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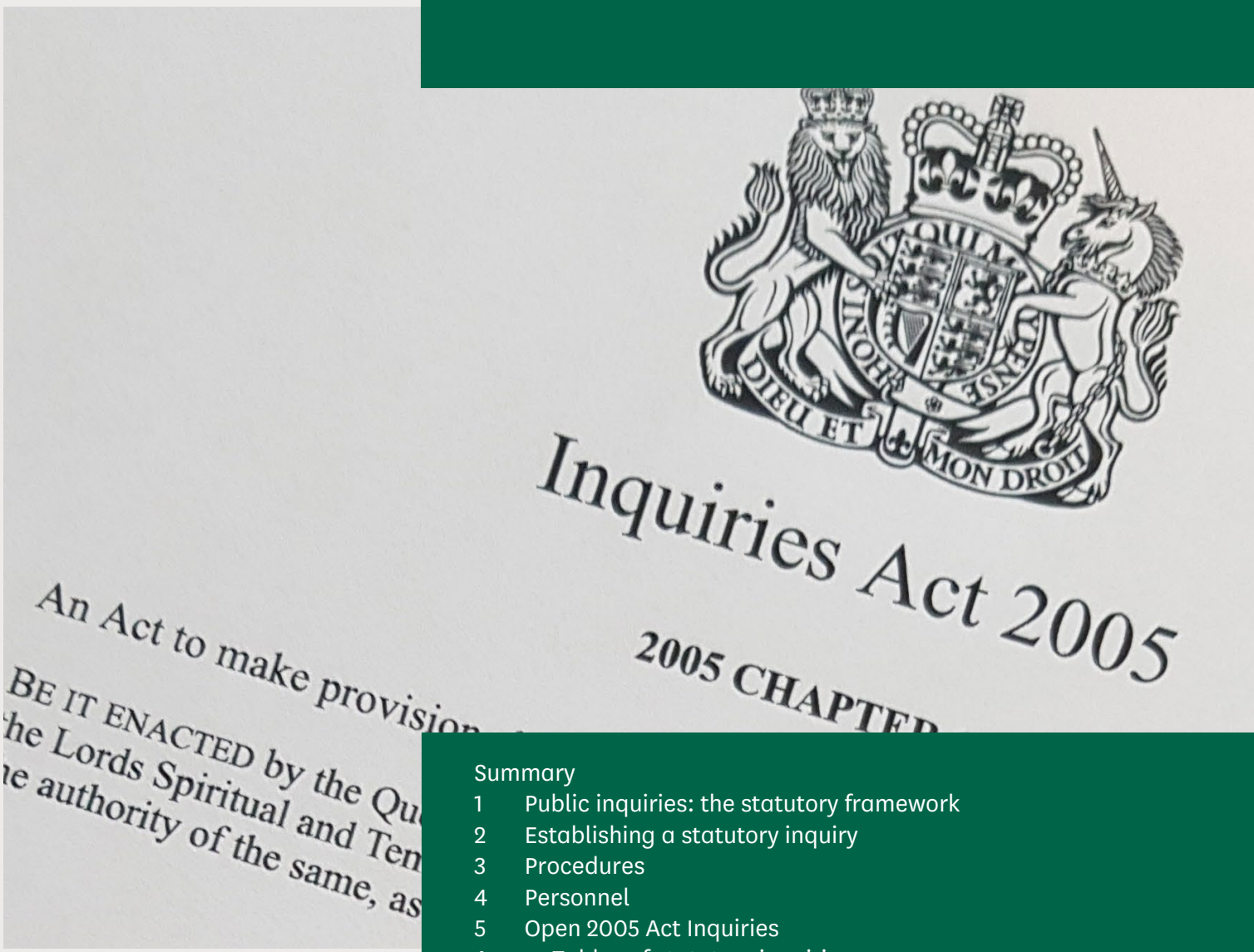
Statutory public inquiries: The Inquiries Act 2005



Contents

Summary

This research briefing examines one type of 'public inquiry' – statutory public inquiries held under the Inquiries Act 2005. It sets out how they are set up and run. It also gives information about current statutory inquiries. These include the UK Covid-19 inquiry and the Post Office Horizon IT inquiry.

What are 'public inquiries'?

'Public inquires' are investigations set up by Government ministers to respond to events of major public concern or to consider controversial public policy issues.

The Cabinet Office advises ministers on establishing and running public inquiries (pdf).

As well as the statutory public inquiries discussed in this research briefing, the Government may set up other types of investigation, such as a non-statutory inquiry, a Royal Commission or a departmental inquiry.

There is more information about those approaches in the Commons Library research briefing Non-statutory public inquiries.

What's different about statutory inquiries?

Statutory inquiries operate in line with the provisions of the Inquiries Act 2005 and the Inquiry Rules 2006. Arrangements are more strictly defined than in other types of inquiry. Statutory inquiries may for instance:

- compel witnesses to provide evidence
- provide certain legal safeguards
- maintain clearer limits on the Government's involvement

Some statutory inquiries, such as the Lampard Inquiry into mental health services in Essex and the Post Office Horizon IT inquiry– have been converted from non-statutory inquiries to help ensure engagement by potential witnesses. Others – such as the inquiry into the death of Jalal Uddin – are converted from inquests to enable proper consideration of otherwise confidential information.

By their nature, statutory inquiries are controversial. There are often questions about who should be the Chair, the terms of reference, the proposed budget and timetable, and the inquiry's working methods.

1 Public inquiries: the statutory framework

1.1 Types of inquiry

The term 'public inquiry' can denote several procedures that are distinct in law. This paper focuses on statutory inquiries under the Inquiries Act 2005.

There are four forms of non-statutory public inquiry:

- non-statutory ad-hoc inquiries (including independent panels)
- Committees of Privy Counsellors
- Royal Commissions
- departmental inquiries[1]

The Inquiries Act 2005 provides for the establishment of a statutory inquiry. It establishes a statutory framework for appointing a chair and other personnel, taking evidence, producing a report and recommendations, and paying expenses.

The 2005 Act replaced the Tribunals of Inquiry (Evidence) Act 1921. Governments considered that Act inflexible so rarely used it. They preferred to use non-statutory and subject-specific statutory inquiries.[2] The 2005 Act sought to make statutory inquiries the default option, and to avoid some of the problems associated with the 1921 Act.[3]

To date 39 inquiries have been established under the 2005 Act, of which 17 are currently operating. Of the open inquiries, 11 were established by the UK Government, five by the Scottish Government and one by the Northern Ireland Executive. Section 5 of this briefing gives further details of these.

The Inquiry Rules 2006 provide several detailed requirements for the administration of inquiries. See section 3.1 for further detail.

[1] See the Commons Library research briefing, Non-statutory public inquiries (SN-02599).
[2] See a table of inquiries established between 1900 and 2004 in Public Administration Select Committee, Government by Inquiry (pdf), HC 51-1, 3 February 2005, p86-95.
[3] See UK Parliament, Public Administration - Minutes of Evidence: Annex B: Review of inquiries and overlapping procedures: Preliminary report, 25 May 2004.

1.2 Establishing a statutory inquiry

Section 1 of the 2005 Act provides that only Government Ministers, from either the UK or the devolved administrations, can establish a statutory inquiry. The formal procedure for establishing an inquiry is set out in a Cabinet Office Guide (pdf).[4] This means that anyone seeking a statutory inquiry into a particular matter must persuade the relevant Minister.

Once they propose an inquiry, Ministers must, as soon as reasonably practicable, make a statement to Parliament or to the relevant devolved legislature. This should set out who is to chair the inquiry, any proposed members of the panel, and the terms of reference.

Statutory inquiries under the Inquiries Act 2005 are generally established by the relevant government department but once established they are formally independent. Their secretariats are normally newly appointed for each inquiry, and mainly seconded from the Civil Service.

The Ministry of Justice is responsible for the Inquiries Act 2005 and the Inquiry Rules 2006 (see section 3.1), and advises on the application of both. But within Government the Cabinet Office is responsible for advising on whether an inquiry should be held under the Inquiries Act 2005 in the first place.

Territorial remits

The UK Government has the power to establish an inquiry covering any part (or the whole) of the UK, and/or to establish an inquiry jointly with the devolved administrations. It can also establish an inquiry on behalf of more than one UK government minister.[5] However, an inquiry set up by a devolved administration has more constrained powers: for instance, the Penrose Inquiry (2008-15) could not compel witnesses outside of Scotland to attend. An inquiry established by the UK Government can look into devolved matters and use the powers in section 21 to compel evidence and witnesses, provided certain conditions are met.

For a UK inquiry to include in its terms of reference a matter that was devolved at the time of the event being inquired into, the relevant devolved administration must be consulted. They must also be consulted if the chair is given power to compel the production of evidence.

Other powers to establish inquiries

The 2005 Act repealed several powers to hold inquiries contained in other legislation. Some similar powers still exist: these include section 14(1)(b) of the Health and Safety at Work Act 1974 (incidents and accidents), sections 68-72 of the Financial Services Act 2012 (serious failure of the regulatory

4 Cabinet Office, Inquiries guidance (pdf)

5 Explanatory Notes to the Inquiries Act 2005, para 81

system), and those the Merchant Shipping Act 1995. The House of Lords report on the 2005 Act includes a list of inquiries established under other powers between 1990 and 2005.[6]

1.3 Operation of the Inquiries Act 2005

Executive control at Parliament's expense

There has been some criticism that the 2005 Act represented a strengthening of ministerial control over statutory inquiries. For example, the Public Administration Select Committee (PASC) expressed concern that Parliament's involvement in inquiries would be diminished by the 2005 Act.[7] Repealing the 1921 Act, as the Committee put it, "remove[d] the opportunity for formal parliamentary involvement in inquiries." Moreover: the new framework:

> strengthens the Executive's position by enabling ministers not just to decide on the form and personnel of an inquiry before it has begun but also influence its operation.[8]

This concern about Parliamentary oversight, or the lack of it, was reiterated more recently by the Public Administration and Constitutional Affairs Committee in its 2017 report (pdf). It said:

> We remain concerned about the lack of mechanisms for meaningful Parliamentary oversight over the establishment of both statutory and non-statutory inquiries.[9]

It argued that the House of Commons should have a greater say in a range of matters before an inquiry is set up. For example, an ad hoc Select Committee, it said, should have the opportunity to report on the Government's proposed terms of reference for a public inquiry, and to recommend whether the inquiry should be a statutory one. Moreover, it argued that there should be a vote on an amendable motion before the terms of reference are formally set, and that this motion should also indicate a timescale and budget for an inquiry. Under the 2005 Act, none of this is required and no such parliamentary activity can bind a Minister or any inquiry they set up.[10]

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6 House of Lords Select Committee on the Inquiries Act, The Inquiries Act 2005: post-legislative scrutiny (pdf), HL 143, 11 March 2014, p108-117

7 Public Administration Select Committee, Government by Inquiry (pdf), HC 51-1, 3 February 2005, p62; see also the Government response (pdf).

8 Public Administration Select Committee, Government by Inquiry (pdf), HC 51-1, 3 February 2005, p62

9 Public Administration and Constitutional Affairs Committee, Lessons still to be learned from the Chilcot Inquiry (pdf), HC 656, 16 March 2017, p14

10 As above

Questions about the independence of inquiries

The Joint Committee on Human Rights expressed concern that certain aspects of the legislation risked compromising the independence of an inquiry, potentially breaching Article 2 of the European Convention on Human Rights where the subject matter of the inquiry concerned the right to life. These included provisions in the Act for:

- ministers to bring an inquiry to a conclusion before publication of the report (section 14)
- ministers to restrict attendance at an inquiry or to restrict disclosure or publication of evidence (section 19)
- the 'default position' on publication whereby a minister may become responsible for publishing the conclusions of an inquiry and for determining whether any material should be withheld in the public interest (section 25).[11]

These powers were linked to a perception within Government that 1921 Act inquiries took longer than other inquiries, though the PASC report disputed this.[12]

Post-legislative review by the House of Lords

On 11 March 2014, the House of Lords Select Committee on the Inquiries Act 2005 published its report The Inquiries Act 2005: post-legislative scrutiny (pdf).[13] The Committee's overall conclusion on the operation of the 2005 Act was positive, and the report noted that concerns over ministerial interference had proved unfounded.[14] The Committee made thirty-three recommendations for how statutory inquiries under the Act could be improved, including a number of changes to the Act itself and to the Inquiry Rules (see section 3.1).[15] The Committee viewed the rules on warning letters (see section 3.5) as burdensome and causing delays. They recommended the rules be redrafted to make the procedure more flexible and proportionate.[16]

- The Committee also recommended setting up a permanent unit within Her Majesty's Courts and Tribunals Service, to be responsible for running inquiries.[17] This would both act as a repository of good practice in inquiry administration and would reduce set-up costs incurred by each new inquiry. The Institute for Government's 2017 report (see below) advocated setting up a similar unit in the Cabinet Office.

[11] Joint Committee on Human Rights, Fourth report session 2004-05 (pdf), HC 224, 12 January 2005
[12] Public Administration Select Committee, Government by Inquiry (pdf), HC 51-1, 3 February 2005, p16
[13] House of Lords Select Committee on the Inquiries Act, The Inquiries Act 2005: post-legislative scrutiny (pdf), HL 143, 11 March 2014
[14] As above, p91
[15] As above, recommendations 6, 9, 4 and 10
[16] As above, recommendation 25
[17] As above, recommendation 12

The Government rejected these recommendations, but it accepted other recommendations to strengthen the way that inquiries processes are handled within Government, including:

- ensuring that on the conclusion of an inquiry the secretary delivers a full lessons learned paper from which best practice can be distilled and continuously updated
- reviewing and amending the Cabinet Office Guidance (pdf) in the light of the Committee's recommendations and the experiences of inquiry secretaries, and publishing it on the Ministry of Justice website
- retaining the contact details of previous secretaries and solicitors, and being prepared to put them in touch with staff of new inquiries
- collating Procedures Protocols and other protocols issued by inquiries and making them available to subsequent inquiries[18]

Institute for Government report 2017

The Institute for Government published a report in December 2017 entitled How public inquiries can lead to change (pdf). This noted several features of the current practice of public inquiries:

- Inquiries are a regular feature of the administrative landscape. The authors note that "since 2000, there [had] never been fewer than three concurrent inquiries running in any month, and at the high point in 2010 there were as many as 15".[19]
- The average inquiry takes two and a half years to publish its final report. This length of time risks diminishing the impact that an inquiry's findings can have. Inquiries should attempt to produce more rapid interim reports wherever possible.
- Inquiries should make more systematic use of expert witnesses, potentially via seminars at an early stage to bring the inquiry panel up to speed on key issues.
  There is no formal process for following-up and implementing the findings of public inquiries. This tends only to occur where individual inquiry chairs take the initiative to follow up results.
- To ensure that good practice in running public inquiries is retained, a central secretarial unit should be established in the Cabinet Office. This could also lead an improved follow-up process. Select committees should also follow up on the implementation of inquiry recommendations annually for the five years following an inquiry.

[18] House of Lords Select Committee on the Inquiries Act, The Inquiries Act 2005: post-legislative scrutiny (pdf), HL 143, 11 March 2014, recommendations 13-16

[19] Emma Norris and Marcus Shepheard, How public inquiries can lead to change (pdf), Institute for Government, 12 December 2017, p9 [accessed 18 January 2024]

2 Establishing a statutory inquiry

2.1 The decision to hold an inquiry

Statutory inquiries may be established into 'matters of public concern', but there is no fixed threshold that identifies when this criterion has been met.[20] The Cabinet Secretary issued a guidance note on the establishment of judicial inquiries in 2010. This noted common characteristics of the events that had led to previous inquiries:

- large scale loss of life
- serious health and safety issues
- failure in regulation
- other events of serious concern.[21]

The Public Administration Select Committee's 2005 report Government by Inquiry (pdf) endorsed six principal purposes for holding an inquiry that had been identified by Lord Howe:

- Establishing the facts – providing a full and fair account of what happened, especially in circumstances where the facts are disputed, or the course and causation of events is not clear
- Learning from events – and so helping to prevent their recurrence by synthesising or distilling lessons that can be used to change practice
- Catharsis or therapeutic exposure – providing an opportunity for reconciliation and resolution, by bringing protagonists face to face with each other's perspectives and problems
- Reassurance – rebuilding public confidence after a major failure by showing that the government is making sure it is fully investigated and dealt with
- Accountability, blame, and retribution – holding people and organisations to account, and sometimes indirectly contributing to the assignation of blame and to mechanisms for retribution

[20] House of Lords Select Committee on the Inquiries Act, The Inquiries Act 2005: post-legislative scrutiny (pdf), HL 143, 11 March 2014, p20

[21] As above, p21; see also Cabinet Office, Public Inquiries (pdf), 19 March 2010, p2

- Political considerations – serving a wider political agenda for government either in demonstrating that "something is being done" or in providing leverage for change.[22]

The report also proposed several criteria for establishing what type of inquiry to hold:

- Can the nature of the problem be clearly described (for example, a serious financial or economic loss, a major accident possibly involving fatalities, serious physical harm or death to one or more persons; a serious and demonstrable failure of public policy)?
- Was it likely that political, administrative or managerial failings were a factor?
- Are there clear implications for public policy including new or poorly understood issues?
- Is there a high and continuing level of public concern over the problem?
- Is there likely to be an adverse impact on public confidence in this area which cannot otherwise be satisfactorily resolved?
- Are any established alternatives available (for example, the legal system; the complaint and redress system; internal and external regulatory systems)?
- Have these alternatives been exhausted or are they considered insufficient or inappropriate to meet the level of public concern?
- Do the potential benefits outweigh the estimated costs (financial and other) of an inquiry?[23]

The Cabinet Office's Inquiries Guidance states that the Government will not automatically favour statutory over non-statutory ad hoc inquiries.[24]

On 19 March 2015, the House of Lords debated a report of the Select Committee on the Inquiries Act 2005. The then Minister of State, Lord Faulks, offered an insight into how decisions over the form of inquiry are made:

> … Ministers will in fact always consider the suitability of the 2005 Act when deciding to establish a public inquiry—it will always be the starting point.
>
> Ministers will, however, also want to consider whether another vehicle would be more appropriate and effective, bearing in mind time and cost. This could be a non-statutory inquiry … an independent review; a parliamentary inquiry; an inquiry of privy counsellors; an investigation with a public hearings element overseen by a judge or QC; an independent review with a public hearings element; or, in a very limited number of cases, an inquiry

[22] Public Administration Select Committee, Government by Inquiry (pdf), HC 51-1, 3 February 2005, p9-10
[23] As above, p66
[24] Cabinet Office, Inquiries guidance (pdf), p3

established under other legislation, such as the Financial Services Act 2012 or the Merchant Shipping Act 1995.

Across government there was consensus that Ministers must retain the option of deciding whether or not to use the Act.... there is always the option to convert an inquest or other form of inquiry, investigation or review, into a 2005 Act inquiry in the event that powers under the Act—such as those to compel witnesses—are felt to be required.[25]

2.2 Terms of reference

The 2005 Act requires the Minister establishing the inquiry to set out the terms of reference of the inquiry in writing, either when appointing the chair or "within reasonable time afterwards".[26] Section 5 defines the terms of reference as follows:

> (a) the matters to which the inquiry relates
>
> (b) any particular matters as to which the inquiry panel is to determine the facts
>
> (c) whether the inquiry panel is to make recommendations
>
> (d) any other matters relating to the scope of the inquiry that the Minister may specify.

An inquiry has no power to act outside of its terms of reference. If the inquiry is to be given a consultative duty, it must be set out in the terms of reference. It is for the inquiry itself to interpret its terms of reference.

The terms of reference may be subject to judicial review. Judicial reviews of the inquiry terms of reference took place at the outset of the Robert Hamill and Billy Wright inquiries.[27]

As a matter of law, the relevant Minister is under a statutory obligation to consult with the Chair as to the terms of reference of a 2005 Act inquiry.[28] There is no statutory obligation to consult more widely on the terms of reference. In practice, however, in several cases the inquiry chair has consulted publicly before making recommendations to the Minister about what the terms of reference should be.[29]

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[25] HL Deb 19 March 2015 [Inquiries Act 2005 (Select Committee Report)], c1174

[26] Inquiries Act 2005, s 5(1)

[27] *Hamill, Re Judicial Review* [2008] NIQB 73; *Wright, Re Application for Judicial Review* [2006] NIQB 90

[28] Inquiries Act 2005, s 5(4)

[29] Sir Martin-Moore Bick, Chair of the Grenfell Tower Inquiry, for example, held three consultation meetings for local residents and survivors and for other interested groups in July 2017.

2.3 Conversion to a statutory inquiry

Government Ministers may choose to convert a non-statutory inquiry into a statutory inquiry, via section 15 of the 2005 Act. The Inquiry Rules 2006 do not automatically apply to converted inquiries, though the Inquiries (Scotland) Rules 2007 do. [30]

The Child Sexual Abuse inquiry and the Bernard Lodge inquiry both began as non-statutory inquiries. The inquiries into the deaths of Billy Wright and Robert Hamill were converted into statutory inquiries under the 2005 Act after originally being established under different powers.

In other instances, such as the Mid-Staffordshire NHS Trust and the infected blood scandal, non-statutory investigations have taken place, but the issues they addressed remained high on the political agenda, leading to a statutory inquiry being established at a later date.

Conversion of an inquest

Schedule 1 of the Coroners and Justice Act 2009 permits inquests to be converted into inquiries held under the 2005 Act. This may happen if:

1. the Lord Chancellor requests the coroner to do so on the ground that the cause of death is likely to be adequately investigated by an inquiry under the Inquiries Act 2005 that is being or is to be held
2. a senior judge has been appointed under that Act as chairman of the inquiry; and
3. the Lord Chief Justice has indicated approval to the Lord Chancellor, for the purposes of this paragraph, of the appointment of that judge.[31]

Further provisions allow the coroner to continue their investigation if there are exceptional reasons for doing so. For more details see the Commons Library research briefing, Inquests and public inquiries.[32]

2.4 Sequencing

Inquiries may often cover issues that might come to be considered in future inquiries or legal proceedings. While a statutory inquiry cannot make a

[30] Jason Beer, Public Inquiries, 2011, p66 says that the Department for Constitutional Affairs' 2006 Response to Consultation wrongly states that converted inquiries are covered by the Rules.

[31] The 1988 Act powers were used in the case of the Anthony Grainger inquiry, and in four inquiries held under the 1921 Act (Ladbroke Grove; Harold Shipman; David Kelly; The FV Gaul): see Beer (2011), p95. The 2009 Act powers were used to suspend the inquest into the death of Alexander Litvinenko before the inquiry was established.

[32] Commons Library research briefing CBP-8012, Inquests and public inquiries, 21 June 2017

finding of individual civil or criminal liability, it could make findings that impact upon future legal cases (see also section 3.7 on liability). Jason Beer KC, a specialist in public inquiries, has noted:

> The primary role… of an inquiry investigating a matter is to make findings of fact. In order to make such findings, however, an inquiry may need to assess and make findings as to the credibility of witnesses. From its findings of fact, the inquiry may draw conclusions as to whether there has been misconduct and who appears to be responsible for it.[33]

Beer also states that it is common for a professional or disciplinary inquiry to run its course before a public inquiry, as it may assist the public inquiry with findings and with shaping its remit. There is no hard and fast rule preventing a public inquiry and criminal investigations running alongside one another: this depends upon the circumstances.

The Inquiries Act 2005 does not preclude an investigation under the Act taking place at the same time as a judicial inquiry, but this is rare due to concerns about prejudicing criminal prosecutions. For instance, the interim report of the Grenfell Tower inquiry, which had originally been due in spring 2018, was delayed because of police investigations.

2.5 Can the decision not to hold an inquiry be challenged?

Section 1 of the 2005 Act makes clear that a Minister "may" establish an inquiry into a matter of "public concern". The decision to hold or not to hold an inquiry has been subject to judicial review. In 2010 the Cabinet Office published advice issued by the then Cabinet Secretary, Gus O'Donnell, to the then Prime Minister Gordon Brown. The advice dealt with the possibility that a Minister's decision to hold a public inquiry could be open to judicial review:

> The Minister may cause an inquiry to be held if he is satisfied by either of the conditions in section 1. In particular, he would need to be satisfied that the case is one where there is public concern. A decision to hold an inquiry under section 1 could be challenged by an interested party by way of judicial review and that challenge could be upheld if the court determined that the decision to hold an inquiry was unreasonable bearing in mind the nature and the level of concern, or that the Minister had taken into account irrelevant considerations in deciding to hold the inquiry.[34]

[33] Jason Beer, Public Inquiries, 2011, p87

[34] Emma Norris and Marcus Shepheard, How public inquiries can lead to change (pdf), Institute for Government, 12 December 2017, p22 [accessed 18 January 2024]

The 2014 Lords Committee report provides examples of cases where Ministers gave detailed reasons for not establishing an inquiry.[35]

A challenge was brought against the Minister's decision to refuse to hold an inquiry into the circumstances of the death of Alexander Litvinenko in 2006.[36] Lawyers acting for Mr Litvinenko's widow argued the only rational way in which the Secretary of State could exercise her discretion under section 1(1) of the 2005 Act was to hold an inquiry into the death of Mr Litvinenko, unless there were overwhelming reasons not to.

In the judgment, given on 11 February 2014, Lord Justice Richards concluded that the "deficiencies in the reasons [given by the Secretary of State] are so substantial that the decision cannot stand".[37] He explained that the Minister was not under a duty to accede to the request to hold an inquiry, but the reasons given had to be stronger than those that she had given in order to meet the standard of rationality. On the nature of section 1 of the 2005 Act, he concluded:

> Her discretion under section 1(1) of the 2005 Act is a very broad one and the question of an inquiry is…difficult and nuanced. I do not think that this court is in a position to say that the Secretary of State has no rational option but to set up a statutory inquiry now. …I would stress that the judgment does not of itself mandate any particular outcome.[38]

Subsequently, on 22 July 2014 the then Home Secretary, Theresa May, announced the establishment of a public inquiry into the death of Alexander Litvinenko under the Inquiries Act 2005.[39]

[35] Cabinet Office, Public Inquiries (pdf), 19 March 2010

[36] For a list of ministerial reasons for not holding an inquiry see House of Lords Select Committee on the Inquiries Act, The Inquiries Act 2005: post-legislative scrutiny (pdf), HL 143, 11 March 2014, p35. A subsequent addition to this list was the decision not to hold a public inquiry into events at Orgreave during the miners' strike in 1984: see HCWS227, 31 October 2016.

[37] *R (Litvinenko) v Secretary of State for the Home Department* [2014] EWHC 194 (Admin)

[38] As above

[39] HCWS 22 July 2014 [Litvinenko Inquiry]

3 Procedures

3.1 The Inquiry Rules 2006

Section 41 of the 2005 Act provides Ministers with the power to make detailed rules on inquiry procedures. The Inquiry Rules 2006 provide a statutory guide for the chair, and include detailed rules on evidence and procedure, records management, legal representation and expenses.

The Rules came into force on 1 August 2006.[40] They cover the following areas:

- designating core participants to the inquiry
- appointing of legal representatives
- taking evidence and procedure for oral proceedings
- disclosing potentially restricted evidence in certain limited circumstances
- issuing warning letters (to witnesses where the chairman believes that they will be subjected to criticism during inquiry proceedings)
- arrangements for publishing reports and records management
- determining, assessing and paying awards

The Scottish Parliament has issued separate rules under the Act, the Inquiries (Scotland) Rules 2007.[41] No rules have yet been issued by the National Assembly for Wales or Northern Ireland Assembly for 2005 Act inquiries. Such rules, where made, would apply only to matters for which Ministers in the devolved legislatures were responsible.

The Ministry of Justice, in its post-legislative memorandum on the Act published in 2010, noted some concerns about how the Inquiry Rules were working. The report concluded:

> … we believe that overall the Act has been successful in meeting its objectives of enabling inquiries to conduct thorough and wide ranging investigations, as well as making satisfactory recommendations. We do, however, take the view that the Act can only enable effective inquiries if the inquiry is conducted by a chairman with the appropriate skill set and who is supported by an appropriately experienced inquiry team… The overwhelming evidence, however, is that the Inquiries Rules as currently drafted

[40] Inquiry Rules (SI 2006/1838)
[41] Inquiries (Scotland) Rules 2007 (SI 2007/56)

> are unduly restrictive and do not always enable the most effective operation of the Act.[42]

The memorandum stated that those consulted by the Ministry had been less positive about the Inquiry Rules.[43] The concerns expressed by consultees about the Inquiry Rules included:

- lack of definition of which records must be retained after an inquiry concludes
- lack of a power for inquiry officials to take witness statements via interview
- difficulties for participants in addressing the issues raised in 'warning letters' without breaching confidentiality
- concerns over the interaction with Freedom of Information

3.2 Taking evidence and obtaining documents

A statutory inquiry may take evidence from witnesses, either via an interview procedure or in a public hearing. Section 17(2) of the 2005 Act allows for evidence to be taken on oath.

Section 21 of the 2005 Act allows for the chair of an inquiry to require a person to give evidence, or to produce any documents. A person is guilty of an offence under section 35 if they intentionally suppress or conceal a relevant document, or prevent it from being given to the inquiry.

Section 35 of the 2005 Act provides sanctions for non-compliance with an inquiry under the Act. The offender may be imprisoned, fined or both. The maximum term of imprisonment is 51 weeks in England and Wales and 6 months in Northern Ireland and Scotland. The current maximum fine is £1,000.

3.3 Standard of proof

The 2005 Act does not dictate what standard of proof an inquiry should use. Public inquiries generally can choose their own standard of proof. In the case of the Baha Mousa Inquiry, Sir William Gage, its Chair, held that he did not feel he was obliged to adopt the criminal standard of proof:

> The 2005 Act makes no express provision as to what standard or degree of certainty is required before an inquiry is able to express its

[42] Ministry of Justice, Memorandum to the Justice Select Committee: Post-legislative assessment of the Inquiries Act 2005 (pdf), October 2010

[43] As above, p16

> findings of fact or make its recommendations. In my judgement it must follow it is for me to determine what standard I should apply when reaching my findings. [...]
>
> However, by section 2 of the 2005 Act, I have no power to determine criminal liability, and the mere fact that criminal culpability might be inferred from my findings, does not in my judgment mean that I must adopt the criminal standard in making findings of fact. On the contrary, I think the usual starting point will be to apply the civil standard...[44]

In contrast, the Undercover Policing Inquiry adopted a more variable approach to the standard of proof.[45]

3.4 Openness and transparency

There is a presumption in section 18 of the 2005 Act that members of the public will be able to watch the inquiry, either in person or via a broadcast. This section imposes duties on an inquiry as to the disclosure of documents and evidence to members of the public. The chair must take reasonable steps to secure that members of the public are able to obtain or view a record of evidence and documents given to the inquiry.

Section 19 provides that the proceedings of an inquiry must be made public unless one of several circumstances apply. The inquiry will consider:

> (a) the extent to which any restriction on attendance, disclosure or publication might inhibit the allaying of public concern
>
> (b) any risk of harm or damage that could be avoided or reduced by any such restriction
>
> (c) any conditions as to confidentiality subject to which a person acquired information that he is to give, or has given, to the inquiry
>
> (d) the extent to which not imposing any particular restriction would be likely
>
> > (i) to cause delay or to impair the efficiency or effectiveness of the inquiry, or
> > (ii) otherwise to result in additional cost (whether to public funds or to witnesses or others).[46]

[44] The Baha Mousa Public Inquiry, Ruling on the Standard of Proof, 7 May 2010
[45] Undercover Policing Inquiry, Standard of Proof – Minded to Note 1 (pdf), 17 December 2015 [accessed 18 January 2024]
[46] Inquiries Act 2005, s19

Restrictions on openness may be applied either by the Chair or a Minister.

Freedom of Information legislation does not apply to a public inquiry as the inquiry is not a public body within the definitions of the Freedom of Information Act 2000. Section 32 of that Act also provides an exemption for documents held by other public authorities for the purposes of an inquiry.

A non-statutory inquiry could hold hearings entirely in private. This could have the advantages of encouraging candour from participants, but it could equally reduce public trust in the outcome.

Witness anonymity

Legal challenges are frequently brought to contest the level of protection that statutory inquiries provide to witnesses. In the Leveson Inquiry, Associated Newspapers Ltd applied for judicial review over a ruling by Leveson that anonymous evidence would be admissible. The application was rejected on the grounds that it was not the court's role to "micromanage the conduct of the Inquiry by the Chairman".[47]

In the Robert Hamill inquiry, a number of ex-RUC officers applied to give their evidence anonymously, claiming that they would otherwise be exposed to an increased risk of terrorist attack. Except for one individual, all applications were rejected by the Inquiry Panel in August 2006.[48] This approach was subsequently endorsed by a House of Lords ruling on 31 July 2007.[49]

Soldiers who were asked to give evidence to the Bloody Sunday inquiry sought to challenge the inquiry's decision that their names should be disclosed. The Court of Appeal concluded that the policy of naming witnesses was procedurally unfair. Lord Woolf emphasised that the implications of the principle of procedural fairness will depend on the nature of the inquiry in question.[50]

3.5 Warning letters ('Maxwellisation')

Rules 13, 14 and 15 of the Inquiry Rules 2006 require an inquiry chair to send a warning letter in advance to any person who may be, or has been, subject to criticism in the inquiry's report. The inquiry panel must not include any explicit or significant criticism of a person in the report, or any interim report, unless that person has been sent a warning letter and been given a reasonable chance to respond. This process is also known as 'Maxwellisation'. This dates from the Pergamon Inquiry in the late 1960s, when the businessman Robert

[47] *R (Associated Newspapers Ltd) v The Rt Hon Lord Justice Leveson (as chairman of the Leveson Inquiry)* [2012] EWHC 57

[48] Robert Hamill Inquiry Press Notice 004, Anonymity Ruling, 16 August 2006

[49] *In re Officer L* (pdf) [2007] UKHL 36

[50] *R (R and Others) v Lord Saville of Newdigate* [2000] 1 WLR 1855

Maxwell issued legal proceedings after being criticised, without prior warning, in the inquiry report.[51]

This practice is generally also used in non-statutory inquiries despite there not being a statutory requirement. It is often viewed as a necessity to ensure procedural fairness.

3.6 Disclosure of findings

The inquiry chair must present the inquiry's report to the relevant Minister, who must publish it.[52]

Procedures exist for disclosing of information during an inquiry to core participants (see section 4.2). This may be done if part of the purpose of the inquiry is to provide information to an identified group of people affected by the issues that the inquiry is investigating.

There are potential problems with this practice: for instance, disclosure could affect subsequent witness statements, which would potentially breach an inquiry's requirement of fairness. For instance, the Hillsborough Independent Panel disclosed information to the affected families before it was made publicly available. This was not a statutory inquiry, so it was not required to consider whether any future evidence statements would be prejudiced by early disclosure.

3.7 Liability

Section 2 of the Inquiries Act 2005 prevents an inquiry from making a finding of civil or criminal liability. This means that the right to a fair trial under Article 6 of the European Convention on Human Rights does not apply to public inquiries. However, inquiry findings have in the past triggered prosecutions.

For instance, the Azelle Rodney inquiry found that there was no lawful justification for Mr Rodney's shooting.[53] After the inquiry, the Crown Prosecution Service announced they would charge Anthony Long,[54] the firearms officer who shot Mr Rodney, with murder.[55] Mr Long had sought a judicial review into the findings of the inquiry on the basis that the report's

[51] The Treasury Select Committee undertook a short review of the Maxwellisation process in late 2016 and early 2017, written by two leading lawyers.

[52] Inquiries Act 2005, s24-25

[53] The Azelle Rodney Inquiry, The Report of The Azelle Rodney Inquiry (pdf), HC 552, p87, 5 July 2013

[54] Throughout the Inquiry the officer was known as E7 to ensure anonymity. Reporting restrictions were lifted during the trial.

[55] BBC News, "Ex-policeman on Azelle Rodney murder charge", 30 July 2014 [accessed 18 January 2024]

findings were irrational. He was backed by the Metropolitan Police.[56] The initial application and a High Court application were refused; Sir Brian Leveson held that there was "no value in granting permission to pursue the issue further, in circumstances where it could not change the fundamental conclusion of the Inquiry."[57]

On 3 July 2015, a jury at the Old Bailey found Anthony Long not guilty of murder.[58]

Following the Robert Hamill Inquiry, in December 2010, the Public Prosecution Service for Northern Ireland announced that it would commence criminal proceedings against three individuals on charges of perverting the course of justice. The inquiry completed its report in February 2011, but owing to ongoing legal proceedings, it has not yet been published, although an interim report with one recommendation was issued in March 2010.[59]

3.8 Costs

The chair of an inquiry has substantial discretion over the incurring of day-to-day costs. Section 40 of the 2005 Act provides that the Chair can meet the expenses of witnesses. In the case of core participants, this might include expenses for legal representation, if so approved by the inquiry. Rules 19-34 of the Inquiry Rules provide detailed rules on expenses. They require that the hourly rates of remuneration for publicly funded legal representation, and the nature and estimated duration of the work, must be agreed in advance.

The 2005 Act also permits the Minister, and the Chair, to take steps to control costs. Concerns over cost overruns formed part of the background to the passage of the 2005 Act, though the 2005 Public Administration Select Committee report (pdf) found that no clear difference could be identified between the costs of statutory and non-statutory inquiries.[60] The Government's post-legislative scrutiny memorandum of 2010 stated:

> [The 1921 Act] contained no provision to control the costs of inquiries. This meant that the Government was unable to control the costs on inquiries set up under the 1921 Act such as the Bloody Sunday Inquiry. Indeed, some of the momentum for the 2005 Act arose specifically from the Bloody Sunday Inquiry which took twelve years to conclude and cost £192m. The Government noted in 1998, in reference to the conduct of the Bloody Sunday Inquiry, that there had been cases

[56] "Azelle Rodney death: Met to support police marksman's legal challenge", The Guardian, 13 August 2013 [accessed 18 January 2024]

[57] *EZ Re Judicial Review* [2014] EWHC 452

[58] BBC News, "The police marksman cleared of murder in Azelle Rodney case", 3 July 2015 [accessed 18 January 2024]

[59] Robert Hamill Inquiry, Interim Report, 29 January 2010

[60] Public Administration Select Committee, Government by Inquiry (pdf), HC 51-1, 3 February 2005, p15

> where inquiries had been marred by arguments about procedure, or had taken much longer or cost more than originally expected.[61]

3.9 Following up inquiries

The 2017 Institute for Government report identified that no process exists for following up the recommendations of an inquiry. Once an inquiry has reported, the chair's involvement normally ends and the secretariat typically disbands. Responsibility for the issue reverts to the department that set the inquiry up. The report suggested that it was relatively rare for Government departments to follow up inquiry recommendations effectively, risking the recurrence of failures identified in the inquiry process.

The Institute for Government also suggested that a central 'inquiries unit', located in the Cabinet Office, would ensure that good practice in the administration of inquiries could be retained. Currently, "secretariats are not always able to access the full range of good practice. Instead, they are heavily dependent on individual experience and informal networks for advice".[62]

The Institute also recommended that following up inquiry recommendations should become an additional 'core task' of select committees. They stated that

> of the 68 inquiries [statutory and non-statutory] that have taken place since 1990, only six have received a full follow-up by a select committee to ensure that government has acted.[63]

It recommended that the relevant department should update the select committee annually on progress in implementing recommendations for five years following the report's publication. The committee would have the option of holding one-off evidence sessions if the reporting was unsatisfactory.

In May 2023, in a letter to the Guardian newspaper, the chair of the Home Affairs Select Committee, Diana Johnson, suggested one way of formally holding the Government to account for its responses to public inquiries might be through the House of Commons select committee structure.[64]

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[61] Ministry of Justice, Memorandum to the Justice Select Committee: Post-legislative assessment of the Inquiries Act 2005 (pdf), October 2010, p3

[62] Emma Norris and Marcus Shepheard, How public inquiries can lead to change (pdf), Institute for Government, 12 December 2017, p20 [accessed 18 January 2024]

[63] As above, p26

[64] Guardian Letters, How to hold the government to account on public inquiries, 30 May 2023 [accessed 18 January 2024]

4 Personnel

4.1 The chair

The identity of the chair is arguably the most significant decision to be made after the decision to hold an inquiry is taken. The 2005 Act provides for a Minister to appoint a chair alone or a chair and other panel members. The Ministerial Code states that the Minister must consult the Prime Minister before appointing the chair.[65]

There is no legal obligation for an inquiry to be chaired by a judge.[66] However, the Minister, in appointing the chair, is under an obligation to ensure that the appointee has the "necessary expertise to undertake the inquiry".[67] In practice, current or retired members of the judiciary are very often asked to chair public inquiries, because of their perceived skill and independence, as well as their ready availability. According to the Institute for Government's 2017 report, 44 out of 68 public inquiries held since 1990 had been chaired by a judge.[68]

Section 10 of the 2005 Act stipulates that before appointing of a sitting judge, the Minister must consult with the relevant head of the judiciary. For judges in England and Wales, this is the Lord Chief Justice.

There is no requirement to appoint a panel for an inquiry. The 2005 Public Administration Select Committee report Government by Inquiry noted that panels could serve to give confidence to people affected by the issues addressed by the inquiry.[69] If a panel is appointed, the Minister is required to have regard to the need to ensure that the panel, taken as a whole, has the necessary expertise to undertake the inquiry.[70] In a statutory inquiry, this legal duty would come before any undertaking to consult on the appointment of the panel.

[65] Cabinet Office, Ministerial Code, 22 December 2022, para 4.13

[66] A discussion of the merits of a judge chairing an inquiry can be found in Public Administration Select Committee, Government by Inquiry (pdf), HC 51-1, 3 February 2005, p19-26.

[67] Inquiries Act 2005, s4

[68] Emma Norris and Marcus Shepheard, How public inquiries can lead to change (pdf), Institute for Government, 12 December 2017, p16 [accessed 18 January 2024]. Note that these figures include several non-statutory inquiries.

[69] Public Administration Select Committee, Government by Inquiry (pdf), HC 51-1, 3 February 2005, p31

[70] Inquiries Act 2005, s8(1)

The Minister is also required not to appoint a person as a member of the inquiry panel if it appears that the person has a direct interest in the matter to which the inquiry relates, or a close association with an interested party.[71]

4.2 Core participants

The Inquiry Rules 2006 provide that:

> 5. (1) The chairman may designate a person as a core participant at any time during the course of the inquiry, provided that person consents to being so designated.
>
> 5. (2) In deciding whether to designate a person as a core participant, the chairman must in particular consider whether
>
> (a) the person played, or may have played, a direct and significant role in relation to the matters to which the inquiry relates
> (b) the person has a significant interest in an important aspect of the matters to which the inquiry relates or
> (c) the person may be subject to explicit or significant criticism during the inquiry proceedings or in the report, or in any interim report.

Core participants have special rights in the inquiry process. These include disclosure of information, being represented and making legal submissions, suggesting questions and receiving advance notice of the inquiry's report. For example, the Leveson inquiry allowed core participants to see in advance, under strict rules of confidentiality, copies of statements that witnesses had provided and which would form the basis of their evidence.

Core participants may not be questioned by anyone other than counsel to the inquiry, the inquiry panel, or (with the permission of the chair) the participant's own lawyer or the lawyer for another core participant. Witnesses who are not core participants may not question core participants, even if the core participant's evidence directly relates to them.

Rule 10 provides the legal representatives of core participants with the right to apply to the chair to question any witness giving oral evidence. This differs from the rights given to witnesses other than core participants, whose legal representatives may only apply for permission to question a witness where the witness's evidence directly relates to their own. Core participants may have their costs of legal representation met by the inquiry, though this is not guaranteed.

[71] Inquiries Act 2005, s9

Rule 17 obliges the chair to provide core participants with copies of the inquiry's report after it has been submitted to the Minister but prior to publication. Rule 17(2) provides that "the contents of the report, and any interim report are to be treated, until the report, or interim report, has been published by the chairman, as subject to an obligation of confidence". No other participants are provided with advance copies.

4.3 Engagement with affected individuals

The 2005 Act appears to enable a Minister to specify how an inquiry interacts with affected individuals. Most inquiry terms of reference do not cover this issue, though some have decided to engage with affected individuals:

- The 2008-09 ICL inquiry examined the circumstances leading to the explosion of a plastics factory in Glasgow in 2004. The bereaved families and injured survivors of the explosion were afforded some assistance to pay for legal representation. If they were on a low income, in receipt of benefits, or could demonstrate a lack of disposable income, the chair agreed to consider making an award of costs of financial representation.[72] The chair also allowed any bereaved family members or injured survivors to approach the inquiry secretariat with suggested questions.[73] This is similar to the rights given to core participants, but it was done under the direction of the chair.
- The inquiry into Mid-Staffordshire NHS Trust arranged a free counselling service for patients, their families and witnesses during the course of the inquiry. The inquiry took evidence from numerous patients or their families,[74] and the Chair said that he was "committed to ensuring the interests of families and patients are fully represented".[75]
- The continuing inquiry into the Grenfell Tower disaster was initially criticised on a number of occasions on the grounds that it had not been open enough to those affected by the fire.[76] The inquiry sought to address this, announcing on its website in a November 2017 update:

> The programme of community engagement which began during the period of consultation on the Inquiry's Terms of Reference has therefore remained a priority, with regular drop-in sessions being

[72] The ICL Inquiry, FAQs [accessed 5 February 2024]
[73] As above
[74] The National Archives, The Mid Staffordshire NHS Foundation Trust Inquiry: List of witnesses, 7 April 2015 [accessed 5 February 2024]
[75] The National Archives, The Mid Staffordshire NHS Foundation Trust Inquiry: Frequently Asked Questions, 7 April 2015 [accessed 5 February 2024]
[76] For instance, see "Grenfell tower residents say public inquiry is ignoring them" Financial Times [£], 11 December 2017;"Grenfell victims' families 'should be placed at heart of inquiry", The Guardian, 9 December 2017 [accessed 5 February 2024]

> held for the local community. This has allowed the Inquiry to provide information about its work and to engage on a one-to-one basis with survivors, families of the bereaved and local residents. The Inquiry's community engagement team has also attended meetings of residents' associations [and from November 2017] the Inquiry will be holding a weekly drop-in… at the Latymer Community Church.[77]

4.4 Assessors

Section 11 of the 2005 Act allows 'assessors' to be appointed to provide technical advice to an inquiry. Either the Minister setting up an inquiry (in consultation with the inquiry chair), or the inquiry chair, may appoint assessors. Assessors are expert advisers, and do not normally give formal evidence to an inquiry. In deciding as to whether to appoint someone as an assessor, the minister may consider the following:

1. Whether it is necessary to receive assistance from a person with special expertise in order properly to determine its terms of reference.
2. If so, what the nature of that assistance is: Advice in the primary evidence gathering stage of the inquiry? Advice in the course of any oral hearings in the inquiry? Advice in the course of writing the report? Advice as what recommendations to make?
3. Once the nature of the assistance required has been determined, other questions arise, including whether that assistance can be provided (i) in the form of evidence (whether written or oral) from an expert witness or witness commissioned by the inquiry and (ii) by appointing additional members to the inquiry panel, pursuant to sections 3(1) and 4 of the 2005 Act. [which relate to appointment of an inquiry panel].[78]

The role of assessor was introduced in the 2005 Act in part to distinguish between panel members (whatever their experience and expertise) and non-panel member expert advisors. Assessors were appointed to the Penrose Inquiry, the Vale of Leven inquiry and the Mid Staffordshire Trust inquiry.

Assessors are not responsible for the content of an inquiry report. When the Minister is appointing the inquiry panel, the Minister may have regard to any assessor who will take part in the inquiry. Any advice submitted by assessors will ordinarily be disclosed to core participants.[79]

The 2014 House of Lords report argued that the Act should be amended "so that the minister can appoint assessors only with the consent of the

[77] Grenfell Tower Inquiry, Update from the inquiry, 15 November 2017
[78] Jason Beer, Public Inquiries, 2011, p128-129
[79] As above

chairman".[80] The Committee noted the experience of Dr Judith Smith, who unusually both gave evidence and acted as an assessor on the Mid-Staffordshire inquiry:

> We heard evidence from Dr Judith Smith, the Nuffield Trust's Director of Policy, whose assistance to the Mid Staffordshire inquiry was unusual, perhaps unique. She started as an expert to the inquiry, prepared extensive written evidence and was one of the two opening witnesses to the inquiry, giving oral evidence over two days. She then had a period of almost two years of work with the inquiry before being appointed as an assessor towards the end of it, at the stage of report writing. In this particular case this seems to have worked satisfactorily, perhaps because of the nature of her expertise, but we doubt whether it would usually be right for the same person to give expert evidence openly to the inquiry and subsequently to advise the chairman privately on the same issues.[81]

[80] House of Lords Select Committee on the Inquiries Act, The Inquiries Act 2005: post-legislative scrutiny (pdf), HL 143, 11 March 2014, para 137

[81] As above, para 140

5 Open 2005 Act Inquiries

5.1 Overview

At the time of publication, there are 17 active 2005 Act inquiries. 11 of these were commissioned or announced by UK Government Ministers, five by Ministers in the Scottish Government and one by a Minister in the Northern Ireland Executive. Below is a summary table of those inquiries. A more detailed table appears in the annex to this briefing.[82]

Active and announced inquiries under the Inquiries Act 2005
As of February 2024

Inquiry	Announced	Chair
Scottish Child Abuse	17/12/14	Lady Smith
Undercover Policing	12/03/15	Sir John Mitting
Grenfell Tower	15/06/17	Sir Martin Moore-Bick
Infected Blood	03/11/17	Sir Brian Langstaff
Scottish Hospitals	17/09/19	Lord Brodie
Death of Sheku Bayoh (replaced FAI)	12/11/19	Lord Bracadale
Muckamore Abbey Hospital	08/09/20	Tom Kark KC
Coronavirus (UK)	12/05/21	Baroness Hallett
Post Office Horizon IT	19/05/21	Sir Wyn Williams
Coronavirus (Scotland)	24/08/21	Lady Poole
Death of Dawn Sturgess (converted inquest)	18/11/21	Lord Hughes
Independent Inquiry relating to Afghanistan	15/12/22	Sir Charles Haddon-Cave
Omagh Bombing	02/02/23	Lord Turnbull
Essex Mental Health	28/06/23	Baroness Lampard
Lucy Letby	30/08/23	Lady Thirlwall
Actions of Sam Eljamel and NHS Tayside	07/09/23	Lord Weir
Death of Jalal Uddin (converted inquest)	09/11/23	Thomas Teague KC
Murder of Emma Caldwell	07/03/24	TBC

The information that follows should be taken as current at the date of publication of this briefing. Certain inquiries may since have moved to a

[82] See also the websites of: Scottish Child Abuse Inquiry; Undercover Policing Inquiry; Grenfell Tower Inquiry; Infected Blood Inquiry; Scottish Hospitals Inquiry; Sheku Bayoh Inquiry; Muckamore Abbey Hospital Inquiry; Coronavirus (UK) Inquiry; Post Office Horizon IT Inquiry; Coronavirus (Scotland) Inquiry; Death of Dawn Sturgess Inquiry; Independent Inquiry relating to Afghanistan; Lampard Inquiry; Thirlwall Inquiry; Inquiry into the death of Jalal Uddin.

subsequent stage, reported, or concluded. New 2005 Act inquiries may also have been commissioned since the date of publication.

5.2 Scottish Child Abuse Inquiry

There were two distinct statutory inquiries into allegations of institutional child abuse: one initiated by the UK Government and another by the Scottish Government. The Independent Inquiry into Child Sexual Abuse, which examined the issue in England and Wales, published its final report in October 2022.[83] The Scottish Child Abuse Inquiry, however, is still taking evidence.

Establishing the inquiry

The Scottish Child Abuse Inquiry was set up to investigate historical claims of institutional child abuse in Scotland. It is chaired by Lady Anne Smith. Its terms of reference are available on its website. The inquiry opened in October 2015 and began public hearings in late May 2017.

The inquiry invited individuals who claim that they have been abused to contact them to submit evidence. The Chair may make a 'restriction order' stipulating that the names of these individuals (and other affected individuals who are now deceased) should be kept private. Several core participants were appointed, amongst them support groups for victims of abuse and institutions that have been the subject of accusations of abuse.

Progress of the inquiry

Hearings were subdivided into different phases. These cover evidence relating to different types of institution, or different contexts in which there have been allegations of systemic historical abuse of children in Scotland. The phases are:

- Phase 1 – overview of care systems and their legislative framework
- Phase 2 – residential establishments run by Catholic Orders
- Phase 3 – residential establishments run by non-religious and voluntary organisations
- Phase 4 – residential establishments run by Male Religious Orders
- Phase 5 – child abuse and migration programmes
- Phase 6 – provision at boarding schools
- Phase 7 – foster care case study
- Phase 8 – residential care and young offenders provision

[83] Independent Inquiry into Child Sexual Abuse, Report, October 2022

- Phase 9 – residential care in establishments for children and young people with long term healthcare needs, additional support needs and disabilities

The inquiry began public hearings on phase 8 on 19 September 2023.

It announced phase 9 on 30 November 2023. It expects to begin public hearings in spring 2025.

Case studies

The inquiry has not yet published an overarching report. However, it has published its findings from nine case studies on its website.

Costs

As of the end of December 2023, the Scottish Child Abuse Inquiry reported cumulative expenditure of £78.21 million.

5.3 Undercover Policing Inquiry

For detailed policy background, see:

- Commons Library, Undercover policing in England and Wales, CBP-9044, 5 November 2020

On 12 March 2015 the Home Secretary established an inquiry into undercover policing.[84] This followed reports that police officers had been infiltrating protest groups by forming relationships with the members, sometimes resulting in marriages and children. The allegations principally concerned the activities of the Special Demonstration Squad (SDS) (part of the Metropolitan Police's Special Branch from 1968 to 2008) and the National Public Order Intelligence Unit (NPOIU) (a national police unit in existence from 1999 to 2011).

The Undercover Policing Inquiry was announced before the conclusion of criminal investigations into SDS officers and a review into potential miscarriages of justice involving undercover police officers. The timing was attributed to the public interest in having an inquiry start as soon as possible.

The Home Secretary previously initiated internal police and Home Office reviews into aspects of the issue (including Operation Herne,[85] the Ellison

[84] HC Deb 12 March 2015 cc43-44WS; see a further statement at HC WS115 2015-16.

[85] See Operation Herne: Report 1: Use of covert identities, July 2013; Report 2: Allegations of Peter Francis, March 2014; and Report 3: Special Demonstration Squad Reporting: Mentions of Sensitive Campaigns, July 2014.

Review into police corruption and the Stephen Taylor report into the relationship between SDS and the Home Office).

Sir Christopher Pitchford, a criminal judge at the Court of Appeal, was appointed as the chair. He was replaced by Sir John Mitting on 25 July 2017. The inquiry's terms of reference are available on its website.[86]

Territorial remit

The Inquiry's territorial remit covers England and Wales. This reflects the fact that justice is a devolved matter in Northern Ireland and Scotland, although certain aspects of policing (for example, those to do with national security and terrorism) remain reserved.

The Scottish Government had urged the UK Government to extend the remit of the inquiry to include policing activity in Scotland, but this was refused. As an alternative, the Cabinet Secretary for Justice in the Scottish Government asked Her Majesty's Inspectorate of Constabulary in Scotland to carry out an independent review into undercover policing under powers in the Police and Fire Reform (Scotland) Act 2012.[87]

Campaigners had also urged for the remit of the public inquiry to be extended to cover Northern Ireland. This call was notably supported by Amnesty International.[88] The territorial remit, however, was not changed. The exclusion of Northern Ireland and Scotland from the remit of the inquiry, and the decision of the Scottish Government not to launch a 2005 Act inquiry of its own, were the subject of judicial review proceedings. The Gifford case in Scotland was unsuccessful; the Northern Ireland case involving Jason Kirkpatrick continues.[89]

Anonymity

The issue of anonymity has been a prominent concern in relation to the Inquiry. Undercover police officers have argued, in many cases successfully, that the disclosure of their real names would constitute a disproportionate interference with their Article 8 ECHR right to a private and family life.

According to the Inquiry's ninth major update (July 2020) the inquiry decided to withhold the real names of at least 100 former members of the Special Demonstration Squad and 19 staff members of the NPOIU. Anonymity orders were also granted to 32 "non-state core participants" including women

[86] Undercover Policing Inquiry, Terms of Reference, 16 July 2015 [accessed 18 January 2024]

[87] The report (pdf) was received by the Cabinet Secretary in November 2017 and published in February 2018.

[88] Amnesty International, Undercover policing inquiry must be extended to Northern Ireland, say Amnesty, 1 March 2018 [accessed 18 January 2024]

[89] *Gifford v Advocate General* [2018] CSOH 108

deceived into relationships by undercover officers.[90] This exercise is now "substantially complete", and decisions are published on the Inquiry website.

Progress of the inquiry

The Undercover Policing Inquiry was slow to commence its public hearings. Its progress was hindered by several preliminary matters.

In 2018 the Inquiry had set out plans to begin Tranche 1 evidence hearings (to do with the SDS between 1968 and 1982) by June or July of 2019. However, in January 2019, the Inquiry chair, Sir John Mitting, announced that these hearings would be delayed until at least 2020. The delays were attributed to:

- complexities concerned with document retrieval
- challenges ascertaining the authorship of intelligence reports
- time needed to issue "rule 9" requests to summon witnesses and written or other forms of evidence
- the need to provide more time for core participants to respond to bundles of evidence supplied to them

Hearings had been planned for June 2020, but were further postponed in March 2020 because of the Covid-19 pandemic. The hearings eventually began in November 2020. These ran through to May 2022.

Hearings for Tranche 2, which focuses on the Special Demonstration Squad Officers in the period 1983-1992, are expected to start in July 2024.[91]

Costs

According to the inquiry's own official figures (to the end of December 2023) the cumulative expenditure from the Undercover Policing Inquiry is £78.2 million.

5.4 Grenfell Inquiry

For detailed policy background, see the following Commons Library research briefings:

- Grenfell Tower fire: Response and tackling fire risk in high rise blocks (CBP-7993), 1 August 2017
- Grenfell Tower Fire: Background (CBP-8305), 20 January 2020

[90] Undercover Policing Inquiry, Ninth Update Note (pdf), July 2020 [accessed 18 January 2024]

[91] Undercover Policing Inquiry, The Undercover Policing Inquiry's Tranche 2 evidence hearings to begin July 2024 [accessed 18 January 2024]

The day after the Grenfell Tower disaster, which killed 71 people on 14 June 2017,[92] the Prime Minister announced that a statutory inquiry would be established.[93] She said that it would "report back to me personally. As Prime Minister, I will be responsible for implementing its findings".[94]

The Prime Minister appointed Sir Martin Moore-Bick, a former Lord Justice of Appeal, as the Chair of the Inquiry, following a recommendation from the Lord Chief Justice.[95] The terms of reference are on the Grenfell Tower Inquiry website.

The Inquiry formally opened on 14 September 2017. It has appointed three assessors and sixteen expert witnesses. Procedural hearings were held in December 2017. As of December 2023, there were 638 core participants.[96]

The Inquiry held hearings each week from mid-June to December 2018, and published its Phase 1 report on 30 October 2019.[97] The report comprised four volumes. The introduction to the report explained that Phase 1 had examined what happened during the fire and the response of the emergency services, while Phase 2 would focus on the underlying causes of the disaster, including design, construction and regulation of the cladding system, as well as the response of central and local government.[98]

Recent activities

Hearings concerned with Phase 2 of the Inquiry began in March 2020, but were periodically interrupted when public health restrictions were imposed in response to the Covid-19 pandemic. Those hearings continued through until July 2022. The Phase 2 hearings were subdivided into seven distinct modules to structure the evidence sessions.

The closing statements for the inquiry took place in November 2022. The chair and panel are preparing a final report. No date for publication has been set at the time of writing. In November 2023 the inquiry said that it did not expect to publish the report before April 2024.[99]

Costs

According to the Inquiry's 2023 Financial Report, the overall cost of the inquiry by the end of financial year 2022-23 was £170 million. As with most inquiries,

[92] BBC News, Grenfell Tower final death toll stands at 71, 16 November 2017 [accessed 18 January 2024]
[93] BBC News, London fire: Prime minister orders full public inquiry, 15 June 2017 [accessed 18 January 2024]
[94] Prime Minister's Office, Grenfell Tower: Statement from the Prime Minister, 17 June 2017
[95] Grenfell Tower Inquiry, Sir Martin Moore-Bick appointed Chair of Grenfell Tower public inquiry, 29 June 2017 [accessed 18 January 2024]
[96] Grenfell Tower Inquiry, December 2023 Newsletter, 29 December 2023 [accessed 18 January 2024]
[97] Grenfell Tower Inquiry, Phase 1 Report, HC 49, 30 October 2019
[98] As above, para 1.7
[99] Grenfell Tower Inquiry, November 2023 Newsletter, 24 November 2023 [accessed 18 January 2024]

the majority of the cost has been in provision of legal services and secretarial support.

5.5 Infected Blood Inquiry

During the 1970s and early 1980s thousands of UK patients contracted HIV, hepatitis C, or both, from contaminated blood or blood products. For some years, successive Governments refused to hold an independent public inquiry.

Previous reviews and inquiries

The Department of Health published a review in 2007 entitled Self-sufficiency in Blood Products in England and Wales (pdf), which provided a chronology of relevant events between 1973 and 1991. Catherine West MP suggested in the House of Commons that that report was "unauthorised, and could be perpetuating inaccuracies and outright lies, as my constituent says in a letter to me".[100] A non-statutory inquiry, the Archer inquiry, reported in 2009.

The Penrose Inquiry covered the issue in Scotland from 2008 to 2015.

Establishing the statutory inquiry

Following pressure from campaign groups and in Parliament, the then Prime Minister, Theresa May, announced a public inquiry on 11 July 2017.[101]

Victims and other parties affected by contaminated blood initially refused to participate fully in the Infected Blood Inquiry because of the involvement of the Department of Health.[102] This point was reiterated by Diana Johnson MP in a debate following an Urgent Question on 20 July 2017:

> …the vast majority of people affected by this scandal, their families, campaign groups and legal representatives, plus many cross-party parliamentarians, are, like me, dismayed to see the Department of Health leading on the establishment of this inquiry. The Department of Health, an implicated party at the heart of so much that has gone wrong over the past 45 years, must have no role in how this inquiry is established…[103]

In response to these concerns, the then Deputy Prime Minister, Damian Green, announced on 3 November 2017 that the administration of the inquiry would move from the Department of Health to the Cabinet Office.[104] The Lord Chief

[100] HC Deb 11 July 2017, c185

[101] PM Office, Press release: PM statement on contaminated blood inquiry: 11 July 2017

[102] "Contaminated blood inquiry runs into trouble as victims boycott consultation", The Guardian, 21 July 2017 [accessed 6 February 2024]

[103] HC Deb 20 July 2017 Vol 627 c984; EDM 408, 16 October 2017

[104] HCWS222, 3 November 2017

Justice was asked to nominate a judge to chair the inquiry.[105] A written statement from the Prime Minister on 21 December 2017 said:

> The Cabinet Office has now completed its analysis of the responses to the consultation on the format of the statutory Inquiry into infected blood announced in July. In addition a series of roundtable meetings were held earlier this month with individuals and groups representing those affected.
>
> The Government committed to making an announcement regarding the Chair of the inquiry before Christmas, taking into account the views we have received. We are therefore announcing today our intention to appoint a judge to Chair the inquiry. We will make a further statement on who that judge will be in the New Year and we will be discussing with them the composition of the Inquiry panel.[106]

On 8 February 2018, the Cabinet Office announced that Sir Brian Langstaff, High Court judge and former Senior President of the Employment Appeals Tribunal, had agreed to chair the inquiry. On 2 July 2018, the Government accepted, in full, the Chair's proposed terms of reference.

Victims have been able to access financial support schemes, but there have been no formal compensation payments to date.[107] In response to a Parliamentary Question in October 2019, the Government stated it would "wait for the determination of legal liability, to which the [Infected Blood] inquiry's deliberations relate, and then make our determination off the back of that".[108]

Compensation Framework Study

Parallel to the inquiry, the Government announced in June 2021 that Sir Robert Francis would lead an independent study into the infected blood compensation framework. He would be accountable to the Paymaster General for his findings.[109] This study had previously been trailed in a Ministerial Statement in March 2021.[110] As the Government's website explained:

> The study is a separate piece of work from the ongoing Infected Blood Inquiry, which is an independent public statutory Inquiry. The findings of the study will be made public and available to the Inquiry before its report is published.

[105] PQ HC121895, 10 January 2018

[106] HCWS388, 21 December 2017

[107] There are support schemes in England, Scotland, Wales and Northern Ireland.

[108] HC Deb 23 October 2019, c957

[109] Infected Blood Inquiry, Terms of Reference for Sir Robert Francis review announced, 23 September 2021

[110] HCWS895, 25 March 2021

> The purpose of doing this work now is to ensure that there is no unnecessary delay in implementing any potential recommendations by the Inquiry in relation to compensation or levels of financial support.[111]

The report was provided to the Paymaster General in March 2022, and published in June 2022. Sir Robert also provided oral evidence to the inquiry in July 2022.

Progress of the inquiry

The Infected Blood Inquiry has set up several "expert groups" to support its work. These groups have been responsible for producing reports to support the work of the inquiry chair. These are published on the inquiry website's Expert Groups page. As the website puts it:

> To help get to the truth of what has happened in the most authoritative and transparent way possible, the Chair has appointed expert groups to advise him openly. These will cover the relevant fields: not only the clinical specialisms such as haematology, transfusion medicine, hepatology and virology but also medical ethics, public health and administration, psychosocial impact, and statistics.
>
> Using expert groups means that everyone will be able to see what expert input is given to the Chair. The reports of the groups will, as evidence, be fully open, accessible and transparent. Where there are significant disagreements among the experts, these will be tested, explored and challenged openly in the public hearings.[112]

As with other inquiries, the intended programme of hearings was disrupted by the Covid-19 pandemic. However, hearings resumed in September 2020 and have carried on almost continuously since then. Hearings were scheduled through to May 2023. In July 2023, the Inquiry announced an additional week of hearings, beginning on Monday 24 July, to take evidence regarding the Government's response to the use of infected blood and blood products and the question of compensation.[113]

The report will be published on 20 May 2024.[114]

On 17 January 2024, the inquiry announced that the report would be published on 20 May 2024, at a closing event to be held in Church House, Westminster.[115]

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[111] Cabinet Office, Infected blood compensation framework study: consultation on terms of reference, 14 June 2021

[112] Infected Blood Inquiry, Expert Groups [accessed 6 February 2024]

[113] Infected Blood Inquiry, Evidence Hearings July 2023, 4 July 2023

[114] Infected Blood Inquiry, New Venue for Report Publication, 2 February 2024

[115] Infected Blood Inquiry, Publication of the Inquiry Report, 17 January 2024

Costs

According to its 2022-23 financial report, the Infected Blood Inquiry has incurred expenditure of £130.35 million since it was set up.[116]

5.6 Scottish Hospitals Inquiry

Between 2015 and 2019, concerns were raised about the ventilation and water quality systems at certain hospitals in Scotland. This most notably included two new "super hospitals": the Queen Elizabeth University Hospital (QEUH) in Glasgow and the Royal Hospital for Children and Young People (RHCYP) in Edinburgh.

A series of infection outbreaks at the QEUH, which opened in 2015, gave rise to broader concerns about building safety and infection control at those new facilities. Subsequent investigations linked several deaths, including those of children on oncology wards, to infections resulting from failures by NHS Greater Glasgow and Clyde and the hospital environment.[117] This also delayed the scheduled opening of the RHCYP, when similar problems were discovered with ventilation as those already identified at QEUH.

Establishing the inquiry

On 17 September 2019, Jeane Freeman, then the Scottish Government's Cabinet Secretary for Health and Sport, announced that there would be a public inquiry into the relevant hospital sites. In June 2020, she provided further details, indicating that the inquiry would be chaired by Lord Brodie (a senior Scottish judge) and would commence its work in August 2020. The terms of reference were published at the same time.[118]

The focus of the Scottish Hospitals Inquiry is to examine the "planning, design, construction, commissioning and, where appropriate, maintenance" of the two hospitals, and how key decisions contributed to the unsafe hospital environment. There is a particular focus on ventilation and water quality. The terms of reference also require it to examine whether information about ventilation or water quality problems was withheld or concealed which could have identified the problems earlier.

[116] Infected Blood Inquiry, Infected Blood Inquiry Finance Report Financial Year April 2022 to March 2023 (pdf) [accessed 6 February 2024]

[117] BBC News "Milly Main: Girl's infection 'probably' caused by hospital environment", 3 May 2021 [accessed 6 February 2024]

[118] Scottish Government, Inquiry into the construction of the QEUH, Glasgow and the RHCYP/DCN, Edinburgh: terms of reference, 15 June 2020

Progress of inquiry

The inquiry has appointed 11 organisations and a further 50 individuals as core participants. Preliminary issues addressed by the inquiry have included orders relating to the anonymity of certain individuals (mainly children) relevant to the inquiry's work.

Oral evidence hearings commenced in September 2021 and are ongoing. Scheduled hearings are in place for February and August 2024.[119]

The inquiry had incurred expenditure of £14.3 million to September 2023.[120]

5.7 Sheku Bayoh Inquiry

In May 2015, Sheku Bayoh died while in police custody in Kirkcaldy, Fife. A Fatal Accident Inquiry (FAI) was commenced under the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. However, in November 2019 it emerged that no criminal charges would be brought against any police officer in relation to the incident. The Lord Advocate had concluded in relation to the death that wider issues needed to be examined than could be dealt with through a Fatal Accident Inquiry.[121]

Establishing the inquiry

On 12 November 2019, in a statement to the Scottish Parliament, Humza Yousaf, the then Scottish Government's Cabinet Secretary for Justice, announced that a statutory public inquiry would be launched into the circumstances surrounding Bayoh's death. In January 2020 the chair of the Sheku Bayoh Inquiry was confirmed as Lord Bracadale (a retired judge), and in May 2020 its terms of reference were announced.

It was reported that job advertisements for the inquiry suggested that its proceedings could last as long as four years.[122]

Progress of inquiry

In March 2021 the inquiry confirmed its core participants which included, among others, the family of Sheku Bayoh. This was later updated to add a further core participant in April 2021.

[119] Scottish Hospitals Inquiry, Hearings

[120] Scottish Hospitals Inquiry, Inquiry Costs [accessed 7 February 2024]

[121] BBC News, "Sheku Bayoh: Public inquiry ordered into death in police custody", 12 November 2019 [accessed 5 February 2024]

[122] The Courier, "Sheku Bayoh family heartbroken that inquiry could go on for four years", 6 July 2020 [accessed 5 February 2024]

On 30 April 2021, Lord Bracadale gave a video update (on the inquiry's YouTube channel) on inquiry personnel, and the approach the inquiry would take to its work. An initial preliminary hearing took place in November 2021.

A scheduled preliminary hearing in early February 2022 was postponed. This was because some core participants were seeking undertakings from the Solicitor General and the Deputy Chief Constable that evidence they gave to the inquiry would not be used against them any resulting prosecutions, or in any police disciplinary proceedings they might face following on from the inquiry.[123]

In March 2022, Lord Bracadale published a ruling, setting out why he had decided to seek those undertakings from the Solicitor General (against the wishes of Sheku Bayoh's family).[124] The Solicitor General rejected the initial request later that month, but indicated that the matter would be kept under review as the inquiry developed.[125] The Chief Constable also denied the request in relation to disciplinary proceedings.[126]

Hearings took place throughout 2022 and 2023, with further hearings beginning on 6 February 2024.[127]

Costs

By 31 December 2023, inquiry costs had reached £16.29 million.[128]

5.8 Muckamore Abbey Hospital Inquiry

Muckamore Abbey Hospital in Belfast provides services to patients with severe learning disabilities and mental health needs. In late 2017, allegations surfaced that members of staff at the hospital had physically and mentally abused patients in their care. This prompted a police investigation, which continues.

By September 2020, there had been eight arrests in connection with the police investigation.[129] As of December 2019, 40 members of staff had been suspended in connection with the Belfast Health and Social Care Trust's own internal investigations.[130] An internal review by the Trust reported in November 2018. It revealed systemic failures of safeguarding, putting

[123] Sheku Bayoh Inquiry, Preliminary hearing announced
[124] Sheku Bayoh Inquiry, Ruling by the Chair (pdf), 1 March 2022
[125] Sheku Bayoh Inquiry, Letter from the Solicitor General (pdf), 22 March 2022
[126] Sheku Bayoh Inquiry, Letter from the Deputy Chief Constable Designate (pdf), 25 March 2022
[127] Sheku Bayoh Inquiry, News [accessed 5 February 2024]
[128] Sheku Bayoh Inquiry, Inquiry costs [accessed 5 February 2024]
[129] BBC News,"Muckamore Abbey Hospital: Timeline of abuse allegations", 7 September 2020 [accessed 6 February 2024]
[130] "Total of 40 staff now suspended from Muckamore ", The Irish News, 5 December 2019 [accessed 6 February 2024]

patients' lives and wellbeing at risk.[131] CCTV evidence has also revealed more than 1,500 criminal acts perpetrated on one of the wards.[132] A review of leadership and governance at the hospital by an Independent Review Team reported in August 2020, which described it as "dysfunctional".[133]

Establishing the inquiry

On 8 September 2020, Robert Swann, Northern Ireland Executive Minister for Health, announced to the Northern Ireland Assembly his intention to set up a 2005 Act public inquiry into the abuse at Muckamore. He said that the terms of reference would be set out at a later date, after consultation with current and former patients and their families.[134]

In November 2020, Swann sent two letters to families and relatives of those potentially impacted by mistreatment in Muckamore Abbey Hospital.[135] The families were invited to participate in video link meetings and through direct one-to-one facilitators in a discussion about the terms of reference of the inquiry, including questions as to timeframe, evidence to be sought and the issues to be addressed. The letter also invited input as to who should be appointed as the chair of the inquiry, and what particular professional expertise or experience the chair ought to have. These meetings took place in December 2020.

On 30 June 2021, Swann announced to the Northern Ireland Assembly that he had appointed Tom Kark QC to chair the Muckamore Abbey Hospital Inquiry.[136] On 29 September 2021, the terms of reference were confirmed, and two panel members were appointed to assist Kark with his work: Professor Glynis Murphy and Dr Peter Carter.[137] It subsequently emerged that Carter had a conflict of interest. He was replaced by Dr Elaine Maxwell on 7 October 2021.[138]

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[131] Belfast Health and Social Care Trust, Summary of 'A Review of Safeguarding at Muckamore Abbey Hospital – A Way to Go', 15 February 2019 2019 [accessed 7 February 2024]

[132] BBC News, "Muckamore Abbey: CCTV reveals 1,500 crimes at hospital", 27 August 2019 [accessed 7 February 2024]

[133] Muckamore Abbey Hospital Review Team, A Review of Leadership and Governance at Muckamore Abbey Hospital (pdf), 31 July 2020 [accessed 7 February 2024]

[134] Department of Health, Swann announces Public Inquiry into Muckamore Abbey Hospital, 8 September 2020

[135] Letter from Robert Swann, Northern Ireland Minister for Health (pdf), 12 November 2020; Letter from Robert Swann, Northern Ireland Minister for Health (pdf), 26 November 2020

[136] Department of Health, Written statement to the Assembly by Health Minister Robin Swann – 30 June 2021 at 12pm – The appointment of chair to the public inquiry into allegations of abuse at Muckamore Abbey Hospital (pdf), 30 June 2021

[137] Department of Health, Urgent written statement to the Assembly by Health Minister Robin Swann – Wednesday 29 September 2021 at 3pm – Muckamore Abbey public inquiry (pdf), 29 September 2021

[138] Department of Health, Urgent written statement to the Assembly by Health Minister Robin Swann – Thursday 7 October 2021 at 7pm – Muckamore Abbey public inquiry (pdf), 7 October 2021

Progress of the inquiry

Hearings began in June 2022.[139] In November 2023, the Chair said that having completed hearings on patient experience, the inquiry was about to embark on a series of hearings on staff experience.

The inquiry has been delayed with hearings restarting in May 2024. This is due to the chair needing urgent surgey.[140]

No data on costs is available on the Inquiry website.

5.9 Coronavirus Response Inquiries

The Coronavirus (COVID-19) pandemic has had a significant impact on a wide variety of aspects of public life. By December 2023, 234,000 deaths in the UK had been attributed to the virus.[141] Many more became seriously ill and required hospitalisation or other medical attention. The measures taken to mitigate the spread of the virus have also had profound implications for other areas of government policy-making and resilience, including for the health service, the economy, the education and care systems; for travel, tourism and hospitality; and for the liberties of ordinary citizens.

Several aspects of the governmental pandemic response, by the UK Government, the devolved administrations and local government, have attracted criticism and scrutiny. This has come both within Parliament and the devolved legislatures and beyond. Calls emerged in 2020 for the Government to set up a public inquiry, in order to ensure effective accountability for decisions taken during the crisis, and to learn lessons that would ensure future health crises were responded to more effectively. In April 2021, the Institute for Government published a report calling for an inquiry to be set up as a matter of urgency.[142]

UK Government Inquiry

On 12 May 2021, in a statement to the House of Commons, the then Prime Minister, Boris Johnson, confirmed that the Government would set up a public inquiry by the spring of 2022. This inquiry would, he confirmed, be:

> an independent public inquiry [set up] on a statutory basis, with full powers under the Inquiries Act of 2005, including the ability to

[139] Muckamore Abbey Hospital Inquiry, Chair's Update on Hearings, Restriction Orders and Witness Expenses, 20 June 2022

[140] Muckamore Abbey Hospital Inquiry, Chair's statement on delay to Inquiry, 19 February 2024

[141] UK Government, Coronavirus (COVID-19) in the UK, 14 December 2023

[142] Marcus Shepheard and Emma Norris, The coronavirus inquiry: the case for an investigation of government actions during the Covid-19 pandemic (pdf), April 2021 {accessed 6 February 2024]

> compel the production of all relevant materials, and take oral evidence in public, under oath.[143]

In explaining why it had not intended to set up the inquiry sooner, the Government argued that an inquiry should not be set up prematurely, while the NHS and other public bodies were still facing acute pressures in responding to the pandemic itself.[144]

The First Minister of Wales, Mark Drakeford, wrote to the UK Government in September 2021 stating that the UK-wide inquiry was the best option to "properly and openly scrutinise the decisions made by the Welsh Government and other public sector organisation in Wales during the pandemic."[145]

Baroness Heather Hallett appointed as Chair

On 15 December 2021, the Government announced that Baroness Heather Hallett DBE, a former Court of Appeal judge, would chair the UK Covid-19 Inquiry. It said that she would be engaging with bereaved families as part of a process to finalise the terms of reference of the inquiry. The Government also announced that a replacement would be found to relieve Baroness Hallett of her role as chair of the public inquiry into the Death of Dawn Sturgess (see below).[146]

Terms of reference

Draft terms of reference were published by the Prime Minister in March 2022, and a public consultation exercise was led by Baroness Hallett about that document and the inquiry's proposed approach.[147] In May 2022, she recommended to the Prime Minister that the terms of reference should be adapted in light of some of the feedback in that consultation.[148] The Prime Minister formally accepted those modifications, and set the terms of reference for the inquiry, in June 2022.[149]

Overall plans for the inquiry

The inquiry formally launched on 21 July 2022. Baroness Hallett outlined her intention to approach the initial work of the inquiry across various modules:[150]

- Module 1: the UK's preparedness for the risk of a Coronavirus pandemic, looking at civil contingencies, resourcing, risk management systems and broader pandemic readiness

[143] HC Deb 12 May 2021 [Covid-19 Update]
[144] As above
[145] Letter from Welsh Government to Chancellor of the Duchy of Lancaster (pdf), 10 September 2021
[146] UK Government, Prime Minister announces COVID-19 Inquiry Chair, 15 December 2021
[147] UK Covid 19 Inquiry, Terms of Reference Consultation Summary Report (pdf), May 2022
[148] UK Covid 19 Inquiry, Letter from Baroness Hallett to the Prime Minister (pdf), 15 May 2022.
[149] UK Covid 19 Inquiry, Letter from the Prime Minister to Baroness Hallett (pdf), 28 June 2022
[150] UK Covid 19 Inquiry, UK Covid-19 Inquiry launches first investigation, 21 July 2022

- Module 2: political and administrative decision-making at the UK-wide level during the pandemic, including non-pharmaceutical interventions (like lockdowns), the use of scientific expertise and data, government and public health communications, Parliamentary oversight and regulatory control
- Modules 2A, 2B and 2C: as Module 2, but in the context of Scotland, Wales and Northern Ireland respectively[151]
- Module 3: healthcare systems, and the impact of the pandemic and key decision-making, structures and resourcing. This will look at, among other things, the vaccine rollout, NHS backlogs, long-covid diagnosis and support, and the impact of the pandemic on patients, hospitals and healthcare workers and staff

In May 2023, the Chair announced further modules:[152]

- Module 4: vaccines, therapeutics and anti-viral treatment
- Module 5: government procurement across the UK
- Module 6: the care sector

The Chair also gave an outline of projected further modules, suggesting that hearings would continue until 2026:

> Future investigations will cover testing and tracing, education, children and young persons, Governmental intervention by way of financial support for business, jobs, and the self employed, additional funding of public services and the voluntary/community sector, benefits and support for vulnerable people. The Inquiry's final modules will specifically investigate impact and inequalities in the context of public services – including key workers – and in the context of businesses. The Inquiry is UK-wide and will examine the responses of both the devolved and UK Government throughout all of its work.
>
> The Inquiry is aiming to complete public hearings by summer 2026.[153]

Progress of the inquiry

The Inquiry started public hearing sessions on Module 1 in June 2023 and ran until July 2023.

Module 2 evidence was heard between October and December 2023.

[151] It has been acknowledged, however, that much of Module 2A will be covered by the Scottish Covid-19 Inquiry, and that the inquiries will co-ordinate to avoid duplication of work in areas of devolved decision-making.

[152] UK Covid 19 Inquiry, Inquiry update: New investigations announced, 30 May 2023

[153] UK Covid 19 Inquiry, Inquiry update: New investigations announced, 30 May 2023

Module 2A held public hearing sessions between 15 January and 1 February 2024.

Initial outlines of future hearing dates appear on the Inquiry's Hearings webpage.

Provision of information from Boris Johnson's devices

As part of its evidence-gathering, on 28 April 2023, in line with Section 21(4) of the Inquiries Act 2005, the inquiry asked the Cabinet Office to provide a range of unredacted documents, including diaries, notebooks and WhatsApp messages for the period 1 January 2020 to 24 February 2022 and "recorded on devices owned/used by" the former Prime Minister, Boris Johnson and one of his special advisers, Henry Cook.[154]

The Cabinet Office said that it did not intend to provide information that it considered "unambiguously irrelevant" to the inquiry.[155] On 22 May 2023, the Chair replied that she disagreed with the Cabinet Office's position, arguing that it "undermines the clear purpose of section21(4)."[156]

The Cabinet Office launched a judicial review, arguing that providing the information would compromise individual rights to privacy. On behalf of the inquiry, Hugo Keith KC argued that leaving the decision to the Cabinet Office would allow the Government to "[mark] its own homework" and to "emasculate this and future inquiries".[157]

On 6 July 2923, the High Court found in favour of the inquiry.[158] The Cabinet Office agreed to submit the material requested. [159]

Costs

The inquiry has reported that by 30 September 2023 it had incurred total costs of £78.6 million.[160]

[154] UK Covid=19 Inquiry, Notice requiring the Cabinet Office to provide evidence to the UK Covid-19 Inquiry, 28 April 2023

[155] Cabinet Office, Application on behalf of the Cabinet Office under Section 21(4) of the Inquiries Act 2005, 15 May 2023

[156] Baroness Hallett, Ruling on Section 21(4) application, 22 May 2023

[157] BBC News, "Government loses court battle over Boris Johnson's Covid WhatsApps", 6 July 2023 [accessed 6 February 2024]

[158] *Cabinet Office v Chair of the UK Covid-19 Inquiry*, [2023] EWHC 1702 (Admin), 6 July 2023

[159] BBC, "Government loses court battle over Boris Johnson's Covid WhatsApps", 6 July 2023 [accessed 6 February 2024]

[160] UK Covid-19 Public Inquiry, Financial Report to 31 December 2023 (pdf), p2

Scottish Government Inquiry

Boris Johnson, then Prime Minister, said that the UK Government would "work closely with the Devolved Administrations" in establishing its own inquiry and setting its scope.149F[161] But both the Scottish and Welsh Governments raised concerns about the amount of time the UK Government planned to take to set up its inquiry. The Welsh Government was against setting up a parallel inquiry.[162] In August 2021, the Scottish Government announced that it would set up its own inquiry before the end of 2021, looking at the devolved response to the pandemic.[163]

After consulting throughout August and September 2021 on the terms of reference for such an inquiry, on 14 December 2021, the Scottish Government published an analysis paper on the consultation.[164] It also announced Lady Poole (a senior Scottish judge) as the Chair of Scottish Covid-19 Inquiry, and published the terms of reference.[165]

Lady Poole said that the inquiry would begin to recruit its secretariat, with a view to commencing its work properly in "early summer 2022".[166] It was formally launched in May 2022.

New chair and changed terms of reference

The progress of the Scottish Covid-19 Inquiry has been hindered by personnel issues. In early October 2022, Lady Poole announced her resignation as inquiry chair for personal reasons. Four of the six members of legal counsel to the inquiry had also resigned days earlier.[167]

On 27 October 2022, Deputy First Minister John Swinney announced that Lord Brailsford would succeed Lady Poole as chair of the inquiry. At the same time, the terms of reference were slightly modified, to make more explicit reference to a "human rights-based approach" to the inquiry's work.[168]

The Inquiry held its first preliminary hearing in the summer of 2023, with its impact hearings beginning in October 2023.[169]

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[161] HC Deb 12 May 2021 [Covid-19 Update]

[162] ITV News, Opposition parties demand Wales-only Covid-19 inquiry, 25 August 2021 [accessed 6 February 2024]

[163] Scottish Government, COVID-19 Inquiry, 2 November 2022

[164] Scottish Government, Scottish COVID-19 Inquiry: Analysis of the public and stakeholders views on the approach to establishing the public inquiry, 14 December 2021

[165] Scottish Government, COVID-19 Inquiry, 2 November 2022

[166] Scottish Government, Scottish COVID-19 Inquiry

[167] BBC News, Covid in Scotland: Four lawyers step down from public inquiry, 4 October 2022 [accessed 6 February 2024]

[168] Scottish Government, Scottish COVID-19 Inquiry Chair: Ministerial statement, 27 October 2022

[169] Scottish Covid-19 Inquiry, Hearings and presentations

Costs

By 31 December 2023, the inquiry had incurred costs of £12.8 million.[170]

5.10 Post Office Horizon IT Inquiry

For more background, see:

- Commons Library debate pack CDP-2024-0026, Management culture of the Post office, 7 February 2024

The Post Office adopted an IT system, known as Horizon, in 1999. Investigations by the Post Office into postmasters, using information from the new computer system, led to suspensions, termination of postmasters' contracts, prosecution and conviction of postmasters, for example for false accounting and fraud.

A group representing many of the affected postmasters, the Justice for Postmasters Alliance (JFPA), initiated several legal challenges from late 2015 onwards against the Post Office, leading to a settlement and court victory in December 2019.[171] But the compensation awarded to the 555 claimants fell far short of their liabilities.[172]

Many of the criminal convictions in relation to Horizon were subsequently quashed in April 2021 when it emerged that the fault for accounting irregularities rested, in many cases, with the IT system rather than the postmasters.[173] Others have been referred to the Criminal Cases Review Commission.[174]

Establishing the inquiry

The then Prime Minister, Boris Johnson, said in February 2020 that an inquiry would be launched into the Horizon IT system.[175] At first, this took the form of

[170] Scottish Covid-19 Inquiry, Inquiry costs

[171] JFSA, About us [undated]; Andy Furey, CWU, Letter to branches, 21 November 2019 (pdf) {accessed 6 February 2024]

[172] "Subpostmasters got the best deal possible in legal battle with the Post Office, says lawyer", Computer Weekly, 13 December 2019; "Boris Johnson commits to 'getting to the bottom of' Post Office Horizon IT scandal", Computer Weekly, 26 February 2020 {accessed 6 February 2024]

[173] BBC News, Convicted Post Office workers have names cleared, 23 April 2021 [accessed 6 February 2024]

[174] CCRC, CCRC refers six more Post Office cases, 13 September 2021 [accessed 6 February 2024]

[175] HC Deb 26 February 2020 [Engagements], c315

a "review" announced in June 2020, but it was later turned into a non-statutory inquiry in September 2020, to be chaired by Sir Wyn Williams.[176]

In May 2021, the Government announced that the non-statutory inquiry would be converted into a statutory one under the 2005 Act, with Sir Wyn Williams remaining the chair. The terms of reference would also be expanded to allow the inquiry to look at the Post Office's approach to seeking prosecutions against postmasters.[177]

As of January 2024, the Inquiry had designated 237 named core participants.[178]

Progress of inquiry

The Post Office Horizon IT Inquiry carried out a series of "impact" hearings in different parts of the UK between February and May 2022. In July 2022 two hearings took place on the legal issues concerned with compensation issues.

After opening statements in October 2022, the inquiry conducted hearings through three further phases:[179]

- Phase 2: Horizon IT System (October - December 2022)
- Phase 3: Operation of Horizon (January - May 2023)
- Phase 4: Action against sub-postmasters and others (July 2023 – February 2024)

In July 2023 the chair issued section 21 notices to the Post Office to address what he called "grossly unsatisfactory" disclosure failings by the Post Office.[180]

The inquiry held an additional disclosure hearing on 12 January 2024 to consider "deeper rooted problems" with the Post Office's disclosure.[181]

Forthcoming phases

The inquiry has announced three further phases, all scheduled for spring/summer 2024:[182]

[176] BEIS, Independent review into the Post Office Ltd Horizon IT system, 10 June 2020; HCWS280, 10 June 2020; HCWS477, 30 September 2020.

[177] Post Office HC Deb 19 May 2021 [Post Office Update]; BEIS, Government strengthens Post Office Horizon IT inquiry with statutory powers, 19 May 2021

[178] Post Office Horizon IT Inquiry, Named Core Participants and their recognised legal representatives, 5 January 2024

[179] Post Office Horizon IT Inquiry, Public Hearings Timeline

[180] Post Office Horizon IT Inquiry, Chair announces section 21 notices and further disclosure hearing, 14 July 2023

[181] Post Office Horizon IT Inquiry, Inquiry to hear from Burges Salmon partner on Post Office disclosure, 19 December 2023

[182] Post Office Horizon IT Inquiry, Public Hearings Timeline

- Phase 5: Redress: access to justice, Second Sight, Complaint Review and Mediation Scheme, conduct of the group litigation, responding to the scandal and compensation schemes
- Phase 6: Governance: monitoring of Horizon, contractual arrangements, internal and external audit, technical competence, stakeholder engagement, oversight and whistleblowing
- Phase 7: Current practice and procedure and recommendations for the future

Costs

The inquiry has reported that it had incurred total costs of £21.94 million by 31 March 2023.[183]

5.11 Death of Dawn Sturgess Inquiry

On 8 July 2018, Dawn Sturgess died, nine days after being admitted to Salisbury District Hospital.[184] Police determined that she and her partner Charlie Rowley had been poisoned by Novichok, the same nerve agent that had been attributed to the deaths of Sergei and Yulia Skripal four months earlier. The police investigation indicated that Sturgess and Rowley may have inadvertently come into contact with a discarded vial of the substance, which had originally been used in the Skripal attack.[185]

Initial inquest proceedings

An inquest was established in July 2018, and was to be chaired by Senior Coroner David Ridley. In a scoping decision, Ridley determined that, while the inquest could look at the role of two Russian military officers suspected to have been involved in the Skripal attack, it was beyond his remit to examine wider questions about the source of the nerve agent, or Russian state involvement in the deaths.[186]

The family of Dawn Sturgess successfully challenged this decision in the High Court. It ordered that the scope of the inquest should be revisited.[187]

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[183] Post Office Horizon IT Inquiry, Post Office Horizon IT Inquiry Financial Report 1 April 2020 – 31 March 2023, 3 November 2023

[184] BBC News, "Amesbury Novichok poisoning: Inquest hears of 'goodbye'", 19 July 2018 [accessed 6 February 2024]

[185] Counter Terrorism Policing, Salisbury & Amesbury Investigation, 21 September 2021 [accessed 6 February 2024]

[186] BBC News, "Scope of Novichok victim's inquest 'must be reconsidered'", 24 July 2020 [accessed 6 February 2024]

[187] As above

In January 2021, it was announced that Baroness Heather Hallett would assume responsibility as the coroner for the case, replacing David Ridley. She had previously served as the coroner into the 7/7 London bombings.[188]

In September 2021, Baroness Hallett made a formal request to the then Home Secretary, Priti Patel, to convert the inquest into a public inquiry. She and counsel involved in the inquest expressed frustration that national interest concerns limited the scope of the investigation – and that a public inquiry would allow more sensitive evidence to be considered in private. [189]

Public inquiry announced

On 18 November 2021, the Home Secretary announced that a statutory public inquiry would be established into the death of Dawn Sturgess and that it would be chaired by Baroness Hallett.[190] Priti Patel explained that the decision was taken to ensure that some of the material could be considered in closed proceedings.[191]

New chair Lord Hughes appointed

Following the announcement that Dame Heather Hallett would chair the UK Government's Coronavirus Inquiry she was be replaced as chair of the Sturgess inquiry and inquest. On 10 March 2022, in a written statement the Home Secretary indicated that the former UK Supreme Court judge, Lord Hughes of Ombersley, would chair the inquiry.[192]

Progress of the inquiry

The inquiry was formally established on 17 March 2022.[193]

The inquiry confirms that it "take[s] the place" of the inquest but will take Baroness Hallett's earlier investigations into account. The terms of reference focus on establishing the cause of Dawn Sturgess's death and "so far as consistent with section 2 of the Inquiries Act 2005, where responsibility for the death lies".[194]

[188] "Former high court judge to take over Dawn Sturgess inquest", The Guardian, 29 January 2021 [accessed 6 February 2024]

[189] BBC News, "Dawn Sturgess: Patel considers public inquiry into Novichok death", 23 September 2021 [accessed 6 February 2024]; "Dawn Sturgess death inquest should become public inquiry, says coroner", Salisbury Journal, 22 September 2021 {accessed 7 February 2024]

[190] Home Office, Public inquiry into death of Dawn Sturgess, 18 November 2021

[191] HCWS402, 18 November 2021

[192] HCWS671, 10 March 2022

[193] Dawn Sturgess Inquiry, Overview

[194] As above

By February 2024, the Dawn Sturgess Inquiry had undertaken preliminary hearings related to disclosure and publicity of evidence, with a further hearing scheduled for 15 March 2024.[195]

Costs

By 30 September 2023 the inquiry had incurred total costs of £1.58 million.[196]

5.12 Independent Inquiry relating to Afghanistan

In July 2022, allegations were made that British Special Forces in Afghanistan had been involved in criminal activity, including allegations of ill-treatment and of unlawful killing.[197] The allegations came to light following a BBC Panorama investigation.[198] Previously two families had alleged that the deaths of their relatives formed part of a wider pattern of extrajudicial killings by UK Special Forces in Afghanistan. They had launched judicial review proceedings against the MoD in 2019 and 2020 respectively, challenging its failure to properly investigate the circumstances of their relatives' deaths.[199]

Establishing the inquiry

In December 2022, the Government announced the Secretary of State for Defence, Ben Wallace, had commissioned a statutory public inquiry to investigate and report on alleged unlawful activity by British armed forces during deliberate detention operations in Afghanistan in the period from mid-2010 to mid-2013, and the adequacy of subsequent investigations into such allegations.[200]

At the same time the government announced Sir Charles Haddon-Cave (a senior judge) would chair the inquiry.[201]

The Independent Inquiry relating to Afghanistan was formally launched on 22 March 2023 and initial terms of reference confirmed.[202] It would investigate serious allegations against British Armed Forces relating to detention operations in Afghanistan during the period mid-2010 to mid-2013, in particular that unlawful killings were carried out by members of British armed

[195] As above; Dawn Sturgess Inquiry, Hearings
[196] Dawn Sturgess Inquiry, Financial Report April 2023-September 2023 , 2 November 2023
[197] HC Deb 14 July 2022, c489-96
[198] BBC News, SAS unit repeatedly killed Afghan detainees, BBC finds, 12 July 2022
[199] Leigh Day press release, Bereaved families welcome unprecedented statutory inquiry into allegations of extrajudicial killings by UK Special Forces in Afghanistan, 15 December 2022
[200] HC Deb 15 December 2022, c1259-65
[201] Independent Inquiry relating to Afghanistan press release, 15 December 2022
[202] Ministry of Defence, Independent inquiry into alleged unlawful activity by British Armed Forces during deliberate detention operations in Afghanistan, Terms of reference, 23 March 2023

forces during these operations, that these killings were covered up, and that investigations carried out by the Royal Military Police were inadequate.

In September 2023, the terms of reference were altered to focus on the activities of "UK special forces" rather than "British armed forces".[203]

The Inquiry will make recommendations for further action and identify lessons learnt.[204]

Progress of the inquiry

In his opening statement on 22 March 2023, the chair said:

> It is likely that, for obvious reasons to do with national security - and the need to ensure the safety and anonymity of some witnesses - that many hearings will have to be held in Private. Nevertheless, it is my intention to hold public hearings, where possible and appropriate.[205]

The chair expects four phases of the inquiry:

- Phase 1: information gathering and determining procedure
- Phase 2: seeking a range of background briefings about military operations and the role of UK forces in the conflict in Afghanistan
- Phase 3: conducting hearings
- Phase 4: finalising the report[206]

Two preliminary hearings were held in July 2023. Opening statements and hearings began in October 2023.[207]

5.13 Omagh Bombing Inquiry

On 15 August 1998 the Omagh bombing, carried out by the Real IRA, killed 29 people and two unborn children. It took place months after the signing of the landmark Belfast Good Friday Agreement in April 1998.[208]

In September 2013 the UK Government announced its decision not to instigate a statutory inquiry into the bombing. The then Secretary for State, Theresa Villiers, said:

[203] Ministry of Defence, Independent inquiry into alleged unlawful activity by British Armed Forces during deliberate detention operations in Afghanistan, Terms of reference, 19 September 2023
[204] Independent Inquiry relating to Afghanistan, FAQs [accessed 5 February 2024]
[205] Independent Inquiry relating to Afghanistan, Opening statement by Sir Charles Haddon-Cave (pdf), 22 March 2023
[206] As above
[207] Independent Inquiry relating to Afghanistan, Hearings
[208] Britannica, Omagh bombing [accessed 7 February 2024]

> I considered this matter carefully. I consulted a range of people including survivors, families of those killed in the bomb and other interested parties. Some of them supported an inquiry, but many did not.
>
> These views were weighed against other factors, including the significant number of inquiries that have been held already on the Omagh bomb and the investigation currently underway by the Office of the Police Ombudsman for Northern Ireland.[209]

Michael Gallagher, the father of one of the victims, brought a judicial review of the Government's decision, arguing that it breached Article 2, on the right to life, of the European Convention on Human Rights. The judge ruled that there were "plausible allegations that there was a real prospect of preventing the Omagh bombing" that deserved to be investigated by an investigation that was compliant with Article 2 of the Convention. The judge did not order a public inquiry, but it said it was for the UK Government to decide how to hold an investigation that could allow the scrutiny of material, including closed material, the disclosure of which would be damaging to national security.[210]

Establishing the inquiry

In February 2023 the Secretary of State for Northern Ireland, Chris Heaton-Harris, announced an independent statutory inquiry would be established into the preventability of the Omagh bombing.[211]

The Secretary of State noted that a previous non-statutory review, the Gibson Review of the Omagh bombing, had not had statutory powers and so the Chair had had "no means of compelling witness testimony." The Secretary of State also noted a disclosure protocol would be agreed between the inquiry and all relevant partners to take account of the national security-sensitive material involved in this case.[212]

In June 2023, the Secretary of State for Northern Ireland announced the appointment of Lord Alan Turnbull, a senior Scottish judge, as Chair of the Omagh Bombing Inquiry.[213]

Terms of reference for the inquiry were published on 21 February 2024.[214]

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[209] HC Deb 12 September 2013 [Omagh Bomb (Inquiry)], c62WS

[210] Gallagher's (Michael) Application for Judicial Review and in the matter of a decision by the Secretary of State for Northern Ireland made on 12th September 2013, No: [2021] NIQB 85 (pdf)

[211] HC Deb 2 February 2023 [Omagh bombing], c496-504

[212] As above, c497

[213] Northern Ireland Office, Secretary of State announces Chair of the Omagh Bombing Inquiry, 12 June 2023

[214] Omagh Bombing Inquiry Terms of Reference, 21 February 2024

5.14 Essex Mental Health (Lampard) Inquiry

In June 2019, the Parliamentary and Health Service Ombudsman published a report that highlighted "a series of significant failings in the care and treatment of two vulnerable young men who died shortly after being admitted" to Linden House, then part of the North Essex Partnership University NHS Foundation Trust (NEP)" in Chelmsford.[215]

The report noted "parallels" between the two incidents although they occurred four years apart (in 2008 and 2012) and after a Serious Incident Panel in 2009 had concluded that the Trust had failed in meeting its obligations to Mr R and set out a series of recommendations.

Subsequent reviews, the inquest into Matthew Leahy's death in 2015 and a series of Care Quality Commission (CQC) reports highlighted continuing failings, notably in assessment and management of risks.[216]

Essex Police and the Health and Safety Executive (HSE) launched investigations of up to 25 deaths since 2000 in what was now the Essex Partnership University Trust (EPUT). The Police concluded their investigation in 2018, having found insufficient evidence for corporate manslaughter charges.[217] On 16 June 2021, the HSE's investigation led to EPUT being fined £1.5 million for failing to take adequate steps to prevent suicide.[218]

Non-statutory inquiry

On 21 January 2021, Nadine Dorries, then Minister for Patient Safety, Suicide Prevention and Mental Health, announced that a non-statutory independent inquiry into mental health inpatient deaths in Essex between 2000 and 2020. She said that the inquiry, to be chaired by the psychiatrist Dr Geraldine Strathdee, would launch in April 2021 and aim to report by spring 2023. Ms Dorries said that she had "listened carefully" to calls for a statutory inquiry but had concluded that a non-statutory approach was "the best way to do this" and would lead to a more timely response.[219]

In July 2022, after having invited families and loved ones of people who had died to come forward, the Chair called for staff working in mental healthcare to come forward with their views.[220]

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[215] Parliamentary and Health Service Ombudsman, Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust, HC 2260, 11 June 2019

[216] As above, p10-11

[217] BBC News, "Essex Police drop mental health trust manslaughter probe", 13 November 2018 [accessed 6 February 2024]

[218] "Mental health trust fined £1.5m for failings over deaths of 11 patients", Evening Standard, 17 June 2021 [accessed 6 February 2024]

[219] UIN HCWS729, Independent Inquiry into mental health inpatient deaths in Essex, 21 January 2021

[220] The Lampard Inquiry, Staff call for evidence, 28 July 2022

On 12 January 2023, the Chair wrote an open letter calling for the inquiry to be put onto a statutory footing after only 11 out of 14,000 current and former staff had indicated that they would be willing to appear before the inquiry. In addition, she noted that it had taken two years for EPUT to inform the inquiry that there were 2,000 rather than 1,500 relevant deaths. She concluded that the inquiry would not be able to meet its terms of reference.[221]

In a Westminster Hall debate on the matter on 31 January 2023, Neil O'Brien, Parliamentary Under-Secretary of State for Health and Social Care, reiterated the "faster and more flexible" nature of the non-statutory approach, but said that the Government might come to a different conclusion if engagement did not improve.[222]

On 15 May 2023, Dr Strathdee wrote to the Health Secretary repeating her call for the inquiry to be converted.[223] And on 12 June 2023, a legal firm representing families affected wrote to the Chair saying that they intended to apply for judicial review on the question of converting the inquiry.[224]

Establishing the statutory inquiry

On 28 June 2023, the Health Secretary, Steve Barclay, announced that the existing inquiry would be converted to a statutory inquiry to help meet the "challenges" of engagement and information disclosure that the inquiry had faced so far. He also noted that Dr Strathdee would step down as Chair for personal reasons.[225]

On 4 September 2023 the Health Secretary announced that the statutory inquiry would be chaired by Baroness Lampard, a former barrister.[226]

The Department of Health and Social Care issued a formal notice of conversion to a statutory inquiry – to be known as the Lampard Inquiry – on 27 October 2023.[227] The Chair ran a consultation on the terms of reference between 1 and 28 November 2023 and intends to publish the final version in 2024.[228]

[221] The Lampard Inquiry, Open letter from Dr Geraldine Strathdee, Chair to the Essex Mental Health Independent Inquiry, 12 January 2023
[222] WH Deb, 31 January 2023, c50-53WH
[223] The Lampard Inquiry, Update on the Inquiry's work and letter from the Chair to the Rt Hon Steve Barclay, Health Secretary, 15 May 2023
[224] The Lampard Inquiry, Open letter from Hodge Jones and Allen to Dr Geraldine Strathdee, 12 June 2023
[225] Department of Health and Social Care, Government acts to improve patient safety in mental health care, 28 June 2023
[226] The Lampard Inquiry, About the inquiry [accessed 6 February 2024]
[227] The Lampard Inquiry, About the inquiry
[228] The Lampard Inquiry, Terms of reference [accessed 6 February 2024]

5.15 Lucy Letby (Thirlwall) Inquiry

On 18 August 2023 Lucy Letby, a former neonatal nurse at the Countess of Chester Hospital, was convicted of the murder of seven babies and attempted murder of six babies at the hospital.[229]

Establishing the inquiry

On the same day as the verdict the Government announced an independent inquiry into the circumstances behind the murders and attempted murders. The Government announced the inquiry would be a non-statutory inquiry and would be:

> launched to ensure vital lessons are learned and to provide answers to the parents and families impacted, the inquiry will investigate the wider circumstances around what happened at the Countess of Chester Hospital, including the handling of concerns and governance. It will also look at what actions were taken by regulators and the wider NHS.[230]

Concerns were raised after the announcement. Critics, including the families involved, questioned whether a non-statutory inquiry would be sufficient as it would not have the power to compel witnesses to give evidence.[231]

On 30 August 2023 the Department of Health and Social Care announced that the inquiry would become a statutory inquiry:

> The Health and Social Care Secretary [Steve Barclay] has been clear from the outset that he wants the families impacted in this tragic case to have the opportunity to engage with and shape the scope of the inquiry. Following a meeting with them yesterday, the government has acted swiftly to respect their wishes and put the inquiry on a legal footing.[232]

Steve Barclay told the Commons on 4 September 2023 that the inquiry would be chaired by Lady Justice Thirlwall, a judge in the Court of Appeal.[233]

[229] BBC News, "Nurse Lucy Letby guilty of murdering seven babies on neonatal unit", 18 August 2023 [accessed 6 February 2024]
[230] Department of Health and Social Care, Government orders independent inquiry following Lucy Letby verdict, 18 August 2023
[231] BBC News, "Lucy Letby inquiry should be led by judge, committee chair says", 20 August 2023 [accessed 6 February 2024]
[232] Department of Health and Social Care, Legal powers given to Lucy Letby inquiry, 30 August 2023
[233] HC Deb, 4 September 2023, c35

Terms of reference

The Government agreed terms of reference with Lady Justice Thirlwall, and they were published on the day of the inquiry's official launch, 19 October 2023.[234]

The Chair summarised the terms of reference in her opening statement as:

> Part A is about the experience at the hospital, and elsewhere, of the parents of the babies named on the indictment,
>
> Part B considers the conduct of people working at the hospital and how Letby was able repeatedly to kill and harm babies on the neonatal unit,
>
> Part C will look at the wider NHS, examining relationships between the various groups of professionals, the culture within our hospitals and how these affect the safety of newborns in neonatal units.[235]

Timetable

The inquiry expects to hold a preliminary hearing in spring 2024 and public hearings from autumn 2024.[236]

5.16 Inquiry into the actions of Sam Eljamel and NHS Tayside

Professor Sam Eljamel was the former head of neurosurgery at NHS Tayside in Dundee. In 2018 it emerged that patients in his care had been injured by his actions. He had retired from NHS Tayside in May 2014, having been put under investigation and under supervision in June 2013. Mr Eljamel was suspended by the Royal College of Surgeons in December 2013.[237]

At the time the NHS Tayside's medical director, Prof Andrew Russell, said:

> There has been much learning by the organisation immediately following these events and many improvements have been made over the past five years.[238]

[234] Thirlwall Inquiry, Terms of reference [accessed 6 February 2024]
[235] Thirlwall Inquiry, Transcript of the Chair's opening statement, 22 November 2023 [accessed 6 February 2024]
[236] Thirlwall Inquiry, Frequently asked questions [accessed 6 February 2024]
[237] BBC News, "The top surgeon who harmed patients for years", 3 September 2018 [accessed 6 February 2024]
[238] BBC News, "The top surgeon who harmed patients for years", 3 September 2018 [accessed 6 February 2024]

The Scottish Government rejected calls for a public inquiry and after its own review said NHS Tayside had:

> ...made improvements in their systems and processes as a result of their prior internal reviews when concerns about Prof Eljamel's practice were raised.
>
> The questions that now remain are ones that can be answered by NHS Tayside rather than Government, and we have been very clear with the board that we expect them to give this the highest priority and continue to support and involve those affected.[239]

In December 2022, Liz Smith MSP asked the then First Minister, Nicola Sturgeon, whether a statutory inquiry would be held in the light of more former patients coming forward. The First Minister said "we are not, at this stage, convinced" that a full public inquiry was needed.[240]

NHS Tayside set up a due diligence review to address recommendations in the Scottish Government review. The Tayside review recommended to the Board that professional, clinical and corporate governance processes should continue to be strengthened. The report was shared with the Scottish Government.[241]

Establishing the inquiry

On 7 September 2023 Michael Matheson, the Scottish Health Secretary, announced a statutory public inquiry:

> The report presented last week to the board of NHS Tayside outlines a number of failings that I believe can only be examined thoroughly by a public inquiry. It also brings forward significant information not previously known to the Scottish Government. Given the length of time since the first concerns were raised about Mr Eljamel, this raises real concerns.[242]

The chair for the inquiry was announced in February 2024. Lord Weir, a serving judge of the Supreme Courts in Scotland, will chair.[243]

[239] Scotsman, "Public inquiry urged into disgraced Scottish neurosurgeon", 3 November 2022 [accessed 6 February 2024]

[240] Scottish Parliament Record of Proceedings, 22 December 2022

[241] NHS Tayside, Statement Professor Eljamel due diligence report, 31 August 2023 [accessed 6 February 2024]

[242] Scottish Government, Public Inquiry on former NHS Tayside surgeon, 7 September 2023

[243] Scottish Government, Chairs for Eljamel Inquiry and Reviews appointed, 29 February 2024

5.17 Inquiry into the death of Jalal Uddin

Jalal Uddin, 71, was murdered in Rochdale in February 2016. A police investigation concluded that Mr Uddin had been murdered by Mohammed Kadir and Mohammed Hussein Syeedy. While Mohammed Syeedy was sentenced to life for murder in September 2016, Mohammed Kadir fled the country with the help of a third man, who was later jailed. Mohammed Kadir remains at large.[244]

An inquest into Mr Uddin's death had begun but had been suspended due to the criminal proceedings. In November 2020, at a hearing to decide whether the inquest should resume, concerns were raised that the authorities had been aware of the risk posed by Kadir on the basis of "his Islamist extremist aspirations", but lawyers representing the Home Office denied this. The judge found that there were sufficient grounds for concern and ordered the inquest to be reopened.[245]

In November 2022, the Chief Coroner for England and Wales, Judge Thomas Teague, asked the Home Secretary to convert the inquest into a statutory public inquiry so that all relevant evidence could be considered.[246]

Establishing the inquiry

On 9 November 2023, the then Home Secretary, Suella Braverman, announced that the inquest would be converted into a statutory inquiry, and headed by Judge Thomas Teague.[247]

The inquiry's terms of reference reiterate those of the inquest: to determine how, when and where Mr Uddin died. The inquiry will take account of the work undertaken in the earlier coronial and criminal investigations.[248]

A preliminary hearing took place on Thursday 7 December 2023.[249]

5.18 Inquiry into the murder of Emma Caldwell

On 7 March 2024 the Scottish Government announced a statutory inquiry into the investigation of the murder of Emma Caldwell.[250]

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[244] BBC News, Jalal Uddin killing: Public inquiry to examine imam's murder, 7 December 2023 [accessed 7 February 2024]

[245] "The latest chapter in the tragic case of a much-loved imam murdered in Rochdale", Manchester Evening News, 5 December 2020 [accessed 7 February 2024]

[246] 5 Essex Chambers, Jalal Uddin Public Inquiry, 7 December 2023 [accessed 7 January 2024]

[247] Home Office, Inquiry launched into the death of Jalal Uddin, 9 November 2023

[248] Statutory Inquiry into the death of Jalal Uddin, Terms of reference

[249] Statutory Inquiry into the death of Jalal Uddin, Hearings

[250] Scottish Government, Public Inquiry into Emma Caldwell case, 7 March 2024

Emma Caldwell was murdered in April 2005. Her murderer was convicted in February 2024 and found guilty of Emma's murder and 32 other charges including 11 rapes and multiple sexual assaults against a total of 22 women.[251]

Failings in the original police investigation into the murder came to light after the Lord Advocate ordered police to re-open the investigation in 2015. Police Scotland apologised for how the original inquiry was handled.

In announcing the inquiry, the Cabinet Secretary for Justice and Home Affairs Angela Constance said:

> ...given the gravity of this case; the length of time that it took for justice to be served; the horrific extent of the sexual violence suffered by the victims and survivors; and the suffering endured by their families - the case for holding a Public Inquiry is clear and compelling.[252]

[251] Police Scotland, Iain Packer convicted of murdering Emma Caldwell in 2005, February 2024
[252] Scottish Parliament Record of Proceedings, 7 March 2024

Annex: Tables of statutory inquiries

Table 1: Active and announced 2005 Act public inquiries

Active and announced inquiries under the Inquiries Act 2005 - As of March 2024

Inquiry	Announced	Commissioning minister	Administration/department	Chair
Scottish Child Abuse	17/12/14	Mike Russell	Scottish Government	Lady Smith
Undercover Policing	12/03/15	Theresa May	Home Office	Sir John Mitting
Grenfell Tower	15/06/17	Theresa May	Office of Prime Minister	Sir Martin Moore-Bick
Infected Blood	03/11/17	Damian Green	Cabinet Office	Sir Brian Langstaff
Scottish Hospitals	17/09/19	Jeane Freeman	Scottish Government	Lord Brodie
Death of Sheku Bayoh	12/11/19	Humza Yousaf	Scottish Government	Lord Bracadale
Muckamore Abbey Hospital	08/09/20	Robin Swann	Northern Ireland Executive	Tom Kark QC
Coronavirus (UK)	12/05/21	Boris Johnson	Office of Prime Minister	Baroness Hallett
Post Office Horizon IT	19/05/21	Kwasi Kwarteng	BEIS	Sir Wyn Williams
Coronavirus (Scotland)	24/08/21	Nicola Sturgeon	Scottish Government	Lady Poole
Death of Dawn Sturgess (converted inquest)	18/11/21	Priti Patel	Home Office	Lord Hughes
Independent Inquiry relating to Afghanistan	15/12/22	Ben Wallace	Ministry of Defence	Sir Charles Haddon-Cave
Omagh Bombing Inquiry	02/03/23	Chris Heaton-Harris	Northern Ireland Office	Lord Turnbull
Essex Mental Health	28/06/23	Steve Barclay	Health and Social Care	Baroness Lampard
Lucy Letby Inquiry	30/08/23	Steve Barclay	Health and Social Care	Lady Justice Thirlwall
Actions of Sam Eljamel and NHS Tayside	07/09/23	Michael Matheson	Scottish Government	Lord Weir
Death of Jalal Uddin (converted inquest)	09/11/23	Suella Braverman	Home Office	Thomas Teague KC
Murder of Emma Caldwell	07/03/24	Angela Constance	Scottish Government	TBC

Table 2: Former 2005 Act public inquiries

Former inquiries established under the Inquiries Act 2005 - as of February 2024

Inquiry	Commissioning minister	Commissioning administration	Chair	Start Date	End Date	Cost (£m)
Death of Billy Wright	Peter Hain	UK Government	Lord Ranald McLean	23/11/05	14/09/10	30.5
Death of Robert Hamill	Peter Hain	UK Government	Sir Edwin Jowett	16/11/04	29/01/10	33.0
E-coli	Rhodri Morgan	Welsh Government	Professor Hugh Pennington	13/03/06	19/03/09	2.4
ICL Plastics	Peter Hain/Elish Angiolini	UK and Scottish Governments	Lord Gill	21/11/08	16/07/09	1.9
Death of Bernard Lodge	Shahid Malik	UK Government	Barbara Stow	23/02/09	15/12/09	0.4
Death of Baha Mousa	Des Browne	UK Government	Lord Justice Gage	14/05/08	08/09/11	13.0
The Fingerprint Inquiry	Kenny McAskill	Scottish Government	Sir Anthony Campbell	14/03/08	14/12/11	3.4
The Penrose Inquiry (contaminated blood)	Nicola Sturgeon	Scottish Government	Lord Penrose	23/04/08	26/03/15	12.1
Clostridium Difficile in Northern Trust Hospitals	Michael McGimpsey	Northern Ireland Executive	Dame Deirdre Hine	14/10/08	21/03/11	1.8
Vale of Leven Hospital (clostridium difficile)	Nicola Sturgeon	Scottish Government	Lord Ranald McLean	22/04/09	24/11/14	10.7
Al-Sweady Inquiry	Bob Ainsworth	UK Government	Sir Thaynes Forbes	25/11/09	17/12/14	24.9
Death of Azelle Rodney	Chris Grayling	UK Government	Sir Christopher Holland	10/06/10	05/07/13	2.4
Mid Staffordshire NHS Trust	Andrew Lansley	UK Government	Sir Robert Francis	09/06/10	06/02/13	13.7
Phone Hacking (Leveson Inquiry)	David Cameron	UK Government	Lord Brian Leveson	13/07/11	29/11/12	5.4
Death of Alexander Litvinenko	Theresa May	UK Government	Sir Robert Owen	22/07/14	21/01/16	2.4
Edinburgh Tram	Alex Salmond	Scottish Government	Lord Hardie	05/06/14	19/09/23	13.1
Independent Inquiry into Child Sexual Abuse	Theresa May	UK Government	Professor Alexis Jay	04/02/15	31/10/22	186.1
Death of Anthony Grainger	Theresa May	UK Government	Thomas Teague QC	17/03/16	12/07/19	2.6
Renewable Heat Incentive Inquiry	Máirtín Ó Muilleoir	Northern Ireland Executive	Sir Patrick Coghlin	24/01/17	13/03/20	7.4
Brook House	Priti Patel	UK Government	Kate Eves	05/11/19	19/09/23	18.7 *
Manchester Arena (converted inquest)	Priti Patel	UK Government	Sir John Saunders	22/10/19	08/06/23	32.5 **
Death of Jermaine Baker (converted inquest)	Priti Patel	UK Government	Clement Goldstone QC	12/02/20	31/10/22	4.1

Sources:
a. House of Lords Select Committee on the Inquiries Act, The Inquiries Act 2005: post-legislative scrutiny, HL Paper 143, 11 March 2014
b. National Audit Office, Investigation into government-funded public inquiries, HC 836, 23 May 2018
c. Official and archived websites of individual inquiries

Notes:
* Total up to 30 September 2023
** Total up to end of August 2023

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