



Aldwych House
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The Rt Hon Nick Thomas-Symonds MP
Paymaster General and Minister for the Cabinet Office

31 March 2026

Dear Minister,

Section 14(1)(a) of the Inquiries Act 2005 provides that an Inquiry such as the one I chair comes to an end on the date I notify you that the Inquiry has fulfilled its terms of reference.

The Inquiry was fundamentally about risk and the reaction to it: the horrifying scale of what happened is an enduring warning of what can happen when patient safety is not the paramount guiding principle in response to risks to public health.

Many participants – individuals, their representatives, and organisations – told me that they wanted this Inquiry to reduce the likelihood of anything similar happening in the future. I have told participants in a public statement that I could not emphasise strongly enough that Government (and whilst it remains operative over the next few years, IBCA) must continue to learn from the lessons of the past.

Though you will have read them in Volume 1 of the Inquiry Report, where the lessons to be learned from the Inquiry are summarised, central themes running through most aspects of the Inquiry, featuring in chapter after chapter, are worth repeating again:

- (1) *First and foremost, patient safety should have been the paramount, guiding principle.*
- (2) *Second, a search for certainty can be, and in this case was, an enemy of achieving progress.*

- (3) *Third, risks to public health need to be addressed with speed, consistency, and an objective look at such evidence as there is without making unjustified assumptions.*
- (4) *Fourth, what aids the process is a clear structure for decision-making. Instead of effective decision-making here, there was “decision paralysis”.*
- (5) *Finally, cost, though a relevant factor, should not be the starting point. Patient safety should be.*

I added in the statement I made about the closure of the Inquiry:

“I cannot close the Inquiry without emphasising the essence of what I said in the Additional Report on Compensation. People infected and affected must be given the dignity and respect they deserve. This means ensuring that people’s voices are listened to by involving them in the decisions that matter to them. It means avoiding being paternalistic and patronising. It means transparency as far as possible, so that people can understand (and if need be challenge, or secure change to) those decisions – for transparency and involvement go together. It means respecting a person’s viewpoint. It means not just hearing but listening and acting. It is about truly valuing people so that people infected and affected are at the heart of things that matter.

Transparency, involvement, listening rather than simply hearing, recognising (and remedying) injustice and truly valuing people must be central to all the work that still needs to be undertaken. For the future, the Government and IBCA must ensure that there is a genuine, open-minded and meaningful ongoing dialogue with people infected and affected. Anything less runs a risk of perpetuating the mistakes of the past.”

The Government’s statement in response was that *“The Inquiry’s closure does not mean our work is over, and the Government remains committed to engaging with the community and acting on the Inquiry’s findings.”* I am grateful for that assurance. The Government’s response to the public consultation will be read anxiously in homes right across the whole UK, particularly by families whose lives were devastated by Hepatitis, hoping that this time people’s experiences have been given proper consideration and their voices listened to.

I also noted in the Additional Report on Compensation (on page 207) that more experience delivering compensation would almost undoubtedly reveal further improvements which could and should be made to the scheme. I therefore hope your assurance will extend to engaging with bodies representing the patient voice – such as The Hepatitis C Trust, who wrote to you just a week ago, and the solicitors providing legal support paid for by IBCA who have identified specific amendments that may need to be made to the regulations to correct what are likely to have been unintended consequences.

That said, the purpose of this letter is to notify you so that, formally, the Inquiry comes to an end on the date of this letter: 31 March 2026. The Inquiry has honoured its remit. However, there is a further purpose which this letter can fulfil.

John Glen MP, your predecessor in role, whilst drawing attention to the cost of the Inquiry, asked in Parliament this month whether you had had any conversations with me on when would be the right time to close down the Inquiry, and whether I had wider lessons about the way that public inquiries function. In keeping with the Inquiry's independence, we did not converse behind closed doors, but you replied that John Glen had highlighted *“a really important point about how we will learn lessons. It is really important to learn lessons about public inquiries, their length, and providing value for money going forward.”*

I consider that the Chair of a statutory public inquiry should be expected, at the end of an inquiry, to highlight significant features of its processes which may profitably be adopted by subsequent inquiries, to draw attention to improvements which can be made, and to make a useful contribution to the development of policy in respect of future inquiries. Since that is my view of what should happen generally, I should do the same myself. I am fortified in doing this by the fact that both you and John Glen MP have also recognised the importance of doing so.

I have done this by attaching an Annex which sets out my thoughts and observations.

I closed my letter to participants with admiration and respect for the courage of everyone who brought themselves to give evidence to the Inquiry, and for the way they supported each other in what has been a long fight for justice.

I trust that all those I have worked with on the Inquiry – whether as participants or as members of the Inquiry team, experts, and the British Red Cross – already know the very high regard I have for the way they have each, and all, collaborated in bringing a

hugely challenging and complex Inquiry to answer questions that went unanswered for four decades. I would nonetheless like, in this letter, to thank in particular the Secretary to the Inquiry, Jennifer Cole OBE – whose intellect and mastery of detail has rightly been described to me by one core participant as “awesome”; lead counsel to the Inquiry, Jenni Richards KC, whom I knew would be excellent in that role but who surpassed even my highest expectations (and they were very high); Emma Morris, at first a deputy and then Solicitor to the Inquiry who was rightly awarded the OBE in recognition of her work; and Catherine Nalty, who as Deputy Secretary was responsible for the highly important task of engaging with participants throughout the four countries the Inquiry covered, and whose tireless work enabled the Inquiry to become a collaborative endeavour rather than a battlefield. Each of them has gone “above and beyond”, giving freely of their time, unwavering and continuous in their dedication to resolving any issues, and a source of strength to me. Mary Sampson (just “Mary” to almost all, which speaks to her approachability), seconded from her role as (my) judge’s clerk, was invaluable in helping me in all and anything, and liaising with participants and staff.

I acknowledge here, too, the willingness of Government in 2017 to call, and thereafter to fund and sponsor, an Inquiry which it must have known might result in serious criticisms of governments past. It augurs well for trust in our democratic process that rather than suppress criticism as some other states may do, ours is prepared (albeit belatedly in this case) to inquire properly whether that criticism is justified, and be prepared to learn the lessons if it is.

Throughout the Inquiry I have not had any private discussion nor “back channel” with government, or the NHS administrations, because the Inquiry set out to be and was properly independent. Though I will not depart from my findings in the two Interim Reports, Inquiry Report and Additional Report, I am willing to be of continuing public service, in particular if needed to discuss any of the matters on which I reflect in the Annex.

Yours sincerely,

A handwritten signature in blue ink that reads "Brian J Langstaff". The signature is written in a cursive style and is underlined with a single horizontal line.

Sir Brian Langstaff

Annex: Reflections having chaired the Infected Blood Inquiry

To assist thinking about some of the procedures future public inquiries may choose to adopt, I address the following issues in this annex and conclude with a short synopsis:

- Principles
- Inquiries Act 2005
- Terms of Reference
- Time – and whether it should be limited
- Engagement
- Cost
- Judge led or not?
- Groups of Experts – or Assessors or Co-Panellists?
- Hearing room
- Innovative ways of ensuring people are heard
- Institutional core participants
- Recommendations of inquiries

Principles

A first point to make is that all inquiries are different – some deal with sudden disasters which are seared into the national consciousness (such as Grenfell, Manchester Arena, Piper Alpha); others focus on particular events limited by time or place or person (Mid-Staffordshire, Paterson, Shipman); some involve few people who are directly and personally affected (Edinburgh Tramways). Few investigate events and systems over a timeframe as long as that covered by the Infected Blood Inquiry (over 50 years), of such a scale (more than 3,000 deaths, and around 30,000 people being infected), across as wide a territory (the whole of the UK), involving as many core participants (over 2,000), and with a remit not only to consider what happened and why but also the reaction of successive governments and the NHS to what had occurred, including allegations of cover-up.

What worked for the Infected Blood Inquiry has to be seen in that light – some of its practices may be more appropriate to an inquiry with similar challenges of scale, timeframe and geography than to more closely focused inquiries which face different challenges.

Section 17 of the Inquiries Act provides that “... *the procedure and conduct of an inquiry are to be such as the chairman of the inquiry may direct*” (s.17(1)) but in making any decision as to the procedure or conduct of an inquiry “... *the chairman must act with fairness and with regard also to the need to avoid any unnecessary cost (whether to public funds or to witnesses or others).*”

Subject to that, the procedure and conduct of the Infected Blood Inquiry was based on six core principles which may be general to most inquiries:

(1) To put individuals at the heart of the Inquiry – people infected and affected were heard first (and not just in London but UK wide), and last.

(2) To be as quick as reasonable thoroughness permitted.

(3) To respect a person’s entitlement to be heard. “*The Inquiry recognises that people will bring different perspectives and all will be given a proper hearing.*”

(4) To be as open and transparent as it was legally possible to be.

(5) To be independent of Government and frightened of no-one in the conclusions it drew.

(6) To listen both to procedural suggestions from core participants and to the evidence and to give both proper thought.

Inquiries Act 2005

Though the 2005 Act is in my view fit for purpose when it comes to the day to day running of a statutory inquiry – especially in giving the flexibility to accommodate the differences between inquiries, recognising the dangers of “one size fits all” – it does not deal with any more precise identification of the circumstances in which there should be a public inquiry other than that “... *it appears [to the Minister] ...*” 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*” (section 1(1)).

Recommendation 11 of the Inquiry Report about *Responding to calls for a public inquiry* dealt with this and has been accepted in principle.

Terms of Reference

Nor does the Inquiries Act provide any detail of how terms of reference are determined, save to provide that they are set by the Minister. Terms of reference are critical. They are what give an inquiry the scope within which its powers can be exercised. The wider they are, the longer an inquiry is likely to take, and the more costly it is likely to be – though the public interest may necessitate that.

There needs to be sufficient time for consultation with people likely to be involved in an inquiry in advance of the terms of reference being set. What worked well for the Infected Blood Inquiry was consulting at this stage with a number of small groups of people with different reasons for wishing to be involved in the inquiry, and avoiding calling one single mass meeting of potential participants. I would caution against any such mass meeting to help to set terms of reference since it is unlikely to achieve much of detail or understanding.

The terms of reference I proposed to the Minister (then the Chancellor of the Duchy of Lancaster, David Liddington MP) were accepted as they stood. I believe that my listening to what different people had to say up to this point began a process in which most came to trust that the inquiry would approach its fact-finding with independence, and with integrity, having respected their entitlement to be heard. I consider it will usually be essential for chairs to consult meaningfully about terms of reference with the people most likely to have an interest in the forthcoming inquiry.

Time – and whether it should be limited

There may be inquiries in which an indicative time limit can be imposed. The larger and more complex the issues of public concern seem to be, the more forgiving should be the approach on time. An inquiry is almost certainly called because of what is unknown. If the answer an inquiry is called to find were obvious, or the issue were one more properly for debate than investigation, there would be no need for an inquiry at all. In principle, it is very difficult to determine how long it will take to discover the as yet unknown, especially if it is an “unknown unknown”. Early estimations of how long an inquiry may take rarely allow long enough.

A real-life example of how longer time may help was given by the experience of our Lead Investigator, who had previously worked on the AI-Sweady Inquiry where time to investigate was imperative for the truth to emerge. In the Infected Blood Inquiry itself, a large further cache of documents from the DHSC’s electronic archives came

to light more than three years into the Inquiry and further boxes of documents a year later; so too did a personal archive of documents relating to litigation in the US. The trust (and publicity) that the Inquiry had by then built up significantly contributed to the latter source coming forward.

There should, however, be no doubt that a statutory public inquiry will take some time. Time taken in preparation for hearings is essential if time and quality overall is not to be lost, for example by witnesses having to be recalled later where further questions emerge, or if preliminary conclusions are expressed which then have fundamentally to be reconsidered. In the case of Infected Blood this stage took some nine months.

An inquiry will take longer still if a chair does not sit alone, but with a panel – a point I will come back to.

Where an inquiry is document heavy, as was mine, documents will have to be disclosed on a rolling basis to participants – but on each occasion, they have to be checked to make sure that there is no inadvertent breach of data protection provisions. They need to be disclosed to core participants sufficiently in advance of oral hearings for them to be able to contribute meaningfully to the questioning, as is their entitlement. Obviously, at the start of an inquiry this process is slow – the inquiry will not yet have scheduled its hearings, and cannot sensibly do so until it has a reasonable overview of what documents are likely to be most relevant.

Applications for core participant status, for anonymity (where sought), for being excused appearance orally where there was good reason, for issues relating to documents and their disclosure all take time to determine, and were all issues on which I had to make the decision. So it is inevitable that setting up an inquiry even before it gathers much evidence will take time. Before the terms of reference were agreed and the Inquiry officially started, I had determined how we would approach various issues (we issued “Statements of Approach”, a wording which I commend to other inquiries as being more meaningful and accessible than “Protocols”, so that all involved knew how we intended to deal with these issues).

As to time taken to hear oral evidence, we saved time, and provided a certainty of timetabling which few courts can provide, by sitting for as long in a hearing day as it took to complete the oral evidence of a witness (where it was scheduled to end that day). Witnesses generally accepted this, rather than wishing to return on a later occasion.

If an interim report is made, it takes time. It has to be considered, written, referenced and be subject to the requirements of the Inquiry Rules 2006, rules 13-16 (notifying anyone who is criticised specifically, or impliedly subject to substantial criticism, so that they have a fair chance of explaining or rebutting what might be said). Preparing one takes time out of the hearing room. Yet time itself may demand that there be such an interim report – the First Interim Report of the Infected Blood Inquiry recommending interim payments had to be made if people (many of whom were very ill) who were highly likely to receive compensation eventually were to receive interim payments without unreasonable delay. Similarly, the Second Interim Report followed the government’s acceptance that there was a moral case for compensation, yet its continuing delay to establish a structure to deliver it. Both took time: but both made recommendations about what needed to happen without waiting for the final report.

In the case of every report, time was allocated for core participants to make submissions to me as to what my findings should be. In the case of recommendations, participants were invited nearly a year before the Inquiry Report was produced to suggest what recommendations it would be appropriate for the Inquiry to make, and hearings were held for these suggestions to be explored and discussed. Taking time to consider what recommendations are appropriate, have a clear purpose, and are deliverable is vital if an inquiry is to deliver recommendations which will work and benefit the public.

Some inquiries may split between fact finding (Part 1) and considering recommendations (Part 2), as the Bristol Royal Infirmary Inquiry did. Others may operate in a modular way (such as the Manchester Arena Inquiry and UK Covid-19 Inquiry) producing reports after each element.

I recommend that unless an inquiry lends itself to a modular, or institution-by-institution approach, time will be saved if interim reports are generally confined to recommendations to which effect should be given there and then (such as in respect of public safety), without waiting for a final report.

Finally, the eventual writing up of a report, referenced so that the underlying source material is clearly identified, will inevitably take time in the drafting. It may then have to be adjusted to allow for the responses of people who are criticised in the draft. They must be given a reasonable time to consider and respond to what has been said in draft; time must be taken to consider any response properly. This process

can add months to the overall time taken by an inquiry, but is essential if the findings are to be fair.

A procedure adopted by the Infected Blood Inquiry helped in some cases to shorten the amount of time that would be reasonable to allow those criticised in draft to respond. It published written statements in batches throughout the Inquiry. Where any such statement contained a significant criticism of a third person (explicitly or by implication) that person was notified before the initial statement was published, so that if they wished to make a response that response could be published alongside the initial statement. If the initial statement was made by someone seeking anonymity, it was made clear that the person criticised would be told of the identity of their critic, for it would be unfair to ask a person to respond to criticism from an unknown person. The maker of the initial statement could maintain or withdraw the criticism in the light of the response, before publication. This procedure helped to let individuals who were criticised in similar ways in a number of statements know the nature of any more generalised criticism that might later be made by the Inquiry in its report – such that their time for responding to such a criticism could reasonably be shortened. However, though it was the correct approach to ensuring as level a playing field between critic and criticised as possible, it saved less time than I had hoped. This was because the criticisms made in the Inquiry Report to which individuals or institutions were asked to respond were more often of a systemic, overarching nature, and a judgment had to be made in each case as to the amount of time which it would be reasonable to give to them to answer such a criticism, which inevitably had a different force to criticisms arising out of individual interactions. If future inquiries adopt a similar approach, in the expectation it will save significant time, they may be disappointed: though in my view this process still has the advantage of fairness. More time was saved by ensuring that significant criticisms were explored in oral evidence which helped not only to be fair but also to provide advance notice to a witness of potential criticism, and to understand what their response was

Though I know there has been some comment that the effect of rules 13 - 16 is to build in a delay in producing a final report, and that that delay may be substantial, fairness demands that anyone criticised in an inquiry report should have a fair opportunity to respond to that criticism and to answer it, if they can. I can see no easy way of lessening this delay before final publication of a report without causing substantial unfairness: and it would prejudice the authority of a report if it were to appear to be unfair. An inquiry, however, does not have to engage in back and forth correspondence about criticisms in order to be fair. We chose not to do so (and

made this clear in my statement of approach), which was perhaps key to containing the amount of time the process took in the case of the Infected Blood Inquiry.

In practice, there are tensions between time and thoroughness, and time and fairness. As to the first of these, justice is not served by waiting an inordinate time (for instance while overturning even the smallest stone, so that none is unturned) but by getting an answer in a reasonable time and at reasonable cost in money and resources.

For these reasons, I think it would be a mistake to impose a time limit on most inquiries. There should instead be an expectation that the inquiry is as quick as reasonable thoroughness permits. Nonetheless, for some inquiries with a more limited remit an indicative time limit could be given and kept under review. An inquiry may nevertheless be asked at intervals to explain what work has been taking up its time during the period since its previous update. In practice, the Infected Blood Inquiry did this, largely by an engagement practice in which meetings were held in different parts of the country (so that one would be reasonably accessible without causing difficulty, expense or time in travel to its location) at which inquiry progress could be discussed, and questions about it answered. Keeping participants informed and involved is key to managing expectations about progress.

Engagement

Engagement in a long inquiry is critical. In our Inquiry our engagement team travelled the country. The meetings they organised gave people in that general location an accessible opportunity to hear from the Inquiry team, have their questions answered, meet other people participating in the Inquiry and share reflections with one another about the evidence. During Covid these meetings moved online, and afterwards we retained some online meetings since this meant more people could participate. The British Red Cross team supported the Inquiry throughout, recognising that sometimes it can be easier to talk to a qualified and caring stranger than to family and friends. They provided face-to-face support to over 5,000 people as well as providing a confidential support line. An indication of the value of engagement to participants is given by the fact that after the then government's response to the second interim report, the engagement team met 600 people in 17 cities in three weeks.

I also regarded it as important to explain the Inquiry to the public. After all, a **public** inquiry is called for, and in the interest of, the public. The work of the

communications professionals in the Inquiry team who assisted in presenting the findings and recommendations to the public, particularly when the Inquiry Report was published on 20 May 2024, was central to this.

Cost

A criticism of public inquiries is their cost, in particular fees for the legal profession.

A central question relates to “cost benefit”. An inquiry has at least two functions. It will find facts – what happened, and why, to cause the event, practice or process that has been the centre of concern. And, if it finds that something has happened which should not have occurred, the inquiry should make recommendations to prevent or lessen the risks of it, or something like it, happening again. It may also provide catharsis and even closure for some participants, though that may be a side benefit rather than a purpose.

Very generally, the greater the adverse effect on people caused by the matter of concern, the more important it is likely to be for many people to learn what happened, and why and for action to be taken to minimise the chances of recurrence.

It would follow in purely financial terms that if an inquiry, albeit at significant expense, can make recommendations which are effective to minimise recurrence it is likely in the long run to save considerable sums of money. The benefit of inquiries is, however, not merely to be judged in financial terms. There is a value to be placed on helping people – and the general public – to understand what happened, and why; there is a value in helping to avoid future pain and distress to individuals from a similar recurrence. It will in many cases bring justice, and sometimes closure, to the people to whom it relates. But importantly it will operate as part of a system, reflective of a mature democracy, by providing a form of justice where other means cannot. This can help citizens to trust in a state which, when it seems that things might have gone wrong, does not wrap itself in denial, nor hide behind the costs and difficulty those citizens might otherwise have in bringing it to account, but is prepared to expose whether wrong has been done, and how and why it came about.

It would be a great pity if concern about the money received by lawyers during the process obscured the utility and advantages of inquiries, and led to them being seen as profiting lawyers rather than as an important part of securing a just and accountable democracy.

That said, there are means of keeping lawyers' costs well within control. The Infected Blood Inquiry set up a system of cost budgeting, which meant that the Inquiry had a tight control on legal costs and was able to forecast them with great accuracy. Lawyers for core participants funded through the Inquiry were not paid for work unless it was pre-authorized by a cost award (a budget) and they had to remain within that budget issued for a specific piece of work and claim within 21 days after the month in which the work was completed. All bills were scrutinised by a specialist cost lawyer.

Lawyers funded in this way were paid at public service rates (substantially less than commercial rates usual in the legal marketplace).

I should note, too, that Solicitors to the Inquiry were recruited from the Government Legal Department, or service with other public authorities, rather than utilising the services of solicitors who specialise in offering services under contract to service inquiry work.

Judge led or not?

People often ask for a judge-led statutory public inquiry because they want that inquiry to have the power to compel witnesses and evidence. I suspect that many have in mind that a judge will be independent, will have greater experience in evaluating evidence than many others, and that their appointment will emphasise the seriousness of the proceedings. Judges are also likely to have experience of dealing with a mass of documents, and reconciling them with oral or written testimony. Participants may expect a judge to be truly impartial, and that they are able to understand and deal with many aspects of expert evidence even though not themselves being truly expert in those areas.

A danger may be thought to be that a judge may naturally incline to treat an inquiry as if it were a court. It most definitely is not. A court case has parties; one side will make a case, the other will rebut it. Judges choose between the rival cases, rather than determine for themselves what the truth is. An inquiry has participants, each of whom may have their own unique perspective – inquiry panels do not choose between them, but draw their own conclusions as to where the facts lie. The parties in a civil court case have a private interest in the outcome: the core participants in an inquiry have an interest in the outcome which goes beyond a private, personal one: it is the public interest. In a sense, the public are the client of an inquiry. There may be a risk that judges are wedded by their courtroom experience into thinking that an

inquiry is a version of the same. But courtroom approaches to layout, hearing evidence, relating to participants, etc., do not need to apply to an inquiry. Further, whereas the parties to litigation conduct their own research and appoint their own expertise to assist them, and produce the documents to the court that they consider relevant in advancing or telling against their respective cases, those roles fall to the inquiry itself. Participants do not conduct the investigation: the inquiry does.

Groups of Experts – or Assessors or Co-Panellists?

A drawback of judges as sole decision makers is that though they may have picked up significant familiarity with subject matters (such as, say, medicine or healthcare) in the course of their practice, or when sitting on the bench, they are not true experts in them. The 2005 Act provides for the possibility of panel members, and/or assessors, being appointed to provide the expertise that a chair alone might lack. In some inquiries, that may be sufficient. In larger inquiries, such as Infected Blood, where there may be a number of different areas of expertise to consider, there is room for an innovative approach.

Several discrete areas of expertise were relevant in the Infected Blood Inquiry. I used groups of experts to advise openly, giving evidence orally in panels, rather than as co-determining panel members or assessors. I did so in order to ensure that all the expertise provided to the Inquiry was transparent and subject to scrutiny, and to meet concerns that had been expressed in the consultation on Terms of Reference that there had been a cover-up, a lack of openness and candour, and that the Inquiry might be a whitewash. I did so also so that diverse experts would be encouraged to participate and take forward the recommendations.

When the Terms of Reference were agreed, I wrote to people who had been infected or affected to explain this in these terms:

“Two themes emerged clearly from the consultation: first, that many were concerned that the Inquiry should report quickly. Second is a strong suspicion that Government, officials, public organisations and the medical profession have tried to cover up what has gone on, have knowingly failed to share information about life-threatening infections, and have failed to support the people affected and their families.

Timing, transparency and openness are therefore key. Selecting a small number of experts with their own particular views to sit on a panel would not do

justice to the complexity of this Inquiry. Their input would be given privately and not be subject to challenge by participants, or for that matter by other experts who think differently. And an Inquiry panel must all hear the evidence together to satisfy natural justice – no jury can consist of two parts, each of which hears only half the evidence – and so having panel members would not allow the work of the Inquiry to be pursued in parallel tracks, and indeed experience indicates that having panel members lengthens an inquiry.

A better solution than appointing panel members for this particularly complex inquiry is open to us. To help get to the truth of what has happened in the most transparent way possible, I will be appointing groups of experts covering all the relevant fields, including ethical, clinical, psychosocial, statistical and public administration. The questions that the groups of experts consider will be informed by your experiences. Their reports will, as evidence, be fully open, accessible and transparent. Where there are disagreements among the experts, these will be tested, explored and challenged openly in the public hearings. This means that everyone will be able to see what expert input is given to me. If you wish, you can nominate experts for my consideration and propose questions to the groups of experts through the Inquiry team.”

The Inquiry received – and published – expert reports from around 70 experts in the following groups: psychosocial (three reports), hepatitis (three reports), HIV, blood and bleeding disorders, medical ethics, fractionation, public health and administration, statistics (two reports) and health economics.

I believe that using groups of experts in this way, coupled with the giving of oral evidence arising from their reports, in panels drawn from the expert groups, was an important factor in the regard people have had to the Inquiry and its findings.

Using expert groups also prevented the additional delay having a panel would involve. All panellists would have had to be present throughout; illness and unavailability would have to be accommodated; and time would have to be allocated for discussion and co-authorship, as well as coordinating the panel’s responses to issues as they arose.

Hearing room

At the preliminary hearings I said:

“The hearings will not be in a courtroom ... This is an Inquiry. It is not a court case. Much as I welcome legal representatives, and I do, it is not a trial, whatever it may lead to later. It is not run for the benefit of lawyers, but for people who are involved. So, the hearing room will be designed so that there won't be ranks of lawyers in the front row, obscuring the view of the public, who need to hear, the people who have been infected, affected, those concerned, those touched by the Inquiry. My aim is to have lawyers to one side, press to the other and members of the public in front of the witness, who will take centre stage, as the witness should.”

Throughout, I sat to one side, and the press to the other or at the back – but otherwise it was as these words foreshadowed. I thought it an important principle that since a public inquiry is, as the very name suggests, conducted in and for the public interest, the public should be at the centre of it.

Although the arrangement of a hearing room might be thought largely symbolic, I think in retrospect that it significantly helped to create an atmosphere in which people did not expect to be adversarial, as in a court room; participants felt included and listened to rather than marginalised; and it helped to establish a collaborative approach to finding the facts.

A sense that the process was not one in which people who had reason (as it turned out) to be distrustful of authority should nonetheless show repeated deference to it was augmented in our case by it being made clear that people present in the room were not expected to stand when I entered, or left. My principal reason for this was that it would have been cruel to insist that many people who were in ill health should stand, but subsidiary ones were that it drew a distinction with a court, and illustrated my view that respect for the Inquiry's proceedings was something to be earned rather than to be expected as a matter of course.

I think that future inquiry chairs might want to consider what physical arrangements in respect of their hearing rooms will best suit the needs of their inquiries, given that an inquiry is not a court.

Innovative ways of ensuring people are heard

Many people told the Inquiry that the stigma attached to their experiences meant they would have difficulty in providing witness statements or oral testimony in the traditional way associated with public inquiries. Accordingly, the Inquiry recruited

three trained professionals to act as “intermediaries” and adopted a new approach to evidence gathering. The intermediaries visited those who requested their support, and later submitted summary reports to the Inquiry covering a number of people’s experiences, without revealing their identities. These did not identify the people spoken to but summarised the common experiences of the people infected and affected. The accounts were read by me and my team, published with the rest of the evidence, and the intermediaries were asked to speak during the Inquiry’s hearings.

I told participants that:

“The work of these intermediaries will be especially appropriate for anyone who does not wish to take the time to give a full detailed written account or who may find that process too upsetting for all sorts of reasons. It would be a pity if what they had to say remained unheard and I wanted the Inquiry’s processes to enable them to be heard, despite those difficulties.

The intermediaries will be their voice to the Inquiry and be able to present a narrative account of their findings once they have seen all of those who wish to contribute in this way. It will also allow those who may only wish to contribute one or two points or who have limited knowledge of their or their family’s experiences to play a part in the Inquiry.”

102 people used the intermediaries to add what they had experienced to the material available to the Inquiry. The use of intermediaries may be useful to other inquiries if some of the people they involve find it exceptionally difficult to reveal their personal experiences in more conventional ways.

In order to capture experiences in particular areas people giving oral evidence were heard in groups (panels): this enabled the essence of what they had to say being heard in a shorter time-scale, whilst allowing differing experiences to be compared and contrasted, or consolidated, at one hearing.

Institutional core participants

Learning from an inquiry should not need to await the final report, if good can come sooner by applying some of those lessons.

In Volume 7 of the Report, on the Government Response, I wrote:

... although the Government has admitted that wrongs have been done – the Department of Health and Social Care was clear at the outset of the Inquiry that this was the case – it does not yet appear to be clear what lessons it has learned, or sought to learn, from the history it now accepts. It has said that “DHSC ministers and the wider Government will, in due course, react to the Inquiry’s findings and recommendations but it has not wished to pre-empt that process by offering opinions now.” By contrast, the Blood Services, in particular SNBTS, and the Scottish Territorial Health Boards, have sought to learn during the Inquiry process. Professor Marc Turner, SNBTS Director, wrote their final submission with the assistance of the SNBTS senior management because “it was important that the organisation speak as directly as possible, not only to the infected and affected but to everyone affected by and having an interest in SNBTS’s work.” The submission for the Scottish Territorial Health Boards had significant input from the Boards.

These are two different approaches. Since before the Piper Alpha disaster in 1988, and with renewed vigour since, industries that have suffered catastrophic safety failures have sought to learn lessons rather than waiting for the outcome of external investigation. For future inquiries that are not purely historical (as this is not) I suggest that the Government’s position should be, not only to support an inquiry’s independent work as the Government has done in this case, but to seek to learn lessons from the moment a disaster is recognised.

I stand by those words. In their preparations for the Hillsborough Law, Government Departments and public bodies may find the approach of SNBTS and the Scottish Territorial Health Boards to the final submissions of this Inquiry instructive.

Recommendations of inquiries

I have already reflected on the sparseness of the provisions of the Inquiries Act 2005 when it comes to whether an inquiry should be called, and how best its terms of reference may be drawn up. Though the Act and the 2006 Rules which followed are fit for purpose during an inquiry, providing flexibly for an inquiry to respond to the particular concerns it is asked to address, there is another deficit in the statutory provisions when it comes to the end of an inquiry, and Government responds to the report. What, then, of the recommendations? There is no legislative provision as to follow-up.

I dealt with this in Recommendation 12 of the Inquiry Report, which has been accepted in principle.

I would urge chairs of inquiries to have in mind from the start of an inquiry what recommendations might follow, recognising that they must consider all the evidence and submissions. Recommendations are an integral part of an inquiry's purposes, and not an afterthought or add-on. I favour a small number of recommendations specific to certain purposes – a recommendation should always seek to achieve a specific end, about which it is clear; and the greater the number of recommendations, and the more scatter gun the approach, the less likely it is that government, interested people, the media, expert commentators will follow up on implementation or be concerned about their rejection of certain of them.

They should have a clear rationale, following from the findings of fact eventually made. It should be clear to whom in particular they are addressed.

I think that it is helpful, too, if (wherever appropriate) recommendations include a metric by which the success of the recommended measure in righting the deficiency it addresses can be judged. The question “What does success look like?” is, after all, closely related to asking what the recommendation aims to achieve. It allows for audit – does the recommendation in practice produce the desired effect, or should it be adjusted? And, if adjusted, how has that worked?

It will be easier in many cases to know if some recommendations have been put into effect. In other cases it is more difficult. I acknowledge, here, that the Government accepted all the recommendations in the Infected Blood Inquiry Report, but some “in principle”, for just this reason.

It will be important to continue to update the public on the progress implementing the recommendations of this Inquiry, whether through the online dashboard – though an eye may have to be kept on whether reports of progress which are reflected there accurately reflect experience at grass-roots level – or by setting up a national oversight group that meets regularly, includes patient representatives and people with lived experience and publishes minutes as the Scottish Infected Blood Oversight and Assurance Group does

Summary

A short synopsis of these (selective) reflections is:

- The Inquiries Act 2005 is fit for purpose for the conduct of an inquiry, though it leaves gaps as to the start-up and follow-up processes.
- Subject to statutory provisions, inquiries ideally proceed by principles appropriate to their subject matter.
- I welcome the Government's acceptance in principle of Inquiry Recommendation 11 about responding to calls for a public inquiry and the commitment to provide a further update to Parliament.
- Terms of Reference are critical. Before being set, they should be carefully consulted on with people most closely affected.
- A time limit should not be imposed but, rather, inquiries asked periodically to report on progress. Nonetheless, for some inquiries an indicative time limit may be given and kept under review.
- Inquiry procedures may help reduce time spent.
- Interim reports will take time, so should be used mainly where interim recommendations help to avoid any dangers which may arise before a final report.
- Engagement, keeping participants informed and involved, is critical in most inquiries.
- An inquiry has utility and advantages which have a real value. It would be a great pity if concern about lawyers' fees obscured these: but in any event, limiting lawyers' costs by restricting their work at public expense within limits by pre-authorising and pre-specifying any work within a set budget keeps costs under control, and paying at public service rates further limits total cost.
- There are pros and cons to the appointment of a judge as chair, but their absence of expertise in the particular subject matter can be met in larger multi-factorial inquiries by using groups of experts in relevant disciplines, who report openly.

- An inquiry is emphatically not a court, though it may be considered part of a system of justice.
- The physical arrangement of a hearing room may help towards involvement of participants in the process of an inquiry.
- The use of intermediaries to give a voice to people who would not otherwise be heard works.
- So too does hearing a number of witnesses together as a panel.
- Institutions do not need not await an inquiry's final report to learn from what has happened.
- Recommendations should have a clear aim, not be too many in number, They should aim to be deliverable, and to help achieve that it is useful to invite submissions from core participants well in advance of making them.
- Follow up of recommendations is ideally within Parliament, though may be informed by a system such as the Scottish Infected Blood Oversight and Assurance group.
- As I wrote in my letter to you, transparency, involvement, listening rather than simply hearing, recognising (and remedying) injustice and truly valuing people were central to the work of the Infected Blood Inquiry, and they may prove to be so to other inquiries too.

I am, as I said in my letter, happy to amplify any of these points, or deal with others, if you think it would be useful to you or the public.