpatients". The focus is accordingly on those who died as inpatients rather than those who were being treated in the community. However, my proposed definition of inpatient deaths enables me to examine the circumstances of those who died up to three months post-discharge, including the support provided on discharge as well as the circumstances surrounding assessments and admissions to inpatient wards. This means that some aspects of care received in the community will inevitably fall within the Inquiry's investigations.

The Inquiry will look into serious failings in inpatient treatment and care, including serious harm that did not end in a death. It will also be considering how the NHS engaged with patients and their families, matters relating to physical and sexual safety, the actions of staff as well as the Trusts' approach to staffing, the relevant leadership, culture

and governance within the Trust, the quality of the Trusts' investigations and how they responded when things went wrong and the interactions between the Trusts and other bodies, such as coroners' courts.

I am satisfied that the scope of this Inquiry provides the breadth needed to thoroughly address the significant areas of concern identified, but the terms are also appropriately focused and proportionate, allowing me to report and make recommendations within a reasonable period of time.

My hope and expectation is that any witness I call to give evidence at a hearing or to whom a request is made to provide documents or a written statement will cooperate voluntarily with the Inquiry. Where NHS staff in Essex have relevant information, I will expect them to come forward to the Inquiry with it. I expect the Inquiry's requests for evidence to be met promptly and with complete candour. My strong wish is to work collaboratively with core participants and others engaging with the Inquiry to achieve my objectives. I should, however, make clear from the outset that, where relevant evidence is not provided or is not provided appropriately promptly, I will not hesitate to use my statutory powers to the fullest extent necessary to compel its production. I will also expect the

organisations at the heart of the Inquiry's investigations to be appropriately resourced so that they engage effectively and efficiently with the Inquiry.

I'd like to turn now to speak about the Inquiry team. It's made up of the secretariat, solicitor and counsel teams, who work closely together to support me and advance the Inquiry's work. Kate Ward is the secretary to the Inquiry. Her role is to support and advise me and to act as Chief of Staff to the Inquiry. She is a member of the Senior Civil Service and has wide-ranging experience highly relevant to this Inquiry. She has also worked on the front line as a nurse. She is supported by a highly skilled secretariat team.

Catherine Turtle is lead solicitor to the Inquiry. Her role includes advising me and the Inquiry team on any legal issues which may arise. She has extensive experience of working with inquiry teams, stakeholders and witnesses. She is supported by a team of solicitors with significant inquiry experience.

Nicholas Griffin KC is lead counsel to the Inquiry and you will be hearing from him after me. He has practised extensively as a barrister in major public inquiries. His role includes the presentation of evidence at this Inquiry, which he will do with his team

DATE: 6th June 2025

Our Ref: Operation Tarn

Ms. Sadif Ashraf
Solicitor to the Inquiry
[redacted]

By email only

POLICE SCOTLAND
Keeping people safe
POILEAS ALBA

Legal Services Department – North Hub
Police Scotland
[redacted]
Email – [redacted]

Dear Ms Ashraf,

Procedural Hearing 12 and 13 June

I refer to your correspondence of 4 June requesting confirmation of whether or not oral representation will be made by the Chief Constable at the Procedural Hearing to take place on 12 and 13 June 2025.

The Chief Constable has given careful consideration as to whether oral submissions require to be made on her behalf at the Procedural Hearing.

The Chief Constable has made written submissions but reserved further comment on the Application pending sight of the submissions of the Families and the Note by the Chair. These have since been made available. There are also submissions on behalf of the Inquiry submitted by Jason Beer KC who has joined the Inquiry Counsel team.

Having reviewed the submissions of the Families and the Note by the Chair, the Chief Constable iterates that she is concerned about the necessity of the oral Procedural

Hearing. As presently advised the proposals as regards the conduct of the hearing remain unknown.

From the terms of the submissions of CTI it appears that the position of the Chief Constable has been misunderstood. Contrary to what is suggested by CTI, at no point was it suggested that the Chair should not make the decision about recusal, but rather it was proposed that it was not necessary to convene an oral hearing to do so. The letter of 2 May 2025 should be read as a whole. It was suggested, in the context of there being a timetable for same, that the Chair could make his decision on the basis of the '*written submissions'.* CTI agrees with the SPF position that the Chair *'cannot be the ultimate arbiter of whether he has acted fairly and impartially or is biased in fact'*.

The questions regarding the role of independent counsel were made on the basis that the Chief Constable had understood that the counsel to be instructed was to be independent of the Inquiry rather than be a member of the counsel team to the Inquiry. There was no suggestion made by the Chief Constable that such independent counsel would make the decision.

In terms of the assistance which can be offered by other Core Participants, CTI also appears to agree with the proposition made by the Chief Constable that the issue which one Core Participant has is not going to be resolved by asking other Core participants their views, whether supportive or against the position stated. CTI has stated that '*it is not the principal function of CTI- in the present context- to seek to persuade or convince the Chair what conclusion should be drawn from the facts…in particular when the Core Participants themselves offer a range of views*.' This, we would suggest calls into question the necessity of the oral hearing, in principle.

The cost to Police Scotland of the oral hearing is significant for the reasons previously stated. However, given that the procedure which has been set in train by the Inquiry means that it is now only at the oral hearing that the response of the SPF and others to the Note by the Chair and the submissions of CTI will be known, the Chief Constable is resigned to the oral Procedural Hearing proceeding.

Otherwise, the Chief Constable reaffirms that the Families are at the heart of the Inquiry and has sympathy for the frustration they must feel that the conduct of the Chair has come to be scrutinised at this stage of the Inquiry as a result of the late disclosure of the information about the meetings. The current issue has arisen in a situation which is not of their making, but nor does it lie at the door of any other Core Participant. The Chief Constable understands why there are concerns on the part of the Applicants, those who conjoin in the application, and the Crown.

The issue should be looked at in the context of the aims of the Inquiry and the full ToR. As stated by the then Cabinet Secretary on announcing the Inquiry on 12 November 2019:

> *We must not lose sight of the purpose of this Inquiry: to establish the circumstances leading to and following the tragic death of Mr Bayoh* ***in order to identify any steps which could prevent deaths in similar circumstances – and to improve the post-incident management following such deaths.***

The Chief Constable has been committed to the ascertainment of the facts as to what happened to Sheku Bayoh on 3 May 2015, the investigation of the actions after his death, and as to whether or not Mr Bayoh's 'race' or perceived 'race' was a factor. One of the aims of the Inquiry is to build trust and confidence in policing.

The Chief Constable does not invite the Chair to recuse himself. The issues which the organisation has with the fairness of the conduct of the Inquiry to date will be dealt with fully in her closing submissions. That is a decision the Chief Constable can take because she is committed to continuous improvement in policing. Her engagement with the Inquiry and Police Scotland's organisational learning are aligned completely with the aims of the ToR, which include the aim to maintain and restore confidence in policing.

However, members of Police Scotland, of which she is the leader, have brought before the Chair issues of concern upon which the Chair will need to reflect and to consider fairly. Her decision not to seek recusal should not be interpreted as an indication that she is against the application of the SPF. It will now be for their representatives to

submit, *if and why*, the Note by the Chair and/or the submissions on his behalf by CTI do not allay those concerns.

For these reasons, the Chief Constable does not require for there to be oral submissions made on her behalf at the Procedural Hearing.

Legal representation for the Chief Constable will be in attendance at the Procedural Hearing on 12 and 13 June. I can confirm the details of those attending as follows:

12 June	13 June
Maria Maguire KC	Maria Maguire KC
Lisa Henderson KC	Suzanne Lambert
[redacted]	[redacted]
[redacted]	[redacted]

Yours faithfully,

[redacted]

[redacted]
Principal Solicitor