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THE LEGAL BASIS OF THE DUTY TO INVESTIGATE (1): DOMESTIC AND INTERNATIONAL (NON-ECHR) LAW

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Introduction

1. The "duty" on the State to conduct an investigation into events of significant public concern or interest is not in fact a single duty, but incorporates some duties, and a wide range of powers, derived from common law, statutory and international law sources, which can often overlap in the same case. In this presentation we seek to provide an overview of these various legal sources, and some observations about how the principles and processes inter-relate.

2. This paper focuses on domestic and international law duties and powers with respect to investigations; Adam Straw's paper addresses the investigative obligations generated by Articles 2, 3 and 4 of the European Convention on Human Rights ("the ECHR"), incorporated into domestic law (for now, at least!) via the Human Rights Act 1998 ("the HRA"). These Convention rights have an important role to play in triggering the duties and powers in issue, and in shaping the scope and outcome of the investigations that follow; and so our papers should be considered together for a full understanding of the legal position.

Why investigate?

3. Before considering the different forms of State investigations, it is helpful to pause and consider why there is a need to investigate matters of public concern at all, and what such investigations aim to achieve. The leading textbook on public inquiries quotes the now Sir Stephen Sedley as having said that a public inquiry is "*the organising of*

controversy into a form more catholic than litigation but less anarchic than street fighting"! In a less colourful form it is suggested that the functions of a public inquiry are: (i) establishing the facts; (ii) ensuring accountability, identifying wrongdoing, blameworthy conduct and culpability; (iii) learning lessons; (iv) restoring public confidence in a public authority or the Government; (v) providing an opportunity for catharsis, reconciliation and resolution; (vi) (in some cases) developing policy or legislation; and (vii) discharging investigative obligations derived from the ECHR[1]. These functions often apply to the other forms of investigation with which we are concerned.

Domestic law duties and powers to investigate

The Coroner's duty to investigate certain deaths

4. It makes sense to start with the Coroner's duty to investigate certain deaths, given that: (i) it is this investigative obligation which will first be considered when what are probably rightly regarded as the most egregious breaches of human rights - namely when agents of the State deliberately take a person's life - take place; (ii) this is the clearest example of a domestic law duty to investigate, as opposed to a power to do so; and (iii) this source for an investigation is the oldest we have identified, given that it can be traced back to the Articles of Eyre of September 1194.

5. Under the Articles of Eyre, local knights were appointed to "*keep the pleas of the Crown*" (in Latin, "*custos placitorum coronae*", from which the word "Coroner" is derived). The main historical function of the Coroner at that point was to protect the Crown's resources: a death involved a loss of revenue and potentially other obligations to the Crown, and might mean that property that was rightly owned by the Crown could pass to others. This meant that Coroners had to assess the value of estates and ensure that, where applicable, land passed back to the Crown on the completion of a tenancy. It also included a duty on a Coroner to investigate unnatural or suspicious deaths.

[1] Beer, *Public Inquiries*, paras. 1.01 - 1.10

6. The Coroners Act 1876, and the various Coroners Acts which followed, put the obligation to investigate violent, unnatural and suspicious deaths, including sudden natural deaths where there was reasonable suspicion of a crime, on a statutory footing. The types of deaths a Coroner is required to investigate today are not vastly different from the system established in 1194: under the Coroners and Justice Act 2009 ("the CJA", which came into force in mid-2013), s.1:

> **"(1) A senior coroner[2] who is made aware that the body[3] of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.**
>
> **(2) This subsection applies if the coroner has reason to suspect that—**
>
> **(a) the deceased died a violent or unnatural[4] death,**
>
> **(b) the cause of death is unknown, or**
>
> **(c) the deceased died while in custody or otherwise in state detention[5]"**.

[2] Statutory provision is now made for the transferring of investigations between Coroners (s.2): this will often occur where, for example, a person dies in one Coroner's area but the bulk of the events that are pertinent to their death occurred in another. The Chief Coroner can also now direct one Coroner to take over another's investigation (s.3).

[3] Where a Senior Coroner considers that the investigative duty would be triggered but for the destruction, loss or absence of the body, a report to the Chief Coroner should be made and s/he can direct that an investigation nevertheless takes place (ss.1(4)-(6)).

[4] The phrase **"unnatural death"** is generally used to indicate some suspicion of foul play or wrongdoing, or where a death was at least contributed to by neglect, or where an unexpected death, albeit from natural causes, results from some culpable human failure (*R (Touche) v Inner London North Coroner* [2001] 3 WLR 148, paras. 43-6).

[5] A person is **"in state detention"** if s/he is compulsorily detained by a public authority within the meaning of s.6 of the HRA. This will include detention in prison, in police custody, or an immigration detention centre, or held under mental health legislation, irrespective of whether the detention was lawful or not. Whether or not persons under Deprivation of Liberty Safeguards are always to be regarded as in detention (and if so, whether an inquest is required, and if so, what form of inquest) is a live issue in coronial law at the moment: see the Chief Coroner's Guidance No. 16 at https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-16-dols.pdf.

7. The need to afford particular scrutiny to deaths in custody or quasi-custody (previously including gaols, workhouses and mental hospitals) has long been recognised by domestic coronial practice; and there are some interesting historical examples of jury verdicts that would resonate today: in 1840, the jury determined that James Lisney had died as a result of being treated in an "*inhumane*" way while "*in an infirm state of health*" in a workhouse, and there is at least one example of a death being found to have occurred due to "*the mental effects of imprisonment*"[6].

8. Coroners today exercise their jurisdiction by reference to defined geographical areas. Coroners have indeed always had a particularly close relationship with local communities: historically the Coroner was usually a local nobleman with ties to the community (who was often the only person together with the clergy who could read and write); the law required the immediate four neighbours living either side of the deceased to inform the Coroner about the death; the community was obliged to bring the deceased's kinsmen to Court and in default a *mundrum* fine was payable; and a Coroner had additional powers to fine the community as a whole (in *amercements*) if it was unable properly to account for how a person had died.

9. The concept of an **"investigation"** by a Coroner was first given statutory recognition by the CJA. Under s.1(7) a Coroner can make **"whatever enquiries seem necessary"** in order to decide whether or not the duty to investigate arise.

10. Moreover, under s.4(1), once a Coroner has commenced an investigation, under s.4, s/he is now under a duty to discontinue that investigation if s/he is satisfied that: (i) the post-mortem has **"reveal[ed] the cause of death before the Coroner has begun holding an inquest into the death"**; and (ii) the Coroner thinks that it is **"not necessary"** to continue the investigation, provided that the Coroner does not have reason to suspect that the deceased died a violent or unnatural death or died while in

[6] Sim and Ward, The magistrates of the poor? Coroners and deaths in custody in nineteenth century England (1736), quoted in Thomas et al, *Inquests: A Practitioner's Guide* (2014) at para. 2.7.

custody or otherwise in state detention (s.4(2))[7]. This duty to discontinue an investigation in non-custody cases where the Coroner is satisfied that the death was a natural one, and there is no other cause for concern (to the effect, for example, that there were failings in medical care which hastened the fatal impact of a naturally occurring condition), was introduced by the CJA. The key practical consequence of these provisions appears to have been, as was intended, that straightforward "natural causes" deaths (other than those relating to apparently natural causes deaths in custody) do not generally proceed to inquest.

11. The Broderick Committee (1967-71) identified the key public interest features of the coronial function as being to (i) determine the medical cause of death; (ii) allay rumours of suspicion; (ii) draw attention to the existence of circumstances which, if unremedied, might lead to further deaths; (iv) advance medical knowledge; and (v) preserve the legal interests of the deceased's family, heirs of other interested persons. This illustrates that domestic law has long recognised elements similar to those that Article 2 requires of an investigation which Adam describes.

12. The statutory purposes of a coronial investigation are, under s.5(1), the ascertaining of

> **"(a) who the deceased was;**
>
> **(b) how, when and where the deceased came by his or her death;**
>
> **(c) the particulars (if any) required by the 1953 Act to be registered concerning the death"**.

Further, under s.5(2):

[7] Where a Coroner discontinues an investigation into a death under this section, s/he may not hold an inquest into the death (s.4(3)(a)) and must, if requested to do so in writing by an interested person, provide a written explanation as to why the investigation was discontinued (s.4(4)). This provision does not prevent a fresh investigation under this Part from being conducted into the death (s.4(3)(b)). This would presumably apply should fresh evidence become available.

> **"Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining <u>in what circumstances</u> the deceased came by his or her death"** [emphasis added].

Under s.1(3) neither the Senior Coroner conducting an investigation nor the jury (if there is one) may express any opinion on any matter other than those set out above.

13. In addition, Coroners' investigations have long had an important <u>lessons learning</u> function. This is now found in the CJA, Schedule 5, para. 7:

> **"7 (1)Where —**
>
> **(a) a senior coroner has been conducting an investigation under this Part into a person's death,**
>
> **(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and**
>
> **(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action"**[8].

[8] The "*concern*" aspect of paragraph 7(b) imports a "*relatively low threshold*". The provision does not require that the Coroner has concluded or is satisfied that circumstances creating a risk to life exist: rather a Coroner must be satisfied of a "*concern*" in this regard: see the ruling of Hallett LJ in Westminster Assistant Deputy Coroner in the *London 7/7 Bombings Inquests* dated 6 May 2011, p.16. Moreover the duty to report is triggered where the concern arises in relation to any other deaths, and not simply deaths similar to that with which the inquest is concerned, as the pre-2008 version of the old Rule 43 required. It neither necessary, or appropriate, for a Coroner making a PFD report to identify the necessary remedial action: the Coroner's function is to identify points of concern, not to prescribe solutions: Hallett LJ, *ibid.* and Chief Coroner's Guidance No. 5, paras. 24 and 31: https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-5-reports-to-prevent-future-deaths.pdf.

14. In terms of the scope of a Coroner's investigation, at common law a Coroner must not set the boundary of the inquiry too narrowly, particularly where there is acute public concern regarding the death (*R v HMC for North Humberside, ex parte Jamieson* [1995] QB 1, p.26, para. 14).

15. How is a Coroner's investigation carried out? Historically, a Coroner had the power to "attach" any witnesses, effectively obliging them to attend the Court, and was able to take sureties to secure attendance. Nowadays, it remains the duty of the Coroner to obtain witness and other evidence and s/he now has a power to compel the production of the same, under the CJA, Schedule 5, paragraph 1. The Coroner is required under the CJA, s.47 to recognise within the investigation certain Interested Persons, including certain family members of the deceased and any person who may have caused or contributed to the death of the deceased, and has a discretion to recognise any other person who the Senior Coroner considers has a sufficient interest. Those Interested Persons now have a broad right to disclosure of material which the Coroner considers "relevant" to the inquest, subject to certain exceptions (the Coroners (Inquests) Rules 2013, Rules 12-16).

16. There is now a statutory requirement to ensure that a Coroner's investigation is conducted in a timely manner: under the CJA, s.1(1), the investigation must be conducted **"as soon as practicable"** after the Coroner becomes aware of the presence of the body; under the 2013 Rules, Rule 18, a Coroner must complete an inquest within **6 months** of the date on which the coroner is made aware of the death, or as soon as is reasonably practicable after that date; and under the CJA s.18, any investigations which take longer than **1 year** must be reported to the Chief Coroner.

17. If an investigation is not discontinued under s.4 an inquest must be held (s.6). Under s.7(2), an inquest must be held with a jury if the Senior Coroner:

> **"...has reason to suspect -**

(a) that the deceased died while in custody or otherwise in state detention, and that either—

(i) the death was a violent or unnatural one, or

(ii) the cause of death is unknown,

(b) that the death resulted from an act or omission of—

(i) a police officer, or

(ii) a member of a service police force,

in the purported execution of the officer's or member's duty as such, or

(c) that the death was caused by a notifiable accident, poisoning or disease".

The Coroner has a discretion to summon a jury under s.7(3) if s/he considers that there is sufficient reason for doing so[9].

18. At an inquest, the Coroner will generally ask questions of the witnesses first, and the Interested Persons have the right to ask questions of witnesses (Rule 21). Inquest hearings and pre-inquest reviews must be conducted in public unless the Coroner concludes that interests of national security require the exclusion of the public (Rule 11). A Coroner has no power to reach conclusions based on evidence considered at hearings from which the Interested Persons are excluded (*R (Secretary of State for the Home Department) v Assistant Deputy Coroner for Inner West London* [2010] EWHC 3098 (Admin); [2011] 1 WLR 2564).

19. The outcome of a coronial investigation that ends in inquest is either a "short-form" conclusion (accident, unlawful killing, suicide etc), a "narrative" one, or a combination of the two.

[9] Coroner's juries now are comprised of 7-11 persons (s.8): historically up to 23 people could be called to sit on a Coroner's jury, and the viewing of the body by all concerned was an essential part of the process.

20. The inter-relationship between inquests and criminal proceedings is complex. Historically, there was a direct causal relationship between the two in certain cases: if a bereaved family wanted certain individuals to be tried for murder, they had to come to the Coroner and make an appeal in plea, and on a finding of murder at an inquest a Coroner had the power to prefer a bill and send a person to trial. As a result of the Coroners (Amendment) Act 1926, the police were formally required to investigate murders. The 1936 Wright Committee Report recommended that Coroners should no longer have the power to order indictments for murder to be preferred against named persons, and that senior police officers should have the power to request the adjournment of inquests if criminal proceedings were being considered. These recommendations were implemented. The CJA s.11 and Schedule 1, paras. 1-2 now set out the duties and powers in respect of suspending inquest proceedings where there are overlapping criminal proceedings[10]. There is a power to resume an inquest after a criminal trial where the Senior Coroner considers that there is sufficient reason such resumption (the CJA, Schedule 1, Part 1, paragraph 8(1))[11].

21. In terms of the relationship between inquests and civil proceedings, it is interesting that historically a Coroner's duty to investigative deaths included within it an element of securing compensation for the family of the deceased: a person convicted of murder would forfeit their land to the Crown, but the bereaved family might receive some of the property (especially the actual murder weapon); and if a person had died through misadventure the family might be entitled to some rights to the land he was on at the

[10] For similar reasons, a Coroner must adjourn an inquest and notify the Director of Public Prosecutions if during the course of the inquest, it appears to the Coroner that the death of the deceased is likely to have been due to a homicide offence and that a person may be charged in relation to the offence (Rule 25(4)).

[11] Resumption may be appropriate where there was no ventilation of the issues around the cause of death at the criminal trial (such as where there was a guilty plea), or where wider systemic issues need to be explored (see, for example, *R (Moss) v HM Coroner for the North and South Districts of Durham and Darlington* [2008] EWHC 2940 (Admin), where there had been a criminal trial in which a doctor accused of overmedicating elderly patients had been acquitted of murder, but where wider systemic issues needed to be explored as well as the doctor's individual actions).

time, or the cattle he was herding (a *deodund*). However from the Middle Ages these "compensatory" aspects of the Coroners' investigative obligation diminished. Now, inquest proceedings and private law civil claims are legally separate, although the family remain parties to both and in practical terms the evidence at findings at inquest can often influence the outcome of a civil claim.

22. The Wright Committee's work also led to the provision now to be found in the CJA 2009, s.10(2), to the effect that a Coroner's court determination **"may not be framed in such a way as to appear to determine any question of — (a) criminal liability on the part of a named person, or (b) civil liability"**. This reflects the fact that inquests are formally categorised as inquisitorial in nature, and not adversarial. There is sometimes a tension between the "*appear*" element of this wording and the important role of an inquest, strengthened by Article 2 as we shall see, in identifying wrongdoing and ensuring accountability by agents of the State. Further, it has recently been held that the findings at an inquest are generally not admissible in a civil trial (*Daniel v St George's Healthcare NHS Trust* [2016] EWHC 23 (QB), and this may lead to a rather artificial outcome in some cases.

23. In terms of the relationship between coronial investigations and public inquiries:

- A Coroner must suspend an investigation if the Lord Chancellor requests the same 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 (the CJA, Schedule 1, para. 3);

- A public inquiry can be set up to replace an inquest, where an inquest is required but where it becomes clear that the inquest will not be able to inquire properly into the death. This occurred in the *Alexander Litvinenko* case where the scale of material to which public interest immunity had been held to apply meant that a fair inquest hearing could not take place (given a Coroner's inability to consider "closed" evidence), and in the *Azelle Rodney* and *Anthony Grainger* cases where

covertly obtained material (which could not be considered openly by a Coroner) was in issue;

- A public inquiry can also be appropriate in addition to an inquest, where, for example, an inquest has been properly concluded but there remains an argument that additional issues require investigation that is beyond the scope of the inquest process, or where there is a historic case in which an inquest may or may not have taken place, but where it is held that there is a need to investigate the case afresh (see, for example, the McPherson Inquiry which followed the inquest into the death of *Stephen Lawrence*);

- A public inquiry can perform a function similar to an inquest, where, for example, a death occurred abroad and the body is buried there, but where it is said that the death involved British state agents breaching Article 2, or in "near death" cases (see further below); and

- If an inquiry has already been held by the time the inquest takes place, a Coroner can admit the findings of an inquiry, including any inquiry under the 2005 Act, if the Coroner considers them relevant to the purposes of the inquest (Rule 24).

The power to establish a public inquiry under the Inquiries Act 2005

24. The conducting of public/judicial inquiries in Britain can be traced back centuries (albeit not as far back as the coronial duty to investigate): inquiries of this nature have been recorded from the mid-17th century. From that time until 1921 Parliament generally performed the function of conducting inquiries into government failures and the alleged misconduct of ministers or other public servants. Such investigations often related to the alleged mismanagement of war and acted as a precursor to impeachment. Such inquiries were normally constituted in the form of a Parliamentary Select Committee of Inquiry and occasionally as Commissions of Inquiry[12].

[12] Beer, *ibid.*, paras. 1.11-1.13

25. Under the Special Commission Act 1888, a Special Commission was appointed to investigate certain serious allegations that had been made against Charles Stewart Parnell, the Leader of the Irish Nationalists and a prominent Parliamentarian. The Commission was given all the powers and privileges of the High Court, including powers to enforce the attendance of witnesses, to examine witnesses on oath, to compel the production of documents, to punish persons guilty of contempt and to issue a commission or request to examine witnesses abroad and to issue warrants for arrest. The Act also incorporated mechanisms to safeguard the interests of those who appeared before it, in that the Commissioners had power to order that any document in the possession of any party appearing at the Inquiry should be inspected by any other party, the parties were entitled to be represented by counsel or a solicitor, witnesses could be cross-examined and any evidence given by a person in the course of the Commission was not admissible against the person giving it in any further civil or criminal proceedings (except those for perjury)[13].

26. Gradually dissatisfaction grew with the process of setting up Parliamentary Committees, given their inherently political nature, and in 1921 the Tribunals and Inquiries (Evidence) Act 1921was passed, providing for the conducting of public inquiries chaired by a judge. Under the Act if both Houses of Parliament resolved that it was expedient to establish a tribunal for **"inquiring into a definite matter described in the Resolution as of urgent public importance"**, then such a tribunal would be established with all the powers, rights and privileges vested in the High Court. Accordingly inquiries under the 1921 Act were independent of Parliament, albeit that their institution depended upon Parliamentary resolution: there was no duty to investigate as such, merely a power to do so, and one that was dependent on Parliamentary decision. The 1921 Act in some ways reflected the model used in the

[13] Beer, *ibid.*, paras. 1.13-1.14

Parnell Commission, but there was no provision for disclosure or cross-examination, or the non-admissibility of Commission evidence in other proceedings[14].

27. Examples of inquiries established under the 1921 Act include:

- *The Cullen Inquiry* into the Dunblane shootings;
- *The Harold Shipman Inquiry* into the systems changes that should be made in order to safeguard patients in the future following the conviction of Harold Shipman of the murder of 15 of his patients; and
- *The Bloody Sunday Inquiry* into the events of 30 January 1972, which led to loss of life in connection with the procession in Londonderry on that day.

28. The Royal Commission on Tribunals of Inquiry which reported in November 1966 examined the operation of the 1921 Act and concluded that it required amendment, and that there were six principles that all inquiries set up under the Act should follow to ensure the fairness of inquiry proceedings, namely that:

- Before any person becomes involved in an inquiry, the Tribunal must be satisfied that there are circumstances which affect him and which the Tribunal proposes to investigate;
- Before any person who is involved in an inquiry is called as a witness, he should be informed in advance of the allegations against him and the substance of the evidence in support of them;
- He should have adequate opportunity to prepare his case and be assisted by legal advisers and his legal expenses should normally be me out of public funds;

[14] Beer, *ibid.*, paras. 1.15-1.26

- He should have the opportunity of being examined by his own solicitor or counsel and of stating his case in public at the inquiry;

- Any material witness he wishes to be called at the inquiry should, if reasonably practicable, be heard; and

- He should have the opportunity of testing by cross-examination conducted by his own solicitor or counsel any evidence which may affect him.

In 1973 a White Paper was produced which generally accepted the spirit of the Royal Commission's conclusions and set out various proposals for legislative reform, but these were not progressed. The inquiries system was reviewed further by Sir Roy Beldam and Judith Bernstein in 2002, the House of Commons Public Administration Select Committee in 2004/5 and a Department of Constitutional Affairs consultation in 2004[15].

29. In addition to the 1921 Act, there were various other statutes which provided for the setting up of inquiries. The Inquiries Act 2005, which received Royal Assent on 7 April 2005, was a unifying statute, intended to provide a comprehensive statutory framework for inquiries set by Ministers to look into matters of public concern. It repealed the 1921 Act and many other statutory powers to establish inquiries, and removed the direct role of Parliament in establishing inquiries, albeit that the power to establish an inquiry now rests with a Minister.

30. Concerns were raised at the time of the passage of the Act from a range of quarters as to whether inquiries under it would in fact be sufficiently independent of Parliament given this legal framework. It has also been suggested that the 2005 Act ought to have included within it provision for the institution of an inquiry by Parliament in the event of a refusal by a Minister to do so; that a permanent agency such as an Accident

[15] Beer, *ibid.*, paras. 1.37-1.58

Bureau, should be set up to take charge of major disasters and to determine whether a public inquiry into such disasters should be initiated; and that an ombudsman should be appointed to decide whether an inquiry should be held, and if so, the nature and extent of the inquiry[16].

31. Under s.1 of the 2005 Act:

> **"..."(1)A Minister may cause an inquiry to be held under this Act in relation to a case where it appears to him that—**
>
> **(a) particular events have caused, or are capable of causing, public concern, or**
>
> **(b) there is public concern that particular events may have occurred"**[17].

32. It is apparent from the wording above that a Minister has a very broad discretion as to whether to institute a public inquiry. The circumstances are broader than those in the "trigger provision" under the 1921 Act (**"a definite matter....of urgent public importance"**).

33. The circumstances in which an inquiry might be instituted under the 2005 Act are:

> "*....infinitely variable. A common theme, however, has been that the subject matter of the inquiry has exposed some possible failing in systems or services, and so has shaken public confidence in those systems or services, either locally or nationally....The history of inquiries suggests that ministers will call an inquiry only if there are special circumstances that require something beyond the normal*

[16] For further discussion of these issues of principle, see Beer, *ibid.*, paras. 1.65-1.72 and 2.32-2.36.

[17] There are special provisions for inquiries established by Scottish and Welsh Ministers, largely in relation to issues that are **"wholly or primarily concerned with"** Scottish or Welsh matters (ss.28 and 29 of the 2005 Act). In respect of Northern Ireland there remain a small number of provisions of Northern Irish legislation which provide for the institution of an inquiry and s.30 of the 2005 Act also addresses inquiries for which a Northern Ireland minister is responsible. There is also provision in the 2005 Act for inquiries that cross borders within the UK (s.31), for inquiries for which the responsibility is shared between two or more administrations (s.33) and for inquiries for which two or more Ministers are responsible (s.32).

> *investigative or regulatory procedures*[18]. *For example, a problem might have very wide ranging implications, or responsibility for investigation might be spread across several different agencies. An inquiry has the advantage of being able to address the problem as a whole, to conduct an overarching investigation and identify areas for improvement in communications. Sometimes agreed procedures do already exist for joint investigations by different agencies, but inquiries have proved useful in the past when there have been difficulties in conducting a sufficient investigation through the agreed procedures*"[19].

34. It has been argued that:

> "*The most compelling case for a public inquiry will arise when evidence emerges from a death or number of deaths of an administrative practice...defined [by Articles 2 and 3 case-law] as "an accumulation of identical or analogous breaches which are sufficiently numerous and interconnected to amount not merely to isolated incidents or exceptions but to a pattern or system*"[20].

35. The Inquiry Rules 2006 which came into force on 1 August 2006 address, in respect of inquiries for which a UK minister is responsible, (i) the designation of Core Participants to an inquiry; (ii) the appointment of legal representatives; (iii) the taking of evidence and the procedure for oral hearings; (iv) the disclosure of potentially restricted evidence; (v) the issuing of warning letters to witnesses; (vi) arrangements for publishing reports and records management; and (vii) the determination, assessments and payments of costs. The 2005 Act also makes provision for the conversion of statutory and non-statutory inquiries into an inquiry under the 2005 Act[21].

36. Examples of inquiries established under the 2005 Act include:

[18] Such as the criminal justice system, the civil courts, the coronial jurisdiction, as well as internal NHS investigations, independent commissions such as the Commission for Healthcare Audit and Inspection, special accident investigation branches that deal with air, rail and marine accidents, regulatory bodies such as the Health and Safety Executive, the General Medical Council etc, and the Parliamentary Commissioner for Administration

[19] Beer, *ibid.*, paras. 2.03-4

[20] Thomas et al, *ibid.*, para. 21.25

[21] For a detailed consideration of these provisions, see Beer, *ibid.*, paras. 2.76-2.96

- *The Baha Mousa Inquiry* into the death of an Iraqi man while in British Army custody in Basra, Iraq in September 2003;

- *The Al Sweady Inquiry* into allegations that the human rights of a number of Iraqi nationals were abused by British troops in the aftermath of a 2004 firefight which took place during the Iraq war;

- *The E-coli Inquiry* into the September 2005 outbreak of E.coli O157 in South Wales; and

- *The Mid-Staffordshire NHS Foundation Trust Inquiry* which followed concerns about standards of care at the Trust and an investigation and report published by the Healthcare Commission in March 2009.

37. In terms of the relationship between inquiries under the 2005 Act and other proceedings:

- The 2005 Act provides that an inquiry panel is not to rule on, and has no power to determine, any person's criminal or civil liability, although a panel is not to be inhibited in the discharge of its functions by any likelihood of liability being inferred from facts that it determines or recommendations that it makes (s.2); and

- Generally, any technical, professional, internal, disciplinary or criminal investigation will take place before an inquiry under the 2005 Act, because the outcome of the first proceedings can assist in determining whether a public inquiry is needed and if so, what its focus and parameters should be, and so that information gathered in the course of the first proceedings can be used to inform any subsequent inquiry[22].

[22] For a detailed consideration of the "sequencing" principles, see Beer, *ibid.*, paras. 2.146-2.169

Additional statutory powers to establish a public or judicial inquiry

38. Prior to the 2005 Act inquiries into matters of significant public concern were often conducted under subject-specific legislation, including:

- The Merchant Shipping Act 1995, under which *The Marchioness Inquiry* was instituted into a fatal collision between two rivercraft on the Thames in London on 20 August 1989, drowning 51 people;

- The Health and Safety at Work Act 1974, s.14(2)(b), under which *The Ladbroke Grove Inquiry* was established into the collision between two trains at Ladbroke Grove on 5 October 1999, in which 301 people died; and

- The Children Act 1989, s.81, the National Health Service Act 1977, s.84 and the Police Act 1996, s.69 under which *The Victoria Climbié Inquiry* was established into the death on Victoria Climbié on 25 February 2000.

39. As indicated above the 2005 Act was intended to be a unifying statute and so s.49 and Schedule 5 of it repealed most of these statutory powers. The few powers that remain include those under the National Health Service Act 1977, s.2 and the Health and Safety at Work Act 1974, s.14(2)(b).

40. The Equality and Human Rights Commission also has a power to conduct an investigation under the Equality Act 2010, s.20. Such an investigation will explore compliance with equality legislation where the Commission suspects that an unlawful act may have been committed. The Commission is currently conducting such an investigation into the Metropolitan Police Service[23].

[23] http://www.equalityhumanrights.com/commission-publishes-terms-reference-investigation-metropolitan-police-service

Non-statutory powers to establish a public or judicial inquiry

41. There have been several occasions on which inquiries have been established outside of the 2005 Act or any other statutory regime. It has been suggested that these have been borne out of an acknowledgement by Government that it has a duty (in a broad sense, not necessarily a legally enforceable one) to investigate matters of public concern, especially in relation to those areas where it has direct or indirect responsibility.

42. The reasons for using a non-statutory inquiry include (i) a desire to avoid the *sub judice* rule which formally only applies to statutory inquiries; (ii) anticipation that power to summons witnesses and to certify for contempt will not be needed; (iii) the difficulties in subsequently prosecuting on the basis of evidence obtained under compulsory powers; and (iv) a desire to avoid having to implement some or all of the procedural requirements resulting from the recommendations of the Salmon Commission.

43. The advantages of using a non-statutory inquiry model include (i) greater flexibility to adopt processes and procedures; (ii) release from the strict requirements of the 2005 Act and the 2006 Rules (in particular, perhaps, the presumption that a 2005 Act will sit in public); and (iii) the probability that the inquiry may be completed within a shorter time, with less involvement of lawyers and with a subsequent saving of costs.

44. The disadvantages of using a non-statutory inquiry model include (i) the inability of the inquiry to compel the production of documents or the attendance of witnesses; (ii) the consequent risk that such an inquiry may fail to discharge ECHR obligations; and (iii) the risk that the inquiry's conclusions will be undermined by the non-disclosure of material to it, or that that will be a perception[24].

45. Some of these non-statutory inquiries have been established under the executive power of Ministers. Examples include:

[24] Beer, *ibid.*, para. 2.08-2.28

- *The Hutton Inquiry* into the circumstances surrounding the death of scientist and weapons inspector Dr David Kelly;

- *The Bichard Inquiry* into child protection procedural issues that had been exposed during the Soham murders case; and

- *The Zahid Mubarek Inquiry* which was instituted following the decision of the House of Lords in *R (on the application of Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, that Article 2 required the State to conduct an investigation into Zahid Mubarek's death in custody.

46. Other non-statutory inquiries have been established by Committees of Privy Counsellors, under Orders in Council. These include:

- *The Falkand Islands Inquiry* which conducted a review of the actions of the Government in the lead up to the invasion of the Falkland Islands; and

- *The Butler Inquiry* on the intelligence weapons of mass destruction available up to March 2003.

Thematic reviews and Panel investigations

47. Thematic reviews are "*a device that move away from the formality of an ordinary inquiry, for a fraction of the price, but ideally comparatively similar, if not greater, in-depth learning*". A recent example was the independent *Corston Review of Women with particular vulnerabilities in the criminal justice system*, set up after the self-inflicted deaths of six women in HMP Styal. The review was chaired by an experienced independent figure; had a Reference Group of experts in the field; conducted a paper exercise bringing together all relevant information including reviewing and analysing the profiles and characteristics of women who had committed suicides in prison and followed the pathways that led them there; conducted a range of

site visits to prisons and alternatives to custody; organised a family listening event to enable relatives to share their experiences directly; held other stakeholder events as part of the process; and produced a comprehensive final report with suggested actions[25].

48. Panel investigations provide another investigative model.

49. A key recent example is the Hillsborough Independent Panel ("the HIP"), established by the Government in January 2010 to oversee the release of documents related to the 1989 Hillsborough football disaster. The Panel's role was to ensure that the Hillsborough families and the wider public received the maximum possible disclosure of all relevant information relating to the context, circumstances and aftermath of the tragedy. It was also the Panel's role to research and analyse the documents and provide a comprehensive report on what their disclosure added to the public understanding. Throughout its work the Panel consulted with the families of the deceased and its work was informed by their views and priorities. It was part of the approach of the Panel that disclosure took place first to the families and then to the public. This was "*decidedly neither a judicial nor lawyer led inquiry*" given that the Panel included the Right Reverend James Jones, Bishop of Liverpool, the journalist and broadcaster Peter Sissons, the criminologist Phil Scraton, a medical consultant, a retired police officer, two experts on document archiving and a television producer[26]. The report of the Panel was key to the Attorney-General's application to set aside the original inquest conclusions and thus paved the way for the fresh inquests currently taking place.

50. A Panel investigation has also been set up into the murder of Daniel Morgan, a private investigator who was killed in 1987 in circumstances in which it is suggested police were involved[27].

[25] Thomas et al, *ibid.*, para. 21.53
[26] Thomas et al, *ibid.*, para. 21.55-6
[27] Thomas et al, *ibid.*, para. 21.57

51. In its recent report on the events relating to the 'Battle of Orgreave' during the Miners' Strike of 1984/5, the Independent Police Complaints Commission has alluded to the setting up of a Panel to investigate those events:

> "*The IPCC has made concerted efforts to locate, recover and review documents, but the material that it has been able to obtain, on its own, cannot give a complete picture of what happened at Orgreave. This contrasts with the position in relation to the Hillsborough disaster where the HIP collected and analysed an immense amount of material...*
>
> *These wider questions [about the strike] are beyond the remit of the IPCC. They could only be answered if there is a public inquiry or an exercise like the Hillsborough Independent Panel (HIP), which spent nearly three years examining documents relating to the disaster. Nothing in this report precludes such an exercise; indeed the lengthy work done in finding and reading documentation would provide a starting point for it…*"[28].

Other models of investigation

52. Aside from the more formal methods of investigation described above, there are numerous ways in which senior lawyers, academics, civil servants and police officers can be commissioned to conduct investigations into a particular theme. Recent examples include the first Iraq War investigation conducted by Lord Butler into the publication of evidence supporting the disarmament case, and the review conducted by Mark Ellison QC into allegations that undercover police officers sought to collect information on the family of Stephen Lawrence that would bring their campaign into disrepute[29].

[28] The IPCC Decisions on Matters Relating to the Policing of Events at Orgreave Coking Plant in 1984, paras. 3 and 62
[29] Thomas et al, *ibid.*, para. 21.58

International law duties and powers to investigate

53. The ECHR duties covered in Adam's paper are the international law duties most frequently invoked in discussions and arguments in the UK. There are, however, some additional international law provisions which can be of relevance. A full exploration of these duties is outside the scope of this paper, but the following two examples give a sense of the sort of provisions that may apply.

54. The UN General Assembly Resolution 60/147 of 16 December 2005, setting out The Basic Principles and Guidelines on the Right to Remedy and Reparations for Victims of Violations of International Human Rights and Serious Violations of Humanitarian Law, provides under Article 3(b):

> **"The obligation to ensure respect for and implement international human rights law and international humanitarian law as provided for under the respective bodies of law, includes, inter alia, the duty to: ….**
>
> ***(b)* Investigate violations effectively, promptly, thoroughly and impartially and, where appropriate, take action against those allegedly responsible in accordance with domestic and international law…"**

55. Article 18 of the Basic Principles provides that the victims of gross violations of international human rights law and serious violations of international humanitarian law should be provided with full and effective reparation, which includes restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition. The element of "satisfaction" is particularly pertinent to the investigative duty and is defined by Article 22 of the Basic Principles thus:

> "**22. *Satisfaction* should include, where applicable, any or all of the following:**

> **"(*a*) Effective measures aimed at the cessation of continuing violations;**
>
> **(*b*) Verification of the facts and full and public disclosure of the truth to the extent that such disclosure does not cause further harm or threaten the safety and interests of the victim, the victim's relatives, witnesses, or persons who have intervened to assist the victim or prevent the occurrence of further violations;**
>
> **(*c*) The search for the whereabouts of the disappeared, for the identities of the children abducted, and for the bodies of those killed, and assistance in the recovery, identification and reburial of the bodies in accordance with the expressed or presumed wish of the victims, or the cultural practices of the families and communities;**
>
> **(*d*) An official declaration or a judicial decision restoring the dignity, the reputation and the rights of the victim and of persons closely connected with the victim;**
>
> **(*e*) Public apology, including acknowledgement of the facts and acceptance of responsibility;**
>
> **(*f*) Judicial and administrative sanctions against persons liable for the violations;**
>
> **(*g*) Commemorations and tributes to the victims;**
>
> **(*h*) Inclusion of an accurate account of the violations that occurred in international human rights law and international humanitarian law training and in educational material at all levels"**.

56. The impact of these international law provisions on the duty to investigate were recently considered by the Supreme Court in *R (Keyu) and others v Secretary of State for Foreign and Commonwealth Affairs* [2015] 3 WLR 1665. The appellants in *Keyu* challenged the refusal to inquire further into the killing of 24 unarmed civilians by British soldiers in December 1948, in the rubber plantation village of Batang Kali, Malaya. They argued that an inquiry was required under Article 2. The appellants also argued that customary international law and customary international humanitarian law, particularly the Basic Principles set out above, required the UK government to

investigate the killings, particularly in the light of the evidence now available to support the notion that they were unlawful and may have amounted to a war crime, and that the common law would recognise, and give effect to, this aspect of international law.

57. The Supreme Court in *Keyu* (Lady Hale dissenting) held that by 1948, it had not been established that international law required a formal public investigation into a suspicious death, even if there were strong reasons for believing that a war crime had been committed. Even if such a duty had been imposed by customary international law, it had to be subject to a cut-off date and it was inconceivable that it could be treated as retrospective to events which occurred more than 40 years earlier. In any event, if international law did require such an investigation, that requirement could not be implied into the common law. Parliament had expressly provided for investigations into deaths through the Coroners' Courts and through the 2005 Act. It had also incorporated Article 2 through the HRA. In those circumstances, the Court held that it would be inappropriate for the courts to impose a further duty to hold an inquiry, particularly with such potentially wide and uncertain ramifications, applying *McKerr's Application for Judicial Review* [2004] UKHL 12, [2004] 1 WLR 807 (paras. 112-122).

58. By way of further example the European Convention on Action Against Trafficking in Human Beings ("ECAT") includes at Chapter V various provisions intended to ensure the proper investigation into investigations into or prosecution of trafficking offences under the Convention. These include a rule that such proceedings should not be reliant on a complaint from the victim, provisions for the protection and support of victims and witnesses and a requirement that signatory states adopt measures to ensure that persons or entities within the state are specialised in the fight against trafficking and the protection of victims.

Challenging the refusal to establish an inquiry

59. When a Minister is asked to exercise his or her discretion to establish an inquiry s/he must do so in a manner that conforms to basic public law principles of reasonableness

and due consideration of relevant matters (*Secretary of State for Education v Tameside Metropolitan Borough Council* [1977] AC 1014 at 1065B). That involves providing the party seeking an inquiry with an informed and reasoned decision, including publicly justifying why an inquiry will not take place. Where an issue relates to life, even at common law a Minister is required to have compelling reasons to make decisions that impact adversely on that right (*R v Lord Saville of Newdigate ex p A* [2001] 1 WLR 1855 at para. 37).

60. Most of the recent judicial review challenges to decisions not to institute an inquiry have involved arguments around the extent of the investigative obligations under the ECHR (including as to the territorial application of the ECHR); whether those obligations have been or will be discharged by other means; and if not, what form of investigation should discharge them; and whether the combined effect of the domestic, ECHR and other international obligations has converted what is in strict law a power into a duty to investigate[30].

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[30] See, for example, *R (Lin) v Secretary of State for Transport* [2006] EWHC 2573 (Admin), *R (Scholes) v Secretary of State for the Home Department* [2006] EWCA Civ 1343, *R (M) v Secretary of State for the Home Department* [2010] EWHC 3541 (Admin); *R (Mousa) v Secretary of State for Defence* [2010] EWHC 3304 (Admin); *R (Keyu) and others v Secretary of State for Foreign and Commonwealth Affairs* [2015] 3 WLR 1665 and earlier this month *R (Al-Sadoon) and others v Secretary of State for Defence* [2016] EWHC 773 (Admin).